Societal Perceptions and Attitudes towards Disability, Sexuality and Pregnancy of Disabled Women from Kibra Sub County, Nairobi

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DECLARATION

I, the undersigned, declare that this thesis is my original work and has not been presented for academic award to any university other than Tangaza University e. All sources have been fully cited.

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DEDICATION

This dissertation is in memory of my late parents, Benson Franklin David Otieno and Margaret Atieno Jagero, for their invaluable support during my formative years, especially regarding my education. They ingrained in me the values of honesty, integrity, and curiosity.

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ABSTRACT

Despite the existence of robust global and national frameworks, such as the Sustainable Development Goals, Convention on the Rights of Persons with Disabilities, and Kenya Persons with Disabilities Act, which promote disability inclusion, disabled women in Kenya still face prejudice and stigma in society. The purpose of this study was to examine societal attitudes and perceptions toward the disability, sexuality, pregnancy, and childbirth of disabled women in Kibra, Nairobi. The study utilized the critical disability theory and the Utu conceptualization of disability to understand how attitudes and perceptions contribute to the (de)stigmatization of disabled women. A convergent parallel mixed method design was employed in the study, and fourteen disabled women were interviewed using an interview guide. A perception questionnaire and an Attitude Towards Disabled Persons (ADTP) tool were also administered to 420 non-disabled women and men and 145 healthcare staff. The study findings cited birth complications (37.1%) and genetic factors (40.2%) as the most common cause of impairment. The majority of respondents believed that disabled women have normal sexual organs and feelings, that they can engage in sexual relationships, that they can become pregnant, and that their pregnancy is not unusual. The findings also show that to overcome negative societal stigma and prejudices, disabled women adopt aggressive behaviour, avoidance, self-stigmatization, and solidarity with one another. Non-disabled women and men had a combined mean ATDP score of 117.55 (SD = 24.21), with scores ranging from 26 to 174. The average ATDP scores for females (118.76) and males (116.36) were higher than the suggested threshold values of 110 and 113, respectively, indicating a high positive attitude toward disabled people. Except for gender and age group ($p > 0.05$), all sociodemographic characteristics for non-disabled women and men were statistically significant for positive attitudes toward disabled women. The mean ATDP score for healthcare workers was 118.77 (SD = 19.25), with the highest and lowest values being 54 and 165, respectively. Only the health facility type ($F(3, 141) = [3.517]$, $p = 0.017$) was statistically significant for healthcare workers attitudes. The mean ATDP differed significantly between public and private healthcare facilities ($p = 0.017$, 95% confidence interval = [-38.38, -2.66]). Eliminating beliefs, attitudes, and actions that perpetuate and sustain prejudice and stigma against disabled women is essential to enhancing their agency, social standing, dignity, and human rights. This is possible through applying Utu principles and values like interconnectedness, interdependence, tolerance, fairness, solidarity, respect, compassion, and self-sacrifice.

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LIST OF ABBREVIATIONS AND ACRONYMS

ANSD	-	Agence Nationale de Statistique et de la Démographie
ATDP	-	Attitude Towards Disabled Person
CHWs	-	Community Health Workers
CRPD	-	Convention on the Rights of Persons with Disabilities
CS	-	Caesarean Section
FBO	-	Faith-based Organizations
FGD	-	Focus Group Discussions
GOK	-	Government of Kenya
HR	-	Human Rights
ICESCR	-	International Covenant on Economic, Social and Cultural Rights
ICF	-	International Classification of Functioning, Disability, and Health
IDI	-	In-depth Interviews
KIHBS	-	Kenya Integrated Household Budget Survey
KNBS	-	Kenya National Bureau of Statistics
MOH	-	Ministry of Health
NCPD	-	National Council for Population and Development
NGO	-	Non-Governmental Organization
NISR	-	National Institute of Statistics of Rwanda
SDGs	-	Sustainable Development Goals
UDHR	-	Universal Declaration of Human Rights

UN Women - The United Nations Entity for Gender Equality and the Empowerment of Women

WHO - World Health Organization

WWDs - Women with Disabilities

ZIMSTAT - Zimbabwe National Statistics Agency

OPERATIONAL DEFINITION OF TERMS

Ableism - refers to discrimination or social prejudice against disabled people, manifesting as beliefs, perceptions, attitudes, and actions that devalue their humanity, potential and agency.

Asexual - believe that disabled women lack sexual agency and sexual desires and are not capable of engaging in sexual relationships.

Attitude - an individual's thoughts, feelings, behaviours, or actions regarding disability and disabled women.

Desexualize - depriving disabled women of their sexual identity, expression, desires, and agency solely on account of their disability.

Disability - physical, communication, and social barriers resulting from the interaction of disabled women and their environment.

Disabled women - women who are physically, visually, and hearing/speech impaired, as well as with albinism, and facing difficulties towards their full integration and participation in society.

Healthcare workers - staff and auxiliary volunteers linked to a health facility. They are classified according to their specific roles.

Hearing/speech impaired woman - a woman with functional limitation, hence the inability to hear any sound.

Impairment - functional difficulty experienced by individuals in their body, mind, or both.

Informal settlement - illegal, uncontrolled, or unplanned dwelling, shelter, or settlement with limited social services and with insecure tenure.

Perceptions - how individuals collectively interpret and comprehend information as well as societal beliefs about disability and disabled women.

Physically impaired woman - a woman with functional limitations, such as the inability to move or undertake certain activities without assistance due to impairment.

Speech-impaired woman - a woman with functional limitations, hence the inability to speak using the mouth and tongue.

Visually impaired woman - a woman with functional limitation, hence the inability to permanently see and condition of partial visual loss.

Woman with Albinism - a woman whose skin is affected by loss of pigmentation due to a lack of melamine in her body.

CHAPTER ONE: INTRODUCTION

1.0 Introduction

The present chapter establishes the fundamental basis for this study. It briefly discusses the insertion and its influence on the choice and focus of the study. The insertion illuminates the life and tribulations of Jane (not her real name) as representative of the predicament of disabled women concerning their disability, pregnancy, and childbirth. The researcher also examines key disability constructs and models, as well as disability prevalence at the global, continental, and national levels. Furthermore, the chapter briefly covers the circumstances that disabled women experience as a result of their disability, manifested by prejudiced societal behaviours and attitudes. The chapter discussed the problem statement, the main objectives, and the questions for the study. The chapter, in addition, highlights the significance of the study with a key emphasis on sustainable development goals. Finally, it also focuses on the scope and delimitations of the study.

1.1 Insertion

Jane (not her real name) is a physically impaired middle-aged woman who has lived in Kibra her entire life. Born to casual labourers, Jane never had the opportunity to attend school, and several factors contributed to this predicament. As a disabled child, her parents saw no need to send her to school. They viewed her disability as something unusual for the family and the community and believed that it would be better for her to stay at home. Furthermore, her parents were impoverished, and the family lived from hand to mouth, making it out of their reach to raise money for school fees and uniforms for her and her siblings. Even if there was money to send one of the children to school, her male siblings would be prioritised.

Our paths crossed with Jane during one of the human rights clinics organized by Amnesty International in Kibra with community members, focusing on maternal health rights. Additional clinics also took place in the informal settlements of Mathare, Korogocho and Mukuru, all in the eastern suburbs of Nairobi. Reaching over 2,300 community members, the clinics facilitated awareness of human rights issues and provided an opportunity to hear stories and experiences of inequities in maternal health. Mothers from these communities shared their labour and delivery experiences in public and private health facilities, shedding more light on the issues facing the Kenyan maternal healthcare system.

Back to Jane: I noticed two things about her during the meeting in Kibra. She was on crutches and was overtly quiet in all sessions. However, she seemed troubled by the sad tales expressed by other women about their maternity experiences, and this was evident from her body language. I prompted Jane to join the conversation, and she shed tears and could not speak. During the break, I approached her and inquired why she had cried, and she confided about her previous horrible experience during her pregnancy and delivery at a local health centre. My encounter with Jane was a revelation and raised my curiosity about the specific challenges women like her faced regarding pregnancy and childbirth.

After encountering Jane, I organized forums with disabled women in collaboration with a women's disability organization with roots in Kibra. The forums facilitated interactions and conversations on critical challenges faced by Disabled women. They emerge as a substantial vulnerable population that endures neglect, ostracism, and marginalization. From the conversation and interaction with disabled women, it is apparent that they are overlooked, unaccounted for, and stigmatized over sexual and reproductive health issues, despite the Sustainable Development Goals (SDGs) clarion call to "leave no one behind".[1]

The conversations with Jane and her colleagues gave rise to the idea of this study, which sought to explore societal perceptions and attitudes towards the disability, pregnancy, and childbirth of disabled women. The researcher had specific interests in documenting women's perspectives and individual experiences and the attitudes and perceptions of healthcare workers and non-disabled women and men.

1.2 Background to the Study

The global disability prevalence is estimated to be 15% of the adult population, representing a conservative figure of one billion people worldwide based on WHO projections (World Health Organization & World Bank, 2011; Vos et al., 2020). The United Nations Women's Agency estimates that more than 19% of women globally experience some form of disability. Disabled women are a significant population that cannot be ignored (UN Women, 2007). The insufficient collection and analysis of disability-specific data by the majority of population-based national surveys in Africa and narratives around impairments present challenges in accurately determining the prevalence of disability in the region (Mulwafu et al., 2016; Amosun et al., 2019). However, it is estimated that the prevalence of disability in Africa is around 10% of the total population, with the possibility that the percentage could

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[1] The Sustainable Development Goals framework includes a principle that upholds the inclusion, integration, and de-marginalization of every person, regardless of their background, characteristics, or circumstances. In the context of the study, removing environmental, structural, and attitudinal barriers to disability can extend the benefits of global development initiatives such as health and education, to disabled women.

reach as high as 20% in economically disadvantaged sub-regions (Vanderschuren & Nnene, 2021). In the sub-Saharan African (SSA) context, there is limited difference in the prevalence of disabilities between females and males, as evidenced by data from Rwanda (national = 5%; female = 4.8%; male = 5.2%), Zimbabwe (national = 9.1%; female = 9.9%; male = 8.2%), Senegal (national = 5.7%; female = 6.1%; male = 5.4%), Morocco (national = 5.1%; female = 5.1%; male = 5%), and South Africa (national = 7.5%; female = 8.3%; male = 6.5%). (NISR, 2012; ZIMSTAT, 2017; ANSD, 2014; Ministère De Développement Social, 2014; Statistics South Africa, 2014)

Projections from Kenya on the prevalence of disability are varied and valid for the data collection period and methodology. The Kenya Integrated Household Budget Survey indicates a disability prevalence rate of 2.8% in Kenya but does not provide gender-disaggregated data (KNBS, 2019). Disabled individuals comprise over 4.6% of the Kenyan population (NCPD, 2008). Disabled women represent around 4.6% of the population, and the figure for men stands at 4.5% (NCPD & KNBS, 2008). The survey also reports that at least 43% of Disabled women have become pregnant in their lifetime. The 2009 census reported a combined disability prevalence rate of 3.8%, putting the specific rates for males at 3.7% and females at 3.9%, respectively (KNBS, 2010). On the other hand, the 2019 Kenyan census estimates that the disability prevalence rate is 2.2% of the total population, which is around 900,000 individuals who may have at least one type of disability. The estimated percentage for disabled men and women is 1.2% and 2.5%, translating into more than 600,000 and 300,000 individuals, respectively (KNBS, 2019). Kenya's actual disability numbers may be greater than recorded, and significant stigma around disability and data gathering issues hinder the accuracy of the data. The prevalence of disability is higher in females than in males, according to all available data sets. However, the data contains no specific information on the pregnancy or childbirth challenges experienced by disabled women.

The adoption of the Sustainable Development Goals by world leaders in 2015 was a decisive moment in the push to confront enduring problems associated with poverty, deprivation, and indignity. Their commitment to "leave no one behind" reflects their collective endeavour and aspiration to ensure equal opportunities for all individuals to access the benefits of development, regardless of socioeconomic background, gender, race, religion, and other social identities (United Nations, 2015). There was recognition and admission by world leaders, both implicit and explicit, that the dominant development paradigm was responsible for the widening wealth gap between states and individuals, worrying health indicators, particularly in developing economies and excluding marginalized populations such as disabled persons. According to Stuart and Samman (2017), three crucial elements are associated with the "leave no one behind" approach. These elements include eradicating extreme poverty in all its manifestations, confronting inequalities, and tackling discriminatory obstacles that may arise due to geographical or social factors. They argue that the principle of 'leave no one behind' requires meeting the basic requirements of societies and enabling disadvantaged individuals and groups to make progress faster than those who are more privileged. Buzeti et al. (2020) emphasize that to address inequality and marginalization and put the "leave no one behind" principles into action, it is crucial to recognize and transform the deeply entrenched and interconnected systems of oppression and domination that perpetuate and reinforce them. These systems encompass economic, social, and political systems, governance structures and corporate behaviour and practices.

The fifth Sustainable Development Goal aims to attain gender equality and enhance the empowerment of women and girls worldwide. The SDGs include various targets, but those explicitly addressing the issues of sexual and reproductive health rights as well as discrimination are centred around the objectives of eliminating discrimination against all women and girls globally and guaranteeing universal access to sexual and reproductive health services and rights (Leal Filho et al., 2022; Odera & Mulusa, 2020; Sen, 2019; Hirway, 2018). Although the targets do not specifically mention the sexuality or pregnancy of women with disabilities, these targets are transformative and essential for addressing the unique difficulties that these women encounter concerning their sexual and reproductive health and rights. There is direct and indirect recognition that women with disabilities deserve equal entitlements to bodily autonomy, sexual well-being, and reproductive decisions, similar to all other women (Rade et al., 2023; Beninger, 2021; Hameed et al., 2020).

Generally, at the global level, societal perceptions of disability are often laden with stigma and discrimination. According to Shakespeare (2000), disabled women face desexualization and are almost always considered asexual or incapable of forming sexual relationships. Disabled women stereo-typically face beliefs that they cannot become pregnant and raise children, for they are perceived as asexual and, therefore, unable to procreate. This practice heightens their marginalization within the society already treating them as outcasts (Groce & Trani, 2009). The intersection of disability and sexuality is generally invisible in public health and policy discourse. This oversight contributes to the increased rates of unplanned pregnancies, sexually transmitted infections, and poor prenatal and postpartum care within the population of disabled women (Kallianes & Rubenfeld, 1997). Increased complications during pregnancy and childbirth. Societal assumptions tend to discourage reproductivity in disabled women, hence a lack of policies and services that can support the needs of this special population (Iezzoni et al., 2015).

Disabled women in Africa are characterized as pitiful, asexual and helpless. These perspectives, closely intertwined with cultural and religious beliefs, mistakenly equate disability with impurity, curses, or punishment meted out by some authority higher than humanity (Meekosha & Soldatic, 2011; Mugeere et al., 2020). In Nigeria, for instance, disability is very stigmatized and associated with punishment or bad omen and treat disabled women as such. It is often perceived that disabled women cannot perform their typical roles at home or in society, and this only serves to undermine their self-image and social integration process. In some parts of Ghana, disabled women are often ostracised because of the strong belief that they are a source of bad luck or disgrace to their families. Such adverse cultural stigma not only pushes these women to a corner but also deprives them of opportunities for education, working, and interacting with other human beings.

Disabled women also become victims with regard to violations of their reproductive rights on matters relating to pregnancy and childbirth. They are normally under pressure in Zimbabwe, South Africa, and Nigeria, among other nations, to abort their pregnancies or undergo sterilization based on misconceived ideas of lack of preparedness to be mothers and perceived inability to be responsible mothers (Essack & Strode, 2012; Rugoho & Maphosa, 2017; Ofuani, 2017). Moreover, they are deprived of participating in all necessary deliberations concerning sexuality and reproductive health. Finally, disabled women encounter another challenge in the social sphere, where they are grossly discriminated against with regard to marriage and family life. For instance, many societies always consider it farfetched and incomprehensible to think that a disabled woman can execute the roles of a wife or mother (Tefera et al., 2017; Emmett & Alant, 2006; Peta et al., 2017)

In Kenya, many communities still view disability negatively, an aspect majorly attributed to cultural beliefs and traditional practices that cause stigma and discrimination. In some communities, disability is considered shameful, and the result of superstition or bad luck; basically, what such communities know is that a disabled woman is a curse to the family (Barbareschi et al., 2021; Bunning et al., 2017). Potential barriers to accessing services for sexual and reproductive health among women with disabilities include non–disability-sensitive facilities, information not appropriate or accessible for disabled women, and fear of the providers treating them disrespectfully (Tanabe et al., 2015). Such exclusion will lead to a number of consequences, like high infant and maternal mortality resulting from inadequate prenatal care, unassisted childbirth or lack of access to postpartum care (Kabia et al., 2018).

The Convention on the Rights of Persons with Disabilities (CRDP) holds significance due to its explicit emphasis on safeguarding the fundamental human rights of people with disabilities, thus rendering it inconceivable to overlook. There exists an enormous amount of anticipation regarding the potential for the CRPD to effectively address, if not entirely eradicate, the prevalent discriminatory practices and attitudes towards people with disabilities worldwide (Kayess & French, 2008). The Convention on the Rights of Persons with Disabilities (CRPD) mandates that nations implement necessary legislative measures to amend or eliminate current laws, regulations, customs, and practices perpetuating discrimination against people with disabilities (Article 4). Moreover, it acknowledges that women with disabilities face heightened susceptibility to discrimination. It mandates implementing measures by Member States to guarantee unimpeded access for every person with disabilities to all human rights and essential liberties (Article 6). Finally, it is important to note that the CRDP is highly precise, deliberate, and transformative in its definition of disability. The preamble explicitly acknowledges that disability arises from the interaction between disabled individuals and attitudinal and environmental obstacles that impede the complete and meaningful engagement of people with disabilities in society on par with others. Unlike past human rights models, the CRDP broadens its scope to shoulder responsibility on the state, individuals, and society at large for the promotion and protection of the rights of disabled persons as outlined in the International Bill of Human Rights (Mégret, 2008). The expansion of accountability to both individuals and communities is deliberate, as prejudiced attitudes, perceptions, and behaviours, as well as stigma around disability, are frequently sustained within society beyond the direct control of the State. Stigma, specifically, has been identified as a significant obstacle to the effective implementation of the Convention and the realisation of fundamental human rights for people with disabilities in various African nations, such as South Africa, Nigeria, Kenya, and Tanzania. (Hussey et al. 2017; Mostert 2016).

Kenya officially adopted the CRPD on 19th May 2008, as evidenced in its 2010 Constitution, which mandates respectful and dignified treatment for disabled persons, prohibiting any derogatory address or reference (Constitution of Kenya, 2010, Article 54). The Persons with Disabilities Act of 2003 (revised 2012) provides for the Government of Kenya to ensure the full realization of the rights of persons with disabilities (Article 11), and it is buttressed by the National Disability Mainstreaming Strategy (2018-2022). The policy is centred on ensuring that people with disabilities enjoy their human rights to the fullest extent possible, including protection from discrimination and respect for their inherent dignity. The conceptualization of disability in the context of Kenya's policy, constitution, and legal system is complex and fraught with many uncertainties.

The existence of Kibra and other informal settlements in Nairobi can be traced to official colonial government policies and practices. As early as the 1920s, only African males working for the government were granted residence in Nairobi. Despite this regulation, many Africans settled in Nairobi. They put up shanties on what was then considered unutilized government land. They were frequently evicted, particularly with the enactment of discriminatory and punitive legislation such as the Vagrancy Act of 1922 (Wanjiru & Matsubara, 2017). The net effect of these laws was the deprioritization of development initiatives and social services like healthcare for African natives since they were viewed as temporary residents in the city (Gatabaki-Kamau & Karirah-Gitau, 2004). This same planning paradigm is still afflicting Nairobi's informal settlements, resulting in a lack of essential social services and rights for men and women from Kibra, and the situation is even worse for disabled women experiencing poverty.

1.3 Statement of the Problem

The Sustainable Development Goals (specifically Goal 5), the Convention on the Rights of Persons with Disabilities (CRPD) and Kenya's legal framework, among other laws such as the 2010 Constitution and the 2003 Persons with Disabilities Act revised in 2012, generally advocate for the rights and dignity of disabled persons. However, despite the existence of global and national frameworks that advance disability rights and inclusion, disabled women in Kenya continue to be discriminated against, prejudiced, and stigmatized. This marginalization is fuelled by entrenched social attitudes and structural barriers that greatly minimize the chances of participation of disabled women in community life and access to maternal healthcare. This study aimed to shed light and provide an analysis of the lived experiences of disabled women in addition to the perceptions and attitudes of non-disabled women and men, as well as the healthcare workers, in matters dealing with disability, sexuality, pregnancy, and childbirth of disabled women.

1.4 Overall Objective of the Study

This research aimed to explore societal attitudes and perceptions regarding the disability, sexuality, pregnancy, and childbirth of disabled women in Kibra Sub-county, Nairobi.

1.5 Specific Objectives of the Study

1. To document perspectives and individual experiences of disabled women regarding their disability, sexuality, pregnancy, and childbirth.
2. To examine the perceptions and attitudes of non-disabled women and men towards the disability, sexuality, and pregnancy of disabled women.
3. To investigate the perceptions and attitudes of different categories of healthcare workers towards disability, sexuality, and pregnancy of disabled women.

1.6 Research Questions

1. What are the perspectives and individual experiences of disabled women regarding their disability, sexuality, pregnancy, and childbirth?
2. What are the perceptions and attitudes of non-disabled women and men persons towards the disability, sexuality, and pregnancy of disabled women?
3. What are the perceptions and attitudes of dissimilar categories of healthcare workers towards the disability, sexuality, and pregnancy of disabled women?

1.7 Significance of the Study

Analysing public perceptions and attitudes towards disability, sexuality, pregnancy, and childbirth among disabled women is significant. In the first place, it assists in identifying the obstacles present in all the spheres of society. Women who are disabled face double discrimination, though not their being women, but also their disability. This dual marginalization is indeed a challenge for disabled women's access to vital services like healthcare, education, and employment. Thus, it even aggravates their vulnerability and poverty. By investigating these attitudes, decision-makers and activists can produce specific interventions and work on equal access for people different from society.

The application of international and national regulations, such as the SDGs and the Convention on the Rights of Persons with Disabilities (Civil Rights Act), are the concrete steps in the process of exercising rights, equality, and non-discrimination. This study is intricately linked with the SDGs, particularly SDG 5, which focuses on removing gender equality tensions, and SDG 10, which emphasizes the importance of reducing inequalities. Recognizing and eliminating the biases and prejudices that restrict the choices and rights of disabled women can genuinely lead to their empowerment in society. The study also focuses on CRPD, which Kenya has already ratified. The CPRD establishes respect for the full and effective participation and inclusion of persons with disabilities in society and their enjoyment of all human rights and fundamental freedoms. Article 6 of the CRPD particularly underlines the need to deal with the discrimination against women and girls with disabilities. Developing the knowledge of societal perceptions is a positive step towards actualizing international obligations and thus promoting the rights of disabled people.

The Persons with Disabilities Act of 2012 and the Kenya Constitution in Kenya provide a foundation to protect the rights of people with disabilities nationally. The main aim of the Act is to eliminate bias and ensure that disabled individuals have access to services and opportunities, including areas like sexual and reproductive health and rights. In its Bill of Rights, the Kenyan Constitution guarantees equality and protection from discrimination, affirming every person's right to the attainable standard of health, including reproductive health. This research highlights the gap between the situation and the desired state concerning the rights of disabled women. as well as the challenges that hinder them from fully exercising and enjoying their fundamental rights. This study is significant for both the progress of the rights and welfare of women disabled women and for fulfilling both international and local commitments regarding disability. It emphasizes the necessity of a development plan that acknowledges and addresses the challenges faced by disabled persons to promote a better society for all.

1.8 Scope/Delimitations of the Study

Disabled women of childbearing age, non-disabled women and men, and healthcare workers were recruited from Nairobi's Kibra informal settlements to participate in the study. The researcher documented disabled women's experiences with disability, pregnancy, and childbirth. The researcher has not compared or generalized the study's findings to other deprived or neglected urban or rural populations.

1.9 Summary of Chapter One

The first chapter of this study highlights the essential experiences and insertions of the researcher and their influence on the conceptualization of the study. The focus is primarily on the researcher's encounter with a disabled woman named Jane (pseudonym). This chapter provides an overview of the prevalence of disability at global, continental, and national levels. Chapter One also presents a brief overview of the Kibra informal settlement, including its origins and the continued neglect of development initiatives and social services such as healthcare.

This chapter also highlights the persistent discrimination, prejudice and stigmatization that disabled individuals face despite robust global and national frameworks aimed at promoting their inclusion. In particular, it sheds light on how disabled women are subject to discriminatory attitudes from healthcare workers as well as society regarding their disability, sexuality, pregnancy, and childbirth. Additionally, this chapter presents an overview of the study's problem statement along with its overall objectives and specific research questions. With these issues in mind, our investigation examined both individual perspectives and experiences among disabled women while also analyzing perceptions towards disability during pregnancy or childbirth expressed by non-disabled men/women alongside healthcare professionals. In this chapter, we have also discussed the significance of the study, including its linkage to the SDGs and CRPD, as well as the scope of the study.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

The second chapter is primarily devoted to a literature review. It examines the theoretical literature, focusing on the Critical Disability Theory, models of disability and the Universal Declaration of Human Rights and their implications for disability research and practice. Furthermore, this chapter examines empirical evidence related to the three specific objectives of the study: perspectives and experiences of disabled women, perceptions and attitudes of non-disabled women and men, and perceptions and attitudes of healthcare workers regarding the disability, pregnancy, and childbirth of disabled women. Lastly, the chapter highlights research gaps in the literature and proposes a conceptual framework to anchor this study.

2.1 Theoretical Literature Review

2.1.1 Critical Disability Theory and its Implications for Disability Discourse and Praxis

The critical disability theory is rooted in the philosophical thought of first-generation critical theorists of the Frankfurt School: Max Horkheimer, Leo Löwenthal, Theodor Adorno, Eric Fromm, and Herbert Marcuse, and later Jurgen Habermas, a leading proponent of the second generation (Scambler, 2013; Kuokkanen & Leino-Kilpi, 2000; McLaughlin, 1999; Fulton, 1997; Antonio, 1983). In his early expositions, Max Horkheimer, one of the leading protagonists of critical theory, provides a very insightful comparison of the traditional theory and his emerging new school of thought. He opined that the traditional theory was merely focused on explaining and describing prevailing social conditions and made no attempts to delegitimize oppressive practices and structures. On the other hand, he acknowledges that critical theory has an important attribute that facilitates not only explanations of existing social problems but also offers programmatic and practical responses to them (González et al., 2001; Horkheimer, 1972; Shaw, 1985). Critical theory deemphasizes economic, and class struggles and focuses on understanding and overcoming social conditions perpetuating oppression and domination (Browne, 2000; Fulton, 1997). The distinctive and parallel dimensions of the traditional (scientific) and critical theory are summarized succinctly by Geuss (1981);

> First…Scientific theories aim to manipulate the external world (while) successfully Critical theories aim at emancipation and enlightenment, at making agents aware of hidden coercion...Second…Scientific theories are 'objectifying (whereas) Critical theories, on the other hand, are claimed to be 'reflective,' or 'self-referential'… Finally, (while) Scientific theories require empirical confirmation through observation and experiment, critical theories are cognitively acceptable only if they survive a more complicated evaluation process, the central part of which demonstrates that they are 'reflectively acceptable' (pp. 55-56).

The origins of critical disability theory can be traced to the works of Michael Oliver, who has provided an extensive and insightful framework for analyzing issues related to disability and disabled people (Oliver, 2018). His research and theoretical contributions have become essential elements not only for disability-related research but also for the de-medicalization of disability, which was then seen purely as a medical condition that required curative interventions (Dorfman, 2017; Waddington & Priestley, 2021). Critical Disability Theory posits that the challenges, marginalization, and tribulations experienced by disabled people are primarily attributed to the insufficiency of the socio-political environment in effectively accommodating the diverse, unique needs associated with disability (Devlin & Pothier, 2006; Gillies, 2014). This means that the plight of disabled persons is caused more by society's attitudes, perceptions, behaviours, practises, policies, and beliefs that facilitate discrimination and prejudice than by the impairment itself. Critical Disability Theory has dedicated its focus to the transformation of the social conditions and circumstances that perpetuate and maintain disability-related oppression. It creates opportunities for critical analysis, empowerment, and accountability for Disabled people (Minich, 2016; Procknow et al., 2017; Saxton, 2018).

Disabled women face discrimination and marginalization that emanate from conditions and circumstances perpetuated by their society. Within their communities, they are treated with disdain and contempt on account of their disability and nothing else. Moreover, pregnant, disabled women encounter instances of discrimination throughout their pregnancy and childbirth. Specifically, they frequently face the violation of their sexual and reproductive health rights, both from healthcare providers and within society. Critical Disability Theory possesses the capacity to interrogate the societal and cultural obstacles hindering the inclusion of disabled women while simultaneously addressing the fundamental causes that sustain discriminatory practices, prejudiced attitudes, and oppressive treatment towards this marginalised group. The significance of critical disability theory in research and empowerment has been discussed by several scholars. Using the Critical Theory Disability, Vasanthi (2020) examined how the Indian Rights of Disabled People Act emasculated the rights of disabled people, specifically focusing on the role of language in the context of the right to work. She advocates for re-examining relevant laws to take care of the interests of disabled people.

The critical disability theory was necessary for this study for several reasons. First of all, it provided an invaluable framework for understanding the discrimination, oppression, and prejudice that disabled women face as a result of multiple intersecting identities, including gender, poverty, and disability. The intersectionality of gender, poverty, and disability results in unique expressions of the challenges faced by disabled women, which non-disabled women or disabled men do not encounter. Second, the researcher, based on the argument of critical disability theory, acknowledges that disability is a socially constructed concept that is influenced by a variety of socialisation agents, including schools, the media, and religion. Considering this, the researchers examined how these agents influence individual and societal beliefs, values, behaviours, and norms about disability and disabled persons.

2.1.2 Models of Disability and Their Implications for Disabled Women

Disability is a multifaceted and multidimensional construct. According to Lollar and Crews (2003), individual characteristics and environmental factors influence the conceptualization of disability. This is true when viewed in the context of how different disability scholars have discussed the different models of disability. Four types of disabilities can be distinguished: social, medical, charitable, and moral. (Bhanushali, 2007; Haegele & Hodge, 2016; Jackson, 2018; Kattari et al., 2017).

Disability researchers and scholars consider the moral model the oldest and most deeply engrained in society. Within this model, disability is often associated with sin, shame, and punishment. It is propagated through religious beliefs and practices (Kaplan, 2000). Disability is linked to moral weakness and spiritual uncleanliness (Clare, 2001; Creamer, 2012). Within the African communal system, disability is viewed as a collective retribution by supernatural forces for heinous sins of omission. In this context, families of disabled people are usually targeted, stigmatized, and excluded from mainstream society (Retief & Letšosa, 2018). As a tool of cultural oppression and marginalization, the moral model of disability presents the worst form of ostracism for disabled people at all levels of society (Mona et al., 2005). Ideally, religious communities are supposed to be accessible to everyone. On the contrary, attitudinal and behavioural practices within the religious fraternity have combined effectively to victimize, dehumanize, and banish disabled women to the periphery on account of their gender and disability (Freeman, 2002; Reynolds, 2012).

According to proponents of the medical model, disability exists as a result of an individual's medical flaws. Apologists of the model conceptualize disability as "a problem of the person, directly caused by disease, trauma, or other health condition, which requires medical care provided in the form of individual treatment by professionals" (World Health Organisation, 2007, p. 20). Individuals with disabilities are defined in terms of illness and severe malfunction. The proposed intervention, as perceived by medical professionals, then centres on correcting their deficiencies, a process known as the medicalization of disability. (Haydon-Laurelut, 2015). The emphasis is on managing abnormal conditions and enabling individuals with disabilities to become 'normal' human beings while ignoring other factors, such as social and cultural issues, which contribute to their marginalization. (Imrie, 1997; Llewellyn & Hogan, 2000).

Disabled people are perceived as hopeless and require pity and acts of benevolence from non-disabled people. This perception is propagated by the charity model, which conceptualizes disabled people as individuals facing ‘afflictions‘ and life ‘tragedies,’ whose predicament should be addressed by providing immediate basic needs through charity. The model does not confront the root causes of oppression, exclusion, and marginalization of Disabled people emanating from their disability (Reaume, 2014; Ware & Schuelka, 2019). Charity groups improve the lives of disabled individuals by offering a range of services and support that fill gaps not always covered by government programs. They provide things like assistive devices, financial aid, and individualized counselling to meet the needs of disabled persons. However, they have contributed to the construction of narratives that portray disabled persons as ‘dependent’ and ‘inferior’ and continue to deepen stigma unknowingly or knowingly around disability (Tsai & Ho, 2010). Their marketing and resource mobilization initiatives often characterize disabled people as helpless and hapless victims of circumstances, and this is done through the circulation of negative images of disability, which promotes dependency syndrome (Haller & Ralph, 2006; Panol & McBride, 2001; Waltz, 2012).

Finally, we will discuss the social model of disability. Its origins can be traced to Michael Oliver, who revolutionized scholarly research and development practice in disability. In a radical departure from the medical model, which viewed disability exclusively through the lens of ‘dysfunctionality' in individuals, he argued that it was, in fact, a societal challenge that needed to be addressed collectively and differently. (Oliver, 1983; Oliver, 2018; Oliver, 2013). The medical model sees disability as a result of individual deficiencies, whereas the social model argues that disability is socially constructed. (Shakespear, 2004). The social model focuses on political and social factors that create barriers for disabled people, such as negative attitudinal and behavioural biases. (Hiranandani, 2019).

Several scholars have levelled criticisms against the social model of disability and highlighted its inherent philosophical and theoretical weaknesses. This includes its singularity, dedication to 'over-socialization’ and limited attention to the effects of impairments (Terzi, 2004). Furthermore, it has been recognized that the paradigm overemphasizes socio-structural constraints at the expense of disabled people's personal experiences. (Crow, 1996; Petasis, 2019). Despite these criticisms, the social model is still relevant for understanding attitudes and perceptions around disability and how they perpetuate prejudice towards disabled people. It has the potential to spark social change on disability issues. Shakespeare (2004), one of its ardent proponents, succinctly captures the prospects of this model as a powerful tool for social mobilization and transformation. He contends:

> SSM (social model) was also perfect for consciousness-raising. By redefining the disability problem, it enabled people who had felt in-valid, incompetent, and dependent to relocate the problem of disability from themselves to the discriminatory society in which they lived…the social model should be regarded as a tool, an effective tool for remedying the injustices faced by disabled people and relocating the efforts of service providers from individual solutions to the removal of barriers to participation in the mainstream (Shakespeare, 2004, p. 11).

The research employed the social model as a framework to comprehensively examine the mechanisms and factors that contribute to the marginalisation and prejudice experienced by disabled women within society. This investigation specifically focused on the intersectionality of disability, sexuality, pregnancy, and childbirth. The social model of disability differentiates between *impairment,* referring to an individual's physical, mental, or cognitive condition, and *disability,* which encompasses the societal barriers and discriminatory experiences encountered by disabled people. This conceptual distinction was consistently maintained and applied throughout the study.

2.1.3 Utu Conception of Disability and Implications for Social Transformation

Utu, characterized by community life and ideals, was deeply rooted in various African communities before the pre-colonial period and prevailed during colonialism. However, despite its continued importance and relevance as a central philosophical paradigm and value system, Utu has been persistently suppressed and subordinated by the dominant Western ideologies and intellectual paradigms all along, and this manner of domination continued even after the end of colonialism. Cross-generational African scholars such as Kwasi Wiredu, Ngugi wa Thiong'o, Sabelo J. Ndlovu-Gatsheni and Nkiru Nzegwu have critically examined and interrogated the enduring impact of colonial legacies and the prevailing mode of knowledge production largely dictated by philosophical underpinnings of the North.

Kwasi Wiredu's intellectual contributions have significantly impacted the discourse on decolonization and related ideas in Africa. According to Wiredu, what is needed to set African thought free is "conceptual decolonization." From his point of view, African thinkers have to clean up their conceptual systems from such colonial influences in their thought if they are to arrive at some intellectual and cultural independence. Indeed, the reality is that colonialism had left its mark indelibly on African thought, especially through the imposition of Western philosophical concepts that are out of touch with African reality. Consequently, these imposed ideas come with world perspectives that obfuscate, engender intellectual dependency, and hinder self-understanding. Wiredu recognizes language as the major source of this imposition, and he advocates for using indigenous African concepts in philosophical discourse to render intellectual freedom (Wiredu, 1997). Moreover, Wiredu explores the intricate relationship between philosophy and culture and rejects the view that characterizes it as an abstract discipline standing independently on its own. He feels that philosophical inquiry must be grounded on cultural experiential to remain relevant and accessible. Thus, he argues for the construction of philosophical terminology in African languages, believing that this will align philosophical discourse with local realities and address specific concerns of African societies (1980). According to Ngugi wa Thiong'o, the constant use of foreign languages , such as French and English, in learning and communicating on African continents is a type of intellectual colonialism (Ngugi, 1986). He adds that this type of colonization leads to a reconditioning of the minds as well as the Indigenous cosmologies of the captive population to the extent that they are adapted to the needs of the colonizing entity. Ngugi says the best way to escape the process and consequences of mental decolonization is to embrace and nurture Indigenous languages that inspire cultural sovereignty and self-determination.

Sabelo J. Ndlovu-Gatsheni, one of the contemporary scholars of the decolonization discourse, has written many scholarly works on this topic in great breadth and depth. Sabelo argues that as the colonial project expanded, the continent remained intellectually, economically, culturally, and socially colonized, no matter how African countries achieved political independence after the end of colonialism (2013, p. 158). He explains that the lasting impact of colonialism on the African continent is manifested through aspects through which knowledge, power, and identity conceptualize their organization in ways that privilege features of Western philosophical thought (Ndlovu-Gatsheni & Chambati, 2013). Sabelo posits that far extraordinary efforts must be made for the epistemic liberation and renewal of the African continent to challenge and discourage Eurocentric epistemologies and development paradigms in their continuous reproduction and dominance (Ndlovu-Gatsheni, 2020). The relevance of the philosophical perspectives of Wiredu, Ngugi and Ndlovu-Gatsheni. Radical scientific minds have continued to promote deep scientific insights and discussions about restoring, reconstructing, and revitalising value systems such as Utu, which have long been viewed as subservient and subordinate to the hegemonic Western value system. Lastly, we focus on Nkiru Nzegwu, a Nigerian-American philosopher, artist, and art historian whose scholarship has contributed greatly to African philosophy, feminism, and postcolonial studies. Her work resonates with the clarion call of decoloniality, which focuses on dismantling colonial power structures and knowledge systems. In her works, Nzegwu sustains a critique of Western dominance in understanding African art, culture, and knowledge. She considers centering African perspectives and knowledge systems as cardinal to decolonizing knowledge production (Nzegwu, 2001, 2000). On feminism, Nzegwu presents a new look at the reinterpretation of gender roles and relations within African societies. This is done by critiquing Western feminist ideas that disregard the experiences unique to African women, instead arguing for decolonial feminism situated within African cultural contexts (Nzegwu, 2012). Such is the case, according to Nzegwu, with the art historical work of Nzegwu herself, in which she challenges colonial representations of African art and culture and brings out the prejudices and distortions of Western interpretations (Nzegwu, 1995). Her scholarship invites a rethinking toward an African perspective on understanding African philosophy and feminism through art.

Our discussion will shift to Utu, particularly its classification as a values-based system, philosophical construct, and human-existential approach. The famous statement by J.S. Mbiti: "I am because we are; and since we are, therefore, I am," emphasizes the African concept of identity and community, highlighting the interconnectedness and interdependence of individuals within their communities (Mbiti, 1969, p. 108). As a philosophical concept, Utu thus focuses on and promotes the interconnectedness and interrelationship of the individual with his community (Bongmba, 2016). Actions and behaviours of an individual either directly or indirectly contribute to the well-being or imbalance of the fraternity (Dillard & Neal, 2020; Himonga, 2013). This interdependence promotes peaceful coexistence, shared prosperity and justice while preventing bad practices. Utu defines expectations of how individuals should interact with one another and with others as a values-based framework. The qualities and attributes desirable in Utu include justice, integrity, respect, courtesy, compassion, solidarity, and tolerance (Akinola & Uzodike, 2018; Nhlekisana, 2016; West, 2014; Ndima, 2015; Miller. 2016). This implies that these principles and values aim to create a culture of recognition, acceptance, and cohesion among members of society, not only to regulate behaviour but also to sanction discrimination and marginalization of vulnerable members of the community.

Another outstanding dimension of Utu, which has been highlighted by numerous scholars, is its expression as a humanistic-existential approach. According to Chigangaidze (2021), Utu is an irreducible humanistic-existential approach as it emphasizes the communal nature and the unparalleled commitment to protecting the humanity of all members of the community. Furthermore, Wright and Jayawickrama (2021) point out that the justification of Utu in terms of humanistic-existential aspects depends on the notion of respect in the interpersonal relationships between people. On the other hand, Himonga (2013) acknowledges the importance of Utu in regulating interpersonal behaviour and protecting human value, which are particularly important elements in terms of the humanistic-existential approach. Utu plays a leading role in the humanistic-existential approach as it emphasizes the value of the person and humanity in a social context. Western ethical frameworks are based on an ideal foundation that exhibits a certain degree of individualism and prioritizes the needs and interests of the individual over the collective good of the community. On the other hand, in the Utu context, community value and the well-being of the community as a whole are emphasized. This understanding thus provides a basis for considering disability within the Utu philosophical paradigm and its impact on the existence, rights, and dignity of disabled people within society.

2.1.4 Universal Declaration On Human Rights and Implications for Social Transformation

The period before and after World War II was a watershed moment in the establishment and execution of modern-day human rights frameworks. The effects of the conflict, which included numerous and egregious human rights violations and atrocities, sparked discussion about the necessity of confronting ongoing lawlessness in nations. The horror of the Second World War and the consequent awareness of the close connection between respect for human dignity and peace motivated the Charter's qualitative leap towards promoting human rights (Regilme et al., 2020)

The war's experiences and reflections were instrumental in the foundation of the UN in October 1945, notably following the drafting and acceptance of the UN Charter in the same year. The UN Charter expresses world leaders' collective concerns and ambitions for maintaining global peace and reinforcing respect for human rights. While proclaiming the need to "save succeeding generations from the scourge of war," the Charter reiterated" faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women, and of nations large and small" (UN Charter, 1946, p. 2). It represents a concerted, deliberate action to enhance human rights and counteract State excesses.

> While the Charter supported human rights ideals, it retained the principle of a State's sovereignty over its citizens… Nonetheless, for those who lived through the horrors of World War II, the Charter provided hope that a State would never again have free rein over the treatment of its citizens (Southard, 1995, p. 46).

The 1948 drafting of the Universal Declaration of Human Rights (UDHR) is an important and historically significant milestone in the evolution of the human rights discourse. Aptly referred to as the "constitution of the modern human rights movement" (Glendon, 1998, p. 23), the UDHR not only provides "a common standard of achievement for all peoples and nations" (United Nations, 2015, p. 3) but also exhibits “law-like status and authority and affects not just international relations but also domestic human rights systems” (Mooney, 2014, p. 482).

The principles and spirit of the UN Charter and UDHR have become functional building blocks in the development of overarching human rights instruments, including the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR). Along with the UDHR, the two Covenants form the International Bill of Rights, a reference point for subsequent international and regional human rights frameworks (Peek, 1991). These include the Convention on the Elimination of All Forms of Discrimination Against Women (1979) and the Convention on the Rights of Persons with Disabilities (CRDP), all of which are valuable guidelines for human rights issues related to disability and disabled women in Africa (Gruhn, 1999; Yang, 2013; Dauer & Goetsch, 2006).

The CRDP specifically holds excellent significance due to its explicit emphasis on safeguarding the fundamental human rights of disabled persons, thus rendering it inconceivable to overlook. There existed an enormous amount of anticipation regarding the potential for the CRPD to effectively address, if not entirely eradicate, the prevalent discriminatory practices and attitudes towards disabled persons worldwide (Kayess & French. 2008). The CRPD expects States “to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities" (Article 4). Moreover, it acknowledges that disabled women face heightened susceptibility to discrimination and mandates the implementation of measures by member states aimed at guaranteeing unimpeded access for every individual with disabilities to all human rights and essential liberties (Article 6). Finally, it is important to note that the CRDP is highly precise, deliberate, and transformative in its definition of disability. The preamble explicitly acknowledges that disability arises from the interaction between disabled individuals and attitudinal and environmental obstacles that impede their complete and meaningful engagement in society, on par with others.

In contrast to previous human rights frameworks, the CRDP extends its focus beyond the State as the sole entity accountable for the rights of disabled persons. It also assigns responsibility to individuals and society to facilitate the 'promotion and observance of the rights recognized in the International Bill of Human Rights' for disabled persons (Mégret, 2008). The expansion of accountability to both individuals and communities is an essential component of the CRPD, as prejudiced attitudes, perceptions, and behaviours, as well as stigma around disability, are frequently sustained within society beyond the direct control of the State. Stigma, specifically, has been identified as a significant obstacle to the effective implementation of the Convention and the realisation of fundamental human rights for disabled persons in various African nations, such as South Africa, Nigeria, Kenya, and Tanzania. (Hussey et. al., 2017; Mostert, 2016).

Kenya ratified the CRDP on 19th May 2008, and this is reflected in its 2010 Constitution, which expects disabled persons "to be treated with dignity and respect and to be addressed and referred to in a manner that is not demeaning” (Constitution of Kenya, 2010, Article 54). The Persons with Disabilities Act of 2003 (revised 2012) provides for the Kenyan government to ensure the full realization of the rights of persons with disabilities (Article 11), and it is buttressed by the National Disability Mainstreaming Strategy (2018-2022). The policy is centred on ensuring that disabled persons enjoy their human rights to the fullest extent possible, including protection from discrimination and respect for their inherent dignity. However, the conceptualization of disability within the framework of Kenyan policy, constitution, and legal setting remains multifaceted and fraught with ambiguities.

For example, Article 260 of the Constitution of Kenya (2010) defines disability as any "physical, sensory, mental, psychological or other impairment or illness that has a substantial long-term effect on an individual's ability to carry out ordinary day-to-day activities." This definition builds upon the medical model view of disabilities. In contrast with this view is The Persons with Disabilities Act from 2003 which describes it as including physical and sensory impairments alongside learning and cognitive capabilities that negatively affect individuals' social-economic-environmental participation. Several problems arise with the Constitution and the Act regarding what constitutes disability. It is important to highlight that some disabled individuals, such as those with Albinism, are not adequately represented in both definitions as they do not align with any of the categorizations. ‘

The current wording of the Constitution presupposes that individuals belonging to "significant sectors of the community" will consider conditions such as Albinism and other impairments not explicitly mentioned within the disability framework. Furthermore, both definitions appear to imply that the challenges faced by disabled persons in terms of being unable to perform regular daily tasks or experiencing limited social, economic, or environmental engagement are solely attributed to their disability, without considering the disenabling and disempowering role of society. The status and standing of disabled women in society are shaped by these legislative, legal, and constitutional ambiguities, which often result in their treatment as subservient human beings. Consequently, they are deprived of their fundamental human rights, recognition, and dignity.

2.2 Empirical Literature Review

2.2.1 Disability, Sexuality, Pregnancy, and Childbirth: Perspectives and Experiences of Disabled Women.

The perspectives and experiences of disabled women about their disability, pregnancy, and childbirth exhibit a broad spectrum of diversity, frequently reflecting how they are treated and perceived within their societies. The widespread problem of outright discrimination and stigma, as well as unmet sexual and reproductive health rights, is a frequent phenomenon for disabled women, often influenced by societal perceptions and stereotypes around their disability and sexuality. Disabled women are frequently made to feel inferior and inhuman, and they are subjected to mistreatment, marginalisation, and rejection on account of their disability.

The act of assigning labels to impairments is an often-employed strategy that serves to dehumanise disabled women while also perpetuating a negative perception of disability by depicting it as an abnormality within the structure of society. The consistent, deliberate, and harmful use of labels in connection to disabled women and their disability increases the probability that the impairment will become a defining aspect of their identity. This phenomenon is examined by Green et al. (2005) in their study, which focused on the experiences of disabled persons and mothers of disabled children in the United States of America (USA). They observe that the labelling contributes to the social marginalisation of disabled persons and hinders the occurrence of positive social interactions for this demographic. The negative depiction of disability through labelling is also discussed by Brocco (2015), who observes in an ethnographic investigation of Albinism in Tanzania that language and discourse may constructively as well as adversely characterise disability. To put it plainly, disabled women are not regarded as anything other than their impairment, which shapes their identity and affects their socialisation and place in society.

Vulnerable populations, including disabled women, face significant challenges in accessing sexual and reproductive health treatments, particularly in the context of public health facilities. This often results in adverse health indicators for individuals belonging to this demographic (Matthews et al., 2010; Ronsmans et al., 2003; Silal et al., 2012; Stekelenburg et al., 2004). Due to a variety of circumstances, women from economically disadvantaged backgrounds, particularly those residing in informal settlements, have restricted access to and utilisation of skilled birth attendants. These include low quality of services, unavailability of information on services, prohibitive user fees, mistreatment, and neglect of pregnant women by healthcare workers, incidences of insecurity, and cultural practices. These barriers originate from both supply-side and demand-side deficiencies as well as health facility and home-based factors (Kyei-Nimakoh et al., 2015; Okafor et al., 2015; Riaz et al., 2015; Bohren et al., 2014; Freedman & Kruk, 2014; Onta et al., 2014; Chakraborty et al., 2003).

While the situation for the poor in terms of access to sexual and reproductive healthcare services appears dire, it is even worse for women who are both poor and disabled. Due to the prevalence of doubts, misinformation, and misrepresentations regarding the sexuality of disabled women, both healthcare professionals and society as a whole often do not anticipate their potential for pregnancy. As a consequence, these women frequently encounter deliberate or inadvertent barriers that prevent them from accessing or utilising sexual and reproductive health services.

Numerous studies have demonstrated that disabled women face numerous barriers to accessing sexual and reproductive healthcare. According to the findings of Breckenridge et al. (2014), there is a higher likelihood for disabled women to encounter domestic abuse when pregnant compared to non-disabled women. This unfortunate circumstance may create barriers or hinder their ability to get essential health services, including prenatal care, skilled delivery, and post-natal care.

On the other hand, Ganle et al. (2016) found a range of obstacles that prevent disabled women from accessing and utilising maternal healthcare services. The challenges encompassed in this context consist of inadequate physical health infrastructure that is not conducive to individuals with disabilities, a dearth of guidelines about maternal health services that cater to the needs of disabled individuals, limited accessibility to healthcare facilities, biases exhibited by service providers, and the 'the perception from able-bodied persons that disabled women should be asexual' (Ganle et al., 2016, p. 1). Furthermore, Mitra et al. (2016) highlight the high default rates for pregnant, disabled women for prenatal and postnatal services attributed to negative experiences with service providers. They observed;

> Disabled women 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. The delay in accessing health care could, in part, be attributed to the negative experiences of disabled women with their healthcare providers (p.1030).

The possibility of disabled women accessing and utilising sexual and reproductive healthcare might be impeded by several obstacles, encompassing structural, attitudinal, and systemic factors. Devkota et al. (2018) and Morrison et al. (2014) have documented disabled women being excluded from mainstream maternal health services in Nepal on a systematic and structural level. While the former emphasises inequitable access to maternal healthcare services for Disabled women as a service-related barrier, the latter identifies a critical emerging challenge as a healthcare worker's lack of preparedness to meet their maternal health needs. According to Becker et al. (1997), disabled women face mostly supply-side barriers when accessing services that relate to sexual and reproductive health :

> Interviewees encountered numerous barriers to quality reproductive health care services, including inaccessible equipment and facilities, limited contraceptive options, health care providers' insensitivity and lack of knowledge about disabilities, and limited information tailored to their needs (p. 26).

Stigma and discrimination against disabled women are pervasive in the current African context and deeply rooted in the social and cultural fabric, particularly in issues of sexuality. Disabled women frequently encounter discouragement when it comes to openly embracing their sexuality and pursuing a fulfilling experience with childbearing and motherhood. They are unaccounted for by the health delivery system due to poor data management and face cultural and social barriers merely on account of their disability, as observed in a study in South Africa on hearing-impaired women (Gichane et al., 2017). Additionally, they are also victims of over-referral, as witnessed in Zambia, occasioned by the fear of nurses and midwives about the anticipated delivery complications associated with their disability (Smith et al., 2004). Bassoumah and Mohammed (2020) have observed that societal stigma, discrimination, and oppression contribute to poor maternal clinic attendance in Ghana for disabled women.

The coping mechanisms for disabled women towards societal stigma and prejudice include the use of avoidance strategies as well as the development and internalization of self-stigma (Kassah et al., 2014; Stangl et al., 2019). They will boycott maternal health services or any discussions around their sexuality and desires for intimacy and motherhood. If pregnant, there is the possibility of them avoiding antenatal visits and other maternal health-related interventions.

Researchers agree that disabled women have a favourable experience accessing maternal healthcare services in private health facilities. In their study on the perception and experience of hearing-impaired women towards antenatal clinics in Nigeria, Adigun, and Mngomezulu (2020) reported that they preferred private facilities and had less enthusiasm for public-owned facilities. Burke et al. (2017) observed a preference for private health facilities among the majority of respondents in another study that examined access to sexual and reproductive health for young disabled Senegalese people. This preference was attributed to guaranteeing anonymity, confidentiality, and positive reception from service providers.

Disabled women may be discouraged from seeking expert birth attendance and expressing their sexuality due to negative experiences with maternal healthcare systems and society in relation to their disability, sexuality, pregnancy, and childbirth. This inadvertently exposes them to potential harm by depriving them of essential preventive antenatal care services, thereby significantly impeding the progress towards the attainment of SDG 5. This goal aims to eliminate all forms of discrimination against women and girls worldwide and ensure that all women, including those with disabilities, have equal access to sexual and reproductive health services and rights.

2.2.2 Disability, Sexuality, and Pregnancy: Perceptions and Attitudes of Non-disabled Women and Men

The perceptions and attitudes of non-disabled women and men towards disabled women might exhibit diversity dependent upon various aspects, such as personal encounters, cultural beliefs, and levels of consciousness about disability. Communal beliefs, perceptions, and attitudes towards disabled people determine, to a considerable extent, their acceptance and inclusion in mainstream societal circles. Disabled people are unable to participate effectively in public life and access social services such as education and health care due to deeply ingrained cultural practices (Anthony, 2014; Munsaka & Charnley, 2013; Njelesani et al., 2018; Stone-MacDonald, 2012). There exists a multitude of misconceptions, superstitions, and narratives surrounding the birth and existence of disabled persons, resulting in their frequent exclusion, ostracization, and marginalisation within society.

Numerous African religions and cultures believe that moral shortcomings or sins bring about impairments. These beliefs are present in various narratives, myths, and oral traditions. This phenomenon is evident in several studies, including those conducted in Kenya. In her research on the lived experiences of the physically impaired in Ghana, Naami (2014) noted that the occurrence of disability within particular families has been attributed to a divine curse, presumably as a consequence of a significant transgression committed by an individual within the family or community. Witchcraft' and 'super beings' were indicated as the leading causes of impairments in the study by Akasreku et al. (2018) on community perceptions and disabled women's own experiences with pregnancy and disability.

Additionally, the study conducted in a rural Kenyan community by Bunning et al. (2017) revealed that the local communities associated the existence of impairments to supernatural entities such as demons and evil spirits. The studies above demonstrate a prevailing pattern where impairments are perceived negatively, characterised as undesirable and attributed to divine punishment. Disabled people, particularly women, may experience stigma and social exclusion as a result of societal perceptions and beliefs that associate their impairments with transgressions against the supernatural.

The use of labels, imagery, and language carrying negative connotations towards disabled people is a discriminatory practice that can exert a substantial adverse influence on their well-being. Numerous studies have noted that labels have the power to exclude, dehumanise, and stereotype disabled people. Conversely, disabled individuals have also been subject to negative characterization through the use of imagery. The portrayal of disabled individuals as helpless, dependent, or pitiable can serve to perpetuate the perception that they are dependent on others and unable to take care of themselves. There exists a considerable body of literature exploring the utilisation of labels and language as a means of reinforcing identity for disabled women, specifically concerning their impairments, frequently with an adverse connotation. In Portugal, there is evidence indicating that the use of derogatory phrases such as 'crippled' and 'retarded' is a form of psychological abuse and violence directed at disabled women. These derogatory terms not only reflect a lack of acceptance and tolerance towards disabled women but also infringe upon their inherent human dignity (Pinto, 2016). Similar to this, in Ghanaian society, labels like ‘sick person,’ ‘mad person, ‘dumb’ and ‘imbecile’ are frequently used to describe disabled persons, reinforcing marginalisation, discrimination, and stigma against them (Baffoe, 2013, p. 193). The negative characterizations and associated prejudice against disabled individuals can have detrimental effects on their psychosocial well-being. These effects may manifest as social disruption, loss of social standing, self-stigmatization, and depression (Green et al., 2005).

Negative attitudes towards disabled people are also intentionally or unintentionally propagated through the media and educational curriculum. Their depiction in most media stories revolves around their perceived helplessness and penchant for begging. They are entirely underrepresented or ignored in mainstream television advertisements due to imagined value reduction, a continual media representation of societal stereotyping of disability (Ciot & van Hove, 2010; Panol & McBride, 2001; Pirsl & Popovska, 2001). Educational curriculum resources, on the other hand, reinforce misconceptions and misrepresentations about disability and disabled people as lesser and invisible members of society. This has been documented in studies in Iran, Colombia, Jordan, and Malawi, where cultural and social realities of disability are constructed and maintained through learning interactions and intergenerational discourses (Cheng & Beigi, 2011; Chiponda, 2020; Essa Abu-Hamour et al., 2019; Martínez-Bello & Martínez-Bello, 2016).

The intersection of gender and disability causes diverse manifestations of discrimination, marginalisation, and social exclusion in a variety of circumstances. Disabled women frequently endure multiple disadvantages as a result of prejudice based on both their gender, disability, and other social identities. The prevalence of negative perceptions, attitudes, and doubts around the sexuality of disabled women, as well as their capacity to conceive and keep up motherhood, is a frequently observed phenomenon (Tefera et al., 2017; Walsh-Gallagher et al., 2012b). They are not expected to have active sexual lives, and some question if they can indeed engage in ‘normal’ sexual relations or even control their ‘beastly’ sexual urges given their disability (Santos & Santos, 2018; Afolayan, 2015; Anderson & Kitchin, 2000). If anything, attempts are made by the family and the community to extinguish any sexual desires that they may have. They are also viewed as objects of sexual gratification and predation and considered ‘abnormal’ sexual beings (Akasreku et al., 2018; Dean et al., 2017; Shaqiri et al., 2018).

Carrying a pregnancy to full term and getting delivery support is a daunting task for many disabled women. They must contend with occasional stares and unsavoury comments from non-disabled community members towards their pregnancy and breastfeeding of their newborns (Acheampong et al., 2020; Powell et al., 2017). Disabled women face equal stigma in society and at home from their families. In some communal settings, they are not allowed to mingle with other mothers due to the fear that they may transmit their disability to the unborn children of non-disabled women (Akasreku et al., 2018). Negative attitudes towards disabled people are a result of a lack of understanding and information regarding disability (Morin et al., 2013). There is a great deal of disinformation and negative attitudes about disability in society that have been reinforced through beliefs, narratives and myths and have become normalised throughout generations. They impede disabled women from reaching their full potential and exclude them from mainstream development initiatives and access to social services such as maternal healthcare.

2.2.3 Disability, Sexuality, and Pregnancy: Perceptions and Attitudes of Healthcare Workers

The beliefs, behaviour, and attitudes of healthcare workers towards disabled people, notably disabled women, vary across genders, age groups, professional cadres, and health facility types. These differences are also influenced by cultural and socioeconomic variables and deeply entrenched practices. How healthcare workers receive and provide care to disabled women significantly affects the quality of healthcare received by these individuals. Moreover, it may influence their subsequent healthcare-seeking behaviour, potentially leading to avoiding specific healthcare services entirely.

Using language and imagery, whether imbued with positive or negative connotations, together with how healthcare workers interact with disabled women, serve as indicators of their perceptions and attitudes towards this specific demographic. Joseph et al. (2018) have observed that it is common for some physicians to use the terms 'regular' and 'normal' about non-disabled patients, and this is documented in their study of Physicians' perceptions of barriers to equal access to reproductive health for physically impaired women. This has significance as the implicit portrayal of disabled women often centres around their perceived ‘abnormality’ and "irregularity.’ The utilisation of imagery to contrast non-disabled women and disabled women has also been investigated by Lee et al. (2015). Their study documents the usage of terms such as "deficient," "broken," and "inadequate" about disabled women. Given the prevalent and determined beliefs regarding the deficiency, dysfunctionality, and deviance associated with disabled women, it is likely that healthcare professionals would focus their attention on fixing the undesired problem of impairment through medical interventions.

The phenomenon of misinformation, misrepresentation, and mythologization by healthcare providers surrounding the sexuality of disabled people has been studied in a variety of circumstances, with consistent results and conclusions. The dominant presumption and widely held perception among healthcare workers is that disabled women are inherently "asexual" and "celibate," a perspective primarily rooted in prejudice and influenced by societal and cultural beliefs. (Joseph et al., 2018; Sharma & Sivakami, 2019). Additionally, healthcare workers have also expressed doubts regarding the ability of disabled women to conceive, sustain pregnancy, and deliver "normally" (Ahumuza et al., 2014). The study carried out by Mavuso and Maharaj (2015) presents empirical findings that suggest that deeply entrenched views regarding the perceived asexuality and deviance of disabled women may act as barriers to their obtaining sexual and reproductive health services. They reported that healthcare providers appeared surprised that disabled women could obtain contraceptives, given their presumed inability to engage in sexual relations. In the context of a demeaning characterization and the existence of social stigma, it frequently occurs that disabled women are routinely denied access to essential sexual and reproductive healthcare interventions, encompassing, but not restricted to, family planning services.

Some healthcare workers frequently pathologize disabled women as "high-risk" and "unfit" mothers, and this description usually determines how they are received and cared for in health facilities. (Frederick, 2017). This “pathologizing’ behaviour and perception has turned disabled women into victims of over-referral within the healthcare system. This is attributable to the belief by healthcare workers that their pregnancy will always result in complications, purely due to their disability and nothing else (Trani et al., 2011). This behaviour by healthcare workers narrows their opportunities to access both scheduled and emergency maternal health services. Disabled women may also choose to abstain from utilising standard maternal healthcare facilities as a result of the negative societal attitudes and discriminatory practices they encounter during their pregnancy and birthing experiences. Consequently, this decision places them vulnerable, potentially compromising their well-being and safety (Badu et al., 2016).

Providing appropriate maternal healthcare to women with disabilities necessitates an abundance of patience, understanding, and empathy, qualities that are often lacking among many healthcare workers. It has been observed that medical professionals, including physicians, typically spend a more significant amount of time and effort serving disabled women than non-disabled women. (Agaronnik et al., 2019). The reality of an additional time requirement for providing service to disabled persons poses a potential obstacle, as certain physicians may hesitate to accommodate these demands without the possibility of an extra financial incentive (Alhusen et al., 2020).

During hospital visits, it is common for healthcare workers, particularly physicians, to require disabled people to be accompanied by attendants or helpers. For instance, in the case of hearing-impaired patients, the presence of a companion who understands sign language to facilitate seamless communication with the physician is an important aspect. In a study conducted by McColl et al. (2008) regarding providing primary care to individuals with disabilities, it was observed that many physicians have a prerequisite for patients to have a companion present during specific medical procedures, such as dressing and undressing. This requirement primarily aims to enhance communication, particularly for patients with hearing impairments. There needs to be more intentional efforts within the healthcare system to ensure the provision of in-house attendants for hearing-impaired patients. Consequently, when these patients are not accompanied to healthcare facilities, their access to medical care is significantly reduced. Furthermore, the individual's entitlement to confidentiality and privacy is compromised as a result of the involvement of a third party.

The attitudes, views, and behaviour exhibited by healthcare professionals towards disabled women may differ among various professional groups within the healthcare system.

The observed variations can be attributed to a range of factors, including the presence or absence of disability training, individual belief systems, cultural norms, and the specific roles and duties allocated to various healthcare professionals. The study by Devkota et al. (2017), which looks at healthcare practitioners' attitudes towards disability and the experiences of disabled women seeking maternal healthcare in rural Nepal, makes several observations about these subtle differences. According to the findings of their study, male healthcare professionals demonstrated a more favourable disposition towards women with disabilities in comparison to their female colleagues. Additionally, they noted that nurses displayed a more positive attitude towards disabled women than physicians. Additionally, they noted that younger healthcare professionals exhibited a more receptive demeanour towards disabled women compared to their older colleagues. They linked this age disparity to the generational shift that fosters acceptance and a positive outlook on disability.

However, research conducted by Dorji and Solomon (2009) produced mixed findings regarding the attitudes of various health professional cadres towards disabled persons. The researchers observe that physicians manifest more positive attitudes towards disabled people in comparison to nurses. The disparity is attributed to the additional exposure that doctors may have received through their training experiences outside of Bhutan. Furthermore, their study did not yield any significant differences between male and female healthcare workers regarding their attitudes towards disabled women. Moreover, they reported that exposure to disability experiences did not have any discernible effect on the attitudes of healthcare workers.

The beliefs and attitudes of healthcare workers towards disability, as well as their handling of disabled women in both public and private health institutions, exhibit considerable variation and divergence. Several studies highlight the poor conditions that prevail in public health facilities for marginalised groups, especially disabled women. The study by Rugoho and Maphosa (2017) highlights the persecution and humiliation that Ghanaian Disabled women face from nurses in government facilities when seeking and using maternal healthcare services. They have specifically documented how visually impaired women are denied privacy during examinations in public health facilities due to unannounced entry by other staff, in the mistaken belief that their condition prevents them from noticing the intrusion.

Other studies in Malawi, Pakistan, India, and Cameroon have found widespread violations of the rights of disabled women seeking maternal healthcare services in public health facilities (Ahmad, 2013; Munthali et al., 2019; Zuurmond et al., 2019). The denial of privacy for pregnant, disabled women constitutes an apparent infringement upon their inherent and inalienable human rights. It is imperative to recognise that all individuals, irrespective of their disability status, are entitled to privacy. This entitlement is crucial for upholding human dignity and autonomy. Persistent violations of their right to privacy may potentially result in these women opting to abstain from seeking skilled birth attendance, which is an undesirable outcome.

2.3 Research Gaps

Some studies specific to Kenya have examined the influence of individuals' perceptions, attitudes, and beliefs regarding disabled individuals on their societal acceptance and capacity to avail general health care. However, adequate research attention has not been devoted to examining the societal perspectives and attitudes around the disability, pregnancy, and childbirth encounters of women with disabilities.

The studies examined in the empirical literature review have not adequately explored the gender disparities as regards perceptions and attitudes towards disabled women, as well as their unique experiences and challenges with disability, pregnancy, and childbirth. This study has investigated, analysed, and discussed the distinctive encounters of disabled women, alongside the perceptions and attitudes of non-disabled women and men as well as healthcare workers regarding the disability, pregnancy, and childbirth of disabled women. The intersectionality of poverty, gender and disability is also discussed in the findings.

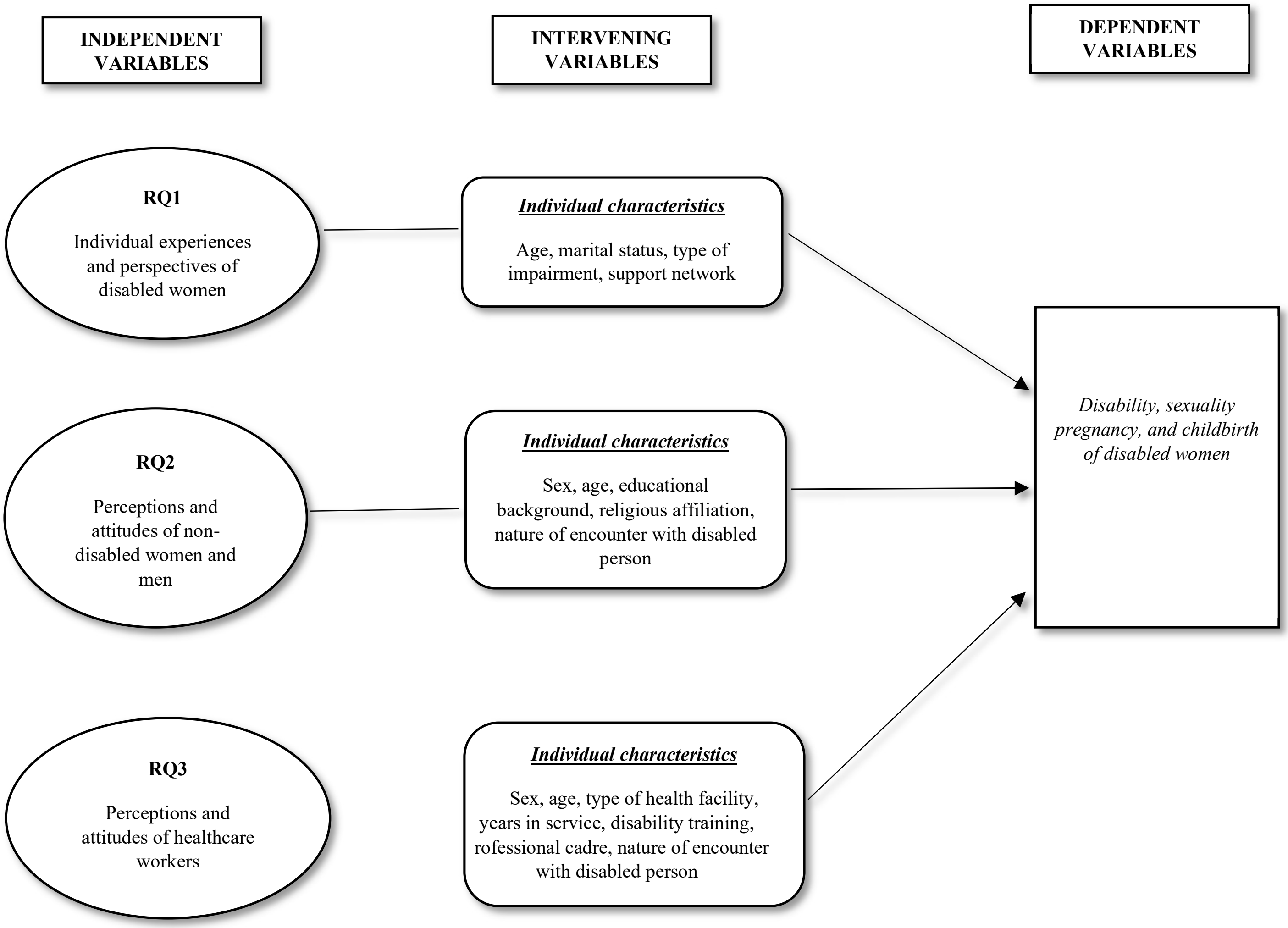
Most of the studies analysed in the empirical literature review have utilised qualitative research approaches to examine the perspectives of non-disabled individuals and healthcare professionals regarding the circumstances and experiences of disabled women. Additionally, there is a dearth of scholarly research undertaken on the African continent that has utilised standardised measures, such as the Attitudes Towards Disabled Persons Scale (ATDP), to examine the phenomenon of prejudice and discrimination against disabled people, with a specific emphasis on disabled women. The research aimed to address this disparity.

2.4 Conceptual Framework

The Individual perspectives and experiences of disabled women, as well as perceptions and attitudes of non-disabled women and men and healthcare workers, are the independent variables in the study. The dependent variable in the research is the disability, sexuality, pregnancy, and childbirth of disabled women. We made assumptions in the study that the experiences and perspectives of disabled women may be influenced by their age, marital status, type of disability, family support and solidarity networks. For instance, physically impaired women would have distinct perspectives and experiences in comparison to those who are visually impaired. On the other hand, we presupposed that individual attitudes and perceptions of non-disabled women and men towards the disability, pregnancy, and childbirth of disabled women would be influenced by sex, age, educational background, religious affiliation, and encounters with disabled people. Lastly, the researcher argued that attitudes and perceptions of healthcare workers on disability, pregnancy, and childbirth of disabled women would be influenced by a variety of factors, including sex, age, health facility type, professional cadre, disability training, years of service, and encounters with disabled individuals. The graphical representation of the conceptual framework is highlighted in *Figure 1*.

Figure 1

Conceptual Framework



2.5 Summary of Chapter Two

The second chapter discussed the theoretical literature review, empirical literature review, conceptual framework, and inherent research gaps. Particular attention was devoted to critical disability theory, models of disability and UDHR. We highlighted the UHDR and the social model of disability and their implications on the status, dignity, and human rights of disabled persons. For the empirical literature research, we examined peer-reviewed scientific articles on the individual experiences and perspectives of disabled women. This is in addition to analyzing the attitudes and perceptions of non-disabled women and men and health workers towards disability and disabled women. Finally, the empirical literature review identified several gaps in the literature review, including the dearth of studies on disability, pregnancy and childbirth and the limited use of standardized instruments such as the ATDP Scale to examine stigma and prejudice against disabled people.

CHAPTER THREE: METHOD

3.0 Introduction

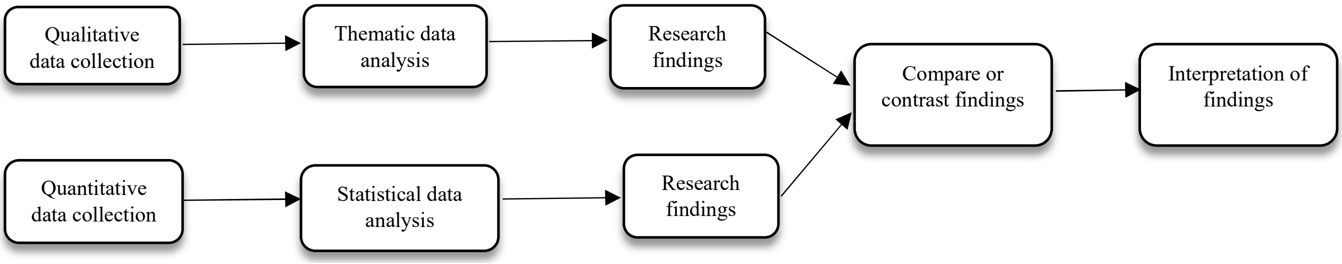
This chapter provides an in-depth overview of the methodology used in the study, including the research design, target population, sample techniques, and data collection tools. The perspectives related to disabled women and their encounters were investigated in the study through a mixed-methods approach. The strategies for investigation of the perspectives and attitudes of non-disabled women and men, as well as healthcare workers, towards the disability, pregnancy, and childbirth of disabled women are also presented in the third chapter. This chapter also emphasises the outcome measurements for perceptions and attitudes. Finally, the chapter examines the techniques used to analyse qualitative and quantitative data and the ethical considerations inherent in the study.

3.1 Research Design

This study employed a convergent parallel mixed method design for the collection, analysis, and interpretation of data regarding the attitudes, perspectives, and perceptions around disability, sexuality, pregnancy, and childbirth among disabled women in Kibra, Nairobi. This design enables the researcher to merge quantitative and qualitative data when analysing an existing research problem (Creswell & Creswell, 2017; Glesne, 2016; Selvam, 2017). The researcher concurrently collected and analysed qualitative and quantitative data using in-depth interview techniques and survey methodology, respectively. The results from the two processes were compared and interpreted collectively. This procedure is summarised in *Figure 2*.

Figure 2

Convergent Parallel Mixed Method Design



Adapted from Edmonds and Kennedy (2017, p. 183)

3.2 Location of the Study

The study was conducted in Kibra Sub County in Nairobi, Kenya. This is a densely populated informal settlement area with approximately 2.5 square kilometres of land. It is divided into four administrative districts: Kibra, Sarang'ombe, Laini Saba, and Woodley. The choice of the Kibra sub-county as the study site was informed by the past human rights work of the researcher in the area, and this was further buttressed by the encounter with Jane, a physically impaired woman. During one of the human rights clinics, Jane narrated to the researcher her sad and horrific experiences during pregnancy and childbirth at a health centre in Kibra Sub County. The story of Jane was very eye-opening and raised my curiosity to probe into those specific challenges women like Jane go through during pregnancy and childbirth in Kibra. According to the master health facility list of the Ministry of Health (MoH), there are approximately eighty-eight operational health facilities in Kibra (MoH, 2021). The health facilities are owned by private entities (43), government agencies (22), faith-based organisations - FBOs (5), and non-governmental organisations - NGOs (18).

3.3 Target Population

In research, the target population contains every case within a study that meets the criteria. Polit and Hungler (1999) emphasised the significance of eligibility criteria in selecting a population for study. They argue that eligibility requirements define the qualities of research participants. The 2019 Kenya Population and Housing Census did not explicitly report the total population of disabled persons, so we can't certainly know the population of disabled women in Kibra. However, it estimates that 2.2% of the population aged five years and above were reported to have a disability and that the prevalence of disability was higher among women (2.5%) than men (1.9%). The research focused on all disabled women of reproductive age in Kibra who have been pregnant before or are already mothers. The population of Kibra stood at 185,777 individuals (KNBS, 2020), and the estimated figures for non-disabled women and men were 94,199 and 91,569, respectively. There is currently a lack of information regarding the count of healthcare workers in Kibra Sub-county. The target population for healthcare workers encompasses different cadres such as doctors, nurses, clinical officers, and community health workers across private, public, faith-based, and non-governmental health facilities.

3.4 Sampling Technique and Sample Size

3.4.1 Sampling of Disabled Women

Most studies propose a sample size of 15 to 30 for qualitative research but emphasise the need for saturation in achieving the desired equilibrium (Moser & Korstjens, 2018; Boddy, 2016; Marshal et al., 2013; Dworkin, 2012). This means that the researcher would keep collecting data until no new information comes from the interviews or observations or any other qualitative methods applied. The researcher employed snowball sampling to identify and choose women of reproductive age who had various impairments, such as physical, visual, speech/hearing, and albinism. However, women with cognitive disability were excluded due to the inherent difficulties in studying this particular group of women (Vehmas, 2019; Dowse, 2009; Keilty & Connelly, 2001). The researcher collaborated with a local community-based disability persons organisation (DPO), *Become Initiative*, based in Kibra and selected the first five respondents who had a prior engagement with the organization based on the selection criteria in *Figure 3.* Specifically, these included women who were physically impaired (2), hearing/speech impaired women (2), and visually impaired women (1). Through interaction with these five women as a starting point, the researcher established connections with additional disabled women who had physical impairments (4), hearing/speech impairments (2), vision impairments (1), and albinism (2), resulting in a total of fourteen (14) respondents were interviewed. The number was considered sufficient owing to the saturation of the data. Hearing/speech-impaired women were interviewed through the use of sign language interpreters.

Figure 3

Criteria for the Selection of Disabled Women

1. Participants must be residents from Kibra informal settlement area
2. They must be women who are of reproductive age and exhibit either physical, visual, or hearing/speech impairment, or albinism.
3. The women may be breastfeeding, expectant, or have young children.
4. The participants must give consent to the researcher to digitally record and transcribe the interviews

The study findings show that most women interviewed were between the ages of 41 and 35 (6), whereas the minority were between the ages of 41 and 50 years (3). Concerning their educational backgrounds, six of them have completed secondary school, five have undergone vocational training, two possess a university degree, and one has only finished primary school.

Regarding marital status, just two women are currently married, while eight are single, three are separated, and one is divorced. Five women who are or were married have been in polygamous relationships, whereas just one has been in a monogamous union. Four of the interviewed women disclosed that their pregnancies were planned, while the remaining ten disclosed that their pregnancies were unexpected. *Table 1* provides a summary of the interviewee's characteristics.

Table 1

Distribution of Disabled Women by Background Characteristics

Background characteristics	Numbers	%
Type of disability	**14**	**100**
Physically impaired	6	43
Hearing/speech impaired	4	29
Visually impaired	2	14
Albinism	2	14
Age Category	**14**	**100**
21 -30 years	5	36
31-40 years	6	43
41-50 years	3	21
Level Education	**14**	
Primary school	1	7
Secondary school	5	36
Vocational training	6	43
University	2	14
Marital status	**14**	
Single	8	57
Married	2	14
Separated	3	21
Divorced	1	7
Type of Marriage	**6**	**100**
Polygamous	5	85
Monogamous	1	17
Pregnancy planned/unplanned	**14**	**100**
Planned	4	29
Unplanned	10	71

3.4.2 Sampling of Non-Disabled Women and Men

Kibra Sub County has an estimated 185,777 residents, representing the study's target population size. (KNBS, 2020). Since the population size is known, the researcher calculated the sample size using a formula by Yamane (1967, p. 886). The formula provides a simplified process for determining sample size. $= \frac{N}{1+N(e)^2}$, where n is the sample size, N is the population, and e is the level of precision.

$$n = \frac{185777}{1+185777(0.05)^2} = \frac{185777}{465} = 399.5 \text{ respondents} = \text{rounded off to } 400$$

The researcher utilised stratified random sampling to select non-disabled women and men as participants for the study, ensuring geographical and gender representation. Three levels of sampling were undertaken during the selection of these participants. In phase I, the researcher created strata for each of the four administrative units based on the ratios regarding the estimated population of Kibra. The tabulation for the strata is indicated in *Table 2*.

Response rates for studies in metropolitan and peri-urban regions have been reported to be significantly lower than in rural areas, and researchers have employed the oversampling technique to overcome this challenge. (Pickery & Carton, 2008; Corry et al., 2017; Mauz et al., 2020). Based on this fact, the researcher added 180 additional respondents (45% of the initial sample size) and adjusted the sample size proportionately, as shown in *Table 3.*

Table 2

Stratified Sample of Research Participants in Administrative Units

Administrative Units	Population (2019 Census)	% of the total Kibra Population	Sample size
Kibra	64,754	35	139
Sarang'ombe	55,303	30	119
Laini Saba	29,605	16	64
Woodley	36,115	19	78
Total	**185,777**	**100**	**400**

Source: KNBS, 2020

Table 3

Adjusted Sample Size (Oversampling)

Administrative Units	Population (2019 Census)	Previous Sample size	Proportionate oversampling	New sample size
Kibra	64,754	139	63	202
Sarang'ombe	55,303	119	54	173
Laini Saba	29,605	64	29	93
Woodley	36,115	78	34	112
Total	**185,777**	**400**	**180**	**580**

Source: KNBS, 2020

In phase II, the researcher proportionately selected non-disabled women and men from the sample size to participate in the study. This process was guided by the population estimates for the 2019 census. The census registered a population of 91,569 and 94,199 for women and men, respectively, in Kibra Sub County, representing a ratio of 49.3% to 50.7%. The tabulation for gender representation is highlighted in *Table 4*.

Table 4

Stratified Sample of Research Participants Based on Gender

Administrative Units	Sample size	Non-disabled men	Non-disabled women
Kibra	202	102	100
Sarang'ombe	173	88	85
Laini Saba	93	47	46
Woodley	112	57	55
Total	**580**	**294**	**286**

Source: KNBS, 2020

In the third phase, the researcher randomly selected non-disabled women and men and administered the survey questionnaire after being granted consent. The study surveyed 420 non-disabled people, representing a 72% response rate. The response rate to the survey in this research for non-disabled women and non-disabled men was 71% and 74%, respectively. Moreover, Kibra, Sarang'ombe, Laini Saba, and Woodley administrative units had response rates of 96%, 84%, 54%, and 63%, respectively. The study findings show that females and males are equally represented in the study's non-disabled sample (50.5% to 49.5%). Most participants (39.3%) were between the ages of 26 and 35, with a small minority (2.1%) older than 56. The remaining respondents were between the ages of 36 and 45 (17.3%), 46 and 55 (11.4%), and 18 and 25 (29.0%). Regarding religious affiliation, most respondents (85%) identified as Christians, while 10.4% and 2.9% identified with Islam and African Traditional Religion, respectively, and only 1.2% were classified as nonreligious. *Table 5* highlights the background characteristics of the 420 non-disabled women and men who participated in the study.

Table 5

Distribution of Non-Disabled Women and Men by Background Characteristics

Background characteristic	Frequency	Percentage
Sex	**420**	**100.0**
Female	208	49.5
Male	212	50.5
Age category	**420**	**100.0**
18-25	125	29.8
26-35	165	39.3
36-45	73	17.4
46-55	48	11.4
56 and over	19	2.1
Religious affiliation	**420**	**100.0**
Christianity	359	85.5
Islam	44	10.5
African traditional religion	12	2.9
Not religious	5	1.2
Educational background	**420**	**100.0**
Bachelor’s degree and above	21	5.0
Some college	82	19.5
Secondary school	164	39.1
Vocational training	39	9.3
Primary school	104	24.8
No formal schooling	10	2.4
Type of encounter with disabled person	**420**	**100.0**
Casual contact	216	51.4
Caregiver	127	30.2
No contact at all	77	18.3

Regarding educational background, the most significant proportion of respondents (39.1%) said they had completed secondary school, while the most negligible proportion

(2.4%) said they had no formal schooling. Furthermore, 5%, 19.5%, 9.3%, and 24.8% of respondents indicated they had a university degree, some college, vocational training, or primary school certification, respectively. Finally, when asked about their encounters with Disabled people, 51.4%, 30.2%, and 18.3% of respondents reported that they had casual contact, were caregivers, or had no contact, respectively.

3.4.3 Sampling of Healthcare Workers

There is no readily available data on the number of healthcare workers in Kibra Sub County because most of the statistics on the health workforce are national in scope. However, information from the Ministry of Health (MoH) indicates that Kibra has eighty-eight functional health facilities that are owned by private entities (43), government agencies (22), faith-based organizations - FBOs (5) and non-governmental organizations - NGOs (18). Using stratified random sampling, the researcher selected participants from health facilities for the study, which was done in three phases. In phase I, the researcher developed a stratum for each health facility category (public, private, FBO and NGO) to obtain proportional representation. The researcher sampled fifty per cent of these four categories of facilities and selected thirty-four health facilities. Eighteen private health institutions declined to participate in the study, whereas five NGOs and two FBOs consented to the data collection. All eight visited public health institutions were included in the final sample for the study. A summary of the categories of the facilities selected for the study is highlighted in *Table 6*.

In phase II, a stratified sampling approach was employed to select healthcare workers from various cadres across healthcare facilities, including doctors, clinical officers, nurses, and community health workers (CHWs). For each selected facility, at least a quarter of the declared number of healthcare personnel were included in the sample. In cases where facilities did not provide specific information on staff composition and numbers, the researcher made estimations. Tables 7 and 8 summarise the sample size and distribution of healthcare personnel by professional cadre and facility type.

Table 6

Selection of Different Categories of Health Facilities

Category of health facility	Number of facilities	Percentage (%)
Private	4	21
Public (MoH)	8	42
FBO facilities	2	11
NGO facilities	5	26
Total	**19**	**100**

In phase II, a stratified sampling approach was employed to select healthcare workers from various cadres across healthcare facilities, including doctors, clinical officers, nurses, and community health workers (CHWs). For each selected facility, at least a quarter of the declared number of healthcare personnel were included in the sample. In cases where facilities did not provide specific information on staff composition and numbers, the researcher made estimations. Tables 7 and 8 summarise the sample size and distribution of healthcare personnel by professional cadre and facility type.

Table 7

Sample Size for Healthcare Workers

Category of health facility	Number of healthcare Workers	Sample size
Private	72	18
Public (MoH)	648	162
Faith-based organizations	44	11
Non-governmental organization	100	25
Total	**864**	**216**

Table 8

Sampling Based on the Type of Health Facility and Professional Cadre

Professional Cadre of healthcare worker	**Sample size (Type of facility)**				
	Private	*Public*	*FBO*	*NGO*	*Total*
Clinical Officers	3	18	2	4	27
Community Health Workers	9	118	3	12	142
Doctors	2	3	2	2	9
Nurses	4	23	4	7	38
Total	**18**	**162**	**11**	**25**	**216**

The response rate to this study was 67% for healthcare workers (145 respondents). The response rate was highest among the nurses at 71% and lowest among the clinical officers at 63%. Community health workers and doctors had similar response rates of 67%. The survey reveals a higher proportion of female healthcare workers than male healthcare workers (68.5% to 31.5%). Most participants were between 26 and 35 (40%), while the minority were 56 and older (4.1%). The remaining respondents' ages ranged from 36 to 45 (29%), 46 to 55 (20%), and 56 and 18 to 25 (6.2%). The demographic information of the 145 healthcare workers who participated in the study is summarized in *Table 9*.

In addition, 76.6% of respondents reported working in a public health institution, while 16.6%, 5.5%, and 1.4% were affiliated with NGO-owned, private, and faith-based facilities, respectively. Most survey respondents (65.5%) were community healthcare workers (volunteers), whereas just 4.2% of the sample comprised medical doctors. The sample consisted of 18.6% nurses and 11.7% clinical officers. When asked where they had received training or awareness on disability, 50.3% of respondents said they had attended such training, but 49.7% said they had not. Most respondents (42.1%) had worked in the health sector for less than five years, while only 2.8% had more than twenty-one years of experience. Moreover, 31%, 17.9%, and 6.2% of the healthcare workers had served between 6 and 10 years, 11 to 15 years, and 16 to 20 years, respectively. Regarding the nature of their encounters with disabled persons, 49% and 17.2% of respondents said it was through the provision of general and specialized services, respectively. However, 33.8% of respondents said that their interactions with disabled persons were casual.

Table 9

Distribution of Healthcare Workers by Demographic Characteristics

Background characteristics	Frequency	Percentage
Sex	**145**	**100**
Female	99	68.7
Male	46	31.7
Age category	**145**	**100**
18-25	9	6.2
26-35	58	40.0
36-45	42	29.0
46-55	30	20.7
56+	6	4.1
Distribution by health facility type	**145**	**100**
Public	111	76.6
Private	8	5.5
NGO	24	16.6
FBO	2	1.4
Professional cadre	**145**	**100**
Doctor	6	4.2
Nurse	27	18.6
Clinical Officer	17	11.7
Community Health Volunteer	95	65.5
Exposure to Disability training	**145**	**100**
Yes	73	50.3
No	72	49.7
Years of service	**145**	**100**
1-5	61	42.1
6-10	45	31.0
11-15	26	17.9
16-20	9	6.2
21+	4	2.8
Type of encounter with disabled person	**145**	**100**
General services	71	49.0
Specialized services	25	17.2
Casual contact	49	33.8

3.6 Methods of Data Collection

The researcher collected both qualitative and quantitative data. Qualitative data was gathered through in-depth interviews with fourteen disabled women to get their individual experiences and perspectives on their disability, pregnancy, and childbirth. The researcher developed and used an interview guide for this process. The interviews were recorded after obtaining consent, transcribed, and prepared for analysis. To facilitate effective communication with hearing/speech impaired respondents, the researcher engaged the services of a sign language interpreter.

The quantitative data for the study was obtained through survey methodology. The research targeted 294 non-disabled women, 286 non-disabled men, and 216 healthcare workers. Using a survey, the researcher collected data at a meagre cost and in a short amount of time. The researcher undertook a perception survey for non-disabled women and men, in addition to healthcare workers. The researcher also investigated attitudes towards disabled women by applying the ATDP scale, initially developed by Yuker, Block, and Young (1970).

The ATDP scale has become an important investigative tool for disability researchers. It has been used in several studies on attitudes towards disabled people. The ATDP Form B data collection tool for non-disabled women and men and healthcare workers used in the study comprised 30 statements with six rating Likert-type scales (-3, -2, -1, 1, 2, 3). The ATDP scale had a score range of 0 to 180. Higher scores indicate less prejudice against disabled women, while lower scores indicate high prejudice. The quantitative data was gathered using the Kobo Toolbox platform and prepared for analysis using Statistical Package for the Social Sciences (SPSS) software.

3.7 Research Instrumentation

The interview guide had open-ended questions that allowed respondents to respond freely, whereas the questionnaire was closed-ended. In-depth interviews are helpful for research relating to perceptions and intimate issues such as sexuality and disability (Schafer &

Koyiet, 2018). Maintaining the objectivity and worthiness of data collected through critical informant interviews requires a very rigorous process for the development of the requisite tools for research (Kallio et al., 2016). The researcher developed interview guides that directly responded to the research questions and conformed to internationally acceptable standards. The interview guides were used to gather data from disabled women.

Questionnaires allow the researcher to get a snapshot of respondents' opinions over a short period and address challenges associated with comprehensive geographical coverage (Burford et al., 2009). In this study, questionnaires were explicitly used to ascertain perceptions and attitudes by healthcare workers and non-disabled women and men towards the disability, sexuality, and pregnancy of disabled women. The survey questionnaire was adapted from the ATDP scale. *Table 10* provides a concise overview of the data-gathering instruments, outlining their significance, intended participants, and areas of emphasis.

Table 10

Data Collection Tools for Research

Method of data collection	Relevance of method	The instrument of data collection	Target respondent	The focus of data collection
In-depth interviews	Useful for in-depth inquiry into pertinent issues affecting Disabled women and coping mechanisms	Interview guide	Disabled women (14)	-Experience with impairment and coping mechanisms -Experience with pregnancy, labour, and childbirth -Community and healthcare attitudes and responses
Attitude Survey Perception survey	Helpful in understanding how healthcare workers think about Disabled women and their behaviour towards them	Perception survey questionnaire and ATDP tool	Healthcare workers (145)	-Firsthand information on how healthcare workers view disability and Disabled people -Perceptions and attitudes towards Disabled women's pregnancy and childbirth

Attitude Survey Perception survey	Critical in gathering public perceptions and attitudes on Disabled women	Perception survey questionnaire and ATDP tool	Non-disabled women and men (420)	-Perceptions and attitudes around Disabled people -Perceptions and attitudes around Disabled women's pregnancy and childbirth

3.8 Validity and Reliability of the Research Instruments

Validity and reliability are essential metrics for assessing the quality of research data collection instruments (Drost, 2011). Reliability is described as the ability of research instruments to consistently provide comparable results if used with the same type of subjects and within the same setting, or "consistency of measure" (Heale & Twycross, 2015; Kimberlin & Winterstein, 2008). There are four methods for establishing research instrument reliability: equivalent form, test-retest, internal consistency, and split-half. The internal consistency technique, which is considered a high-quality test, was employed in the study.

The researcher utilised the Cronbach alpha model to test the internal consistency of the ATDP scale. When the Alpha coefficient is above 0.9, it is considered excellent; when 0.8, it is regarded as good; when it is 0.7, it is considered acceptable; and when it is less than 0.6, it is seen as poor. In this study, Cronbach’s Alpha was calculated to be 0.717 for the 30-item ATDP scale, showing an acceptable level of internal consistency.

Conversely, validity is the level an instrument can measure as intended (Sullivan, 2011). We have two types of validity: external and internal, which measure the ability of data to be generalised across individuals and the ability of research instruments to measure measures, respectively (Bannigan & Watson, 2009). Four main categories of validity exist: Construct Validity, Content Validity, Face Validity, and Criterion Validity. To ensure that the study’s instruments accurately measured their corresponding intended elements, the researcher utilized a content validity technique. The evaluation process compared data from in-depth interviews and surveys with other evidence gathered through comparable analytical means. The researcher also engaged senior faculty members for feedback purposes during this phase.

The researcher carried out a pilot study in one of the administrative areas in Kibra Sub County before the primary research to ascertain the usability and appropriateness of the survey tools. The researcher sampled 5% of the overall study sample size to maintain the sample's representativeness. The pre-test focused on the sequence of the questions as well as the simplicity and appropriateness of the language. The findings from the pre-test were used to improve the research instruments.

3.9 Procedures of the Research

The researcher obtained ethical clearance from Tangaza University College before the commencement of the study. Additionally, the researcher secured a research permit from the National Commission for Science, Technology, and Innovation (NACOSTI). He also held consultative meetings with existing disability groups in Kibra Sub County and the Kibra Sub County health team. These meetings helped discuss the reasons for the research, the process for selecting the research participants, the research tools, and the probable strategy for utilising the research findings. After the conclusion of the fieldwork, the researcher proceeded to analyse both the qualitative and quantitative data, which informed the drafting of the study findings.

3.10 Measurement of Perceptions of Non-Disabled Women and Men

The causes of disability, heredity of disability, sexuality (including feelings, organs, and activity), and pregnancy and childbirth were the four dimensions used to measure the perceptions of non-disabled women and men regarding disability, pregnancy, and childbirth of disabled women. Multiple contextual factors were considered to comprehend the socio-demographic attributes of non-disabled women and men. These include sex, age, religious affiliation, and level of education, in addition to the nature of their encounters with disabled people. The descriptions of the variables are highlighted in *Table 11.*

3.11 Measurement of Perceptions of Healthcare Workers

Three dimensions - sexuality (sexual feelings, sexual organs, and sexual activity), pregnancy, and childbirth - were used in the survey to measure the perceptions of healthcare workers of the disability, pregnancy, and childbirth of disabled women. Various background characteristics were used to understand the sociodemographic characteristics of the healthcare workers. Sex, age category, health facility type, professional cadre, exposure to disability training, years of experience, and the nature of their encounters with disabled people were all considered. *Table 12* outlines the descriptions of the variables.

3.12 Variables for Attitude of Non-Disabled Women and Men and Healthcare Workers

The ATDP Form B was used to assess the attitude of non-disabled women and men and healthcare workers towards disabled women. The attitude is an overall algebraic sum of the respondents' rating scores and ranges between 0 and 180. The interpretation of the score is premised on variations in the perspectives of individuals concerning distinctions between disabled and non-disabled persons. An ATDP score lower than average denotes a negative disposition towards disabled people and, conversely, higher scores. According to Yuker et al. (1970, p. 28), scores of 110 for males and 113 for females indicate positive attitudes.

Respondents were required to agree or disagree with 30 statements on the ATDP scale. They were tasked with selecting the most suitable response. The participants in the study were instructed to select a value that fell within predetermined parameters, which ranged from +3 to -3. These values denoted "I strongly agree" and " disagree very much," respectively. The final scores for the ATDP scale were calculated using comprehensive guidelines outlined by Yuker, Block, and Young's seminal work published in 1970.

The original ATDP scale of this study included both positive and negative statements. In the first phase, the algebraic signs of all positive statements on the ATDP scale were reversed. This was done for ATDP items 17, 19, 20, 23, 24, and 26 for non-disabled women and men and healthcare workers. Next, the algebraic total of each item was calculated. The final sum's algebraic sign was changed from positive to negative and vice versa. In order to eliminate negative scores, a constant value of +90 was added to each score, which resulted in only positive scores. The final ATDP score is between 0 and 180; higher scores indicate more positive attitudes towards disabled women. *Tables 13 and 14* provide an overview of the outcome and background variables for non-disabled women and men and healthcare workers.

3.13 Normality of Data Distribution Test

When analysing quantitative data, researchers must evaluate the level of normality of the data. They must determine whether the data have a standard or non-normal distribution. This will enable the researcher to decide whether parametric or nonparametric tests will be used to test hypotheses. Typically, the Shapiro-Will test determines if a continuous variable follows a normal distribution. The Shapiro-Wilk test can be easily interpreted as follows: If the p-value is **less than or equal to 0.05**, then the null hypothesis can be rejected, indicating that the variable in question is not normally distributed. If the p-value is **more than 0.05**, it is not possible to reject the null hypothesis, indicating that there is a possibility that the variable is normally distributed.

The distribution of ATDP scores for non-disabled women, men, and healthcare workers was assessed using the Shapiro-Will test. The test results indicate that the distribution of ATDP scores among non-disabled women and men exhibited non-normality ($W = 0.99$, p-value < 0.01). Based on the test results and non-parametric hypothesis tests, the Mann-Whitney U and Kruskal-Wallis tests were used to examine the influence of demographic characteristics on the ATDP scores of non-disabled women and men. The Shapiro-Will test also suggests that the ATDP scores for healthcare workers were typically distributed ($W = 0.99$, p-value $= 0.275$). Based on the results, parametric tests, specifically the one-way ANOVA, were run, and the mean and statistical significance of the ATDP scores were calculated to determine how demographic variables affect the ATDP scores of healthcare workers.

Table 11

Variables for the Perceptions of Non-Disabled Women and Men

Measure	Definition and coding	Measurement Level
Dependent variable		
Causes of disability	Perceived causes of disability :- *(1 = accidents, 2 = birth complications, 3 = curses, 4 = evil spirits, 5 = genetics, 6 = God's punishment, 7 = sickness, 8 = witchcraft)*	Nominal
Inheritance of disability	Perceptions on the likelihood of a disabled woman giving birth to a disabled child. *(1 = strongly agree, 2 = agree, 3 = strongly disagree, 4 = disagree, 5 = neutral)*	Nominal
Sexual feelings of disabled women.'	Perceptions of community members on disabled women's sexual feelings *(1 = have sexual feelings, 2 = lack sexual feelings)*	Nominal
Sexual organs of disabled women	Perceptions of community members on disabled women's sexual organs *(1 = have abnormal sexual organs, 2 = have normal sexual organs)*	Nominal
Sexual activity of disabled women	Perceptions of community members on disabled women's sexual activity *(1 = are sexually active, 2 = are sexual inactive)*	Nominal
Fertility of disabled Women	Perceptions about the possibility of pregnancy among disabled women *(1 = strongly agree, 2 = agree, 3 = strongly disagree, 4 = disagree, 5 = neutral)*	Nominal
Abnormality/normality of disabled women pregnancy	Perceptions about the abnormality (or normality) of pregnancy of disabled women *(1 = strongly agree, 2 = agree, 3 = strongly disagree, 4 = disagree, 5 = neutral)*	Nominal
Background variables		
Sex	Self-identification by respondents on their sex :- *(1 = female, 2 = male)*	Nominal
Age	Age of the respondents expressed in years *(1= 18 - 25, 2 = 26 - 35, 3 = 36 - 45, 4 = 46 - 55, 5 = 56+)*	Ordinal
Religious affiliation	Professed status of the religion of the respondent at the time of the survey *(1 = Christianity, 2 = Islam, 3 = African traditional religion, 4 = not religious)*	
Educational background	Level of education of the respondent at the time of the survey. *(1 = bachelor's degree and above, 2 = some college, 3 = secondary school, 4 = vocational training, 5 = primary school, 6 = no formal schooling)*	Nominal
Encounter with disabled people.	Level of interaction between the respondent and disabled people *(1 = casual contact, 2 = caregiver of PWD, 3 = no contact)*	Nominal

Table 12

Variables for the Perceptions of Healthcare Workers

Measure	Definition and coding	Measurement Level
Dependent variable		
Sexual feelings of disabled women.'	Perceptions of the sexual feelings of disabled women :- *(1 = have sexual feelings, 2 = lack sexual feelings)*	Nominal
Sexual organs of disabled women	Perceptions of sexual organs of disabled women *(1 = have abnormal sexual organs, 2 = have normal sexual organs)*	Nominal
Sexual activity of disabled women	Perceptions of sexual activity of disabled women *(1 = are sexually active, 2 = are sexual inactive)*	Nominal
Fertility of disabled women	Perceptions about the possibility of pregnancy among disabled women *(1 = strongly agree, 2 = agree, 3 = strongly disagree, 4 = disagree, 5 = neutral)*	Nominal
Abnormality/normality of disabled women pregnancy	Perceptions about the abnormality (or normality) of pregnancy of disabled women *(1 = strongly agree, 2 = agree, 3 = strongly disagree, 4 = disagree, 5 = neutral)*	Nominal
Background variables		
Sex	Self-identification by respondents on their sex :- *(1 = female, 2 = male, 3 = binary)*	Nominal
Age	Age of the respondents expressed in years *(1= 18 - 25, 2 = 26 - 35, 3 = 36 - 45, 4 = 46 - 55, 5 = 56+)*	Ordinal
Health facility type	Ownership type of the health facility at the time of the survey *(1 = Public, 2 = private, 3 = NGO, 4 = FBO)*	Nominal
Professional cadre	The professional level of healthcare worker *(1 = doctor, 2 = nurse, 3 = clinical officer, 4 = community health volunteer)*	Nominal
Disability-related training or workshop	Attendance to disability-related training or targeted disability awareness forums *(1 = yes, 2 = no)*	Nominal
Years in service	The number of years served as a healthcare worker is captured in categories. *(1= 1 - 5, 2 = 6 - 10, 3 = 11 - 15, 4 = 16 - 20, 5 = 20+)*	Ordinal
Encounter with disabled people.	Level of interaction between the respondent and disabled people *(1 = general services, 2 = specialized services, 3 = casual contact, 4 = no contact)*	Nominal

Table 13

Variables for Attitude of Non-Disabled Women and Men

Measure	Definition and coding	Measurement level
Dependent variable		
Attitude score	Sum of the respondents' ATDP scores (0 - 180)	Numerical
Background variables		
Sex	Self-identification by respondents on their sex *(1 = female, 2 = male)*	Nominal
Age	Age of the respondents expressed in years *(1= 18 - 25, 2 = 26 - 35, 3 = 36 - 45, 4 = 46 - 55, 5 = 56+)*	Ordinal
Religious affiliation	Professed the status of the religion of the respondent at the time of the survey *(1 = Christianity, 2 = Islam, 3 = African traditional religion, 4 = not religious)*	
Educational background	Level of education of the respondent at the time of the survey. *(1 = bachelor's degree and above, 2 = some college, 3 = secondary school, 4 = vocational training, 5 = primary school, 6 = no formal schooling)*	Nominal
Encounter with disabled people.	Level of interaction between the respondent and Disabled people *(1 = casual contact, 2 = caregiver of PWD, 3 = no contact)*	Nominal

Table 14

Variables for Attitude of Healthcare Workers

Measure	**Definition and coding**	**Measurement Level**
Dependent variable		
Attitude score	Sum of the respondents' ATDP scores (0 - 180)	Numerical
Background variables		
Sex	Self-identification by respondents on their sex *(1 = female, 2 = male, 3 = binary)*	Nominal
Age category	Age of the respondents expressed in years *(1= 18 - 25, 2 = 26 - 35, 3 = 36 - 45, 4 = 46 - 55, 5 = 56+)*	Ordinal
Health facility type	Ownership type of the health facility at the time of the survey *(1 = Public, 2 = private, 3 = NGO, 4 = FBO)*	Nominal
Professional cadre	The professional level of healthcare workers at a given facility *(1 = doctor, 2 = nurse, 3 = clinical officer, 4 = community health volunteer)*	Nominal
Disability-related training or workshop	Attendance to disability-related training or targeted disability awareness forums *(1 = yes, 2 = no)*	Nominal
Years in service	The number of years served as a healthcare worker is captured in categories. *(1= 1 - 5, 2 = 6 - 10, 3 = 11 - 15, 4 = 16 - 20, 5 = 20+)*	Ordinal
Encounter with disabled people.	Level of interaction between the respondent and Disabled people *(1 = general services, 2 = specialized services, 3 = casual contact, 4 = no contact)*	Nominal

3.14 Data Analysis

Data analysis is a vital aspect of any research undertaking. In this study, the quantitative data was subjected to statistical analysis, while thematic analysis was employed for the qualitative data. Selvam (2017) has identified and categorized two distinct approaches to thematic data analysis: deductive-inductive and pure inductive. The former approach is suitable when a theoretical framework is present in the research, encompassing the creation of a coding template, identifying initial codes, and generating themes. The latter approach prioritizes the initial use of open coding, followed by axial coding and the subsequent generation of themes. The research employed the methodology of pure inductive thematic analysis, which consists of three distinct stages.

1. Step 1—Open coding entails reading data line by line to extract relevant phrases and expressions. The original words serve as nodes.
2. Step 2 - Axial coding minimizes the number of nodes by combining related nodes into multiple distinct codes.
3. Step 3 – Identification of themes by merging closely comparable codes to generate themes from a data set.

Statistical methods were used to analyse quantitative data. The researcher examined the perceptions and attitudes of non-disabled women, men, and healthcare workers concerning disabled women concerning demographic characteristics. The analysis was described using frequency distribution tables, means, percentages, and cross-tabulations. The study employed the Chi-Square Test of Independence to analyse the association between the perceptions of non-disabled women and men, healthcare workers, and various demographic variables. Non-parametric statistical tests, specifically the Mann-Whitney U and Kruskal-Wallis tests, were also used to investigate the influence of demographic factors on the ATDP scores of non-disabled women and men. The relationship was considered significant with $p = < 0.05$. Lastly, the ANOVA test was utilised to examine the influence of demographic variables on the ATDP scores of healthcare workers. The relationship was considered significant with $p = < 0.05$.

3.15 Ethical Considerations in the Study

Research ethics encompasses the "protection of the dignity of subjects and the publication of the information in the research" (Fouka & Mantzorou, 2011, p. 4). The researcher must protect the respondents' rights while conducting and reporting research. There are several ethical issues to consider when conducting research. Four major ethical issues guided the study: informed consent, anonymity, confidentiality, avoiding harm, and conflict of interest. The researcher ensured that respondents understood the purpose of the study, the methodology used to select them, and the intended use of the research data. While recruiting respondents, the researcher packaged targeted information that included the reasons for the study. Informed consent was obtained from all the respondents before participating in the study.

During the research process, the identities of the respondents must be anonymized and kept confidential. Private details such as name, age, and location should not be publicly disclosed (Openshaw et al., 1997). In presenting the research findings, the researcher has hidden the respondents' identities and called them pseudonyms. Avoiding harm is another key ethical consideration during research. Some of the harm emanating from research initiatives includes physiological, emotional, social, and economic issues (Steele, 2005). In the study, the researcher made monetary contributions to *Become Initiative*, a local community-based disability persons organisation (DPO) in Kibra, for logistical purposes and did not offer any personal incentives to the research respondents. The research team also ensured that the interviews were as brief as possible and minimised interference with the social and economic activities of the respondents.

The researcher has previously implemented human rights advocacy projects in the Kibra informal settlement, and there was the looming danger of subjectivity. Curzer and Santillanes (2012) have discussed the impact of conflicts of interest on the research process and researchers. They observe:

> Conflict of interest threatens all aspects of research. The research process is at risk, from the choice of research problem to research design, recruitment and treatment of research subjects, data interpretation, peer-review of publication and grant applications. (Curzer & Santillanes, 2012, p. 143)

The data collection instruments, findings, and all aspects of this study were subjected to peer review processes to eliminate possibilities of bias. Existing theories and studies on disability and access to maternal health were compared with the research findings to address any inconsistencies that may have emerged. COVID-19 has presented severe health challenges to the country, and the government has implemented measures to manage its impact. This includes guidelines for community gatherings that are expected to apply recommended social distancing practises and masking to halt the spread of the pandemic. The researcher ensured that all activities related to the research conformed to advisories and laid down public health regulations for COVID-19.

In Kenya, legal and institutional mechanisms are currently in place for collecting, using, processing, and retaining personal data. By the provisions of the Kenya Data Protection

Act (2019), the researcher for this study was classified as a data processor, owing to the researcher's role of collecting, analysing, and publishing personal data from individuals (data subjects) in Kibra informal settlements. As required by the Act, the researcher created a specific consent form that was filled out and signed by all the study's respondents (data subjects). The data subjects were informed of their right to withdraw consent and the purpose for which the data would be used. Additionally, they were informed that the study's findings would be published without reference to their personal information. In line with Article 40 of the Act, all personal data will be erased from all existing databases after the final approval of the research thesis. The researcher worked with data collection, processing, and archiving guidelines developed by Tangaza University College (the data controller).

3.16 Envisaged Impact of the Study

It is the expectation of the researcher that the findings will spark policy and community conversations about how to address challenges and concerns around the disability, pregnancy, and childbirth of disabled women. The researcher anticipates that the policy recommendations generated by this study will stimulate the development of long-term strategies for reaching out to these underserved populations. The research findings will be shared with the Nairobi County Health Management Team members.

Furthermore, considering the study's findings and the unique Kenyan setting, the researcher has proposed potential contributions of the Utu philosophical paradigm to the critical disability theory. This is covered in chapter five of the thesis.

3.17 Summary of Chapter Three

The chapter provides a comprehensive overview of the study's research design, sampling procedures, data collection instruments, data analysis methods, and ethical considerations. the study employed convergent parallel mixed methods design to gather and analyze data regarding the disability, pregnancy and childbirth of disabled women perceptions and attitudes of disabled women towards disability as well as pregnancy and childbirth for ease of analysis. Fourteen disabled women were interviewed using comprehensive interview techniques. On the other hand, a Perception Survey and Attitudes ATDP scale were administered to 420 non-disabled women and men and 145 healthcare workers. In the study, quantitative data was analyzed using statistical analysis while qualitative data was subjected to thematic analysis. The ethical considerations considered included adhering to informed consent, maintaining anonymity and confidentiality of participants, preventing any potential harm or conflicts of interest that may arise as well as complying with COVID-19 protocols and provisions outlined in the Kenya Data Protection Act (2019).

CHAPTER FOUR: RESULTS

4.0 Introduction

The fourth chapter discusses the study's findings in light of the three research questions. The first research question addresses the perspectives and individual experiences of disabled women concerning their disability, pregnancy, and childbirth. Personal interviews were used to collect qualitative data, and the thematic analysis generated two overarching themes: stereotypes and stigma around disability and disabled women's sexuality, pregnancy, and childbirth, which are supported by participant quotations.

The second and third research questions examined the perceptions and attitudes of two different groups, non-disabled women and men and healthcare workers, regarding disability, sexuality, and pregnancy among women with a disability. Information for these two sets of respondents was obtained through survey methodology, specifically by using the Perception Survey and ATDP tool. The Chi-Square Test of Independence was conducted to establish the relationships between perceptions of non-disabled women and men and healthcare workers, respectively, and various demographic variables.

The study employed non-parametric statistical tests, specifically the Mann-Whitney U and Kruskal-Wallis tests, to investigate the influence of demographic variables on the ATDP scores of non-disabled women and men. Furthermore, the researchers utilised the ANOVA test to assess the impact of demographic variables on the ATDP scores of healthcare workers The relationship was considered significant in all the statistical tests with $p = < 0.05$.

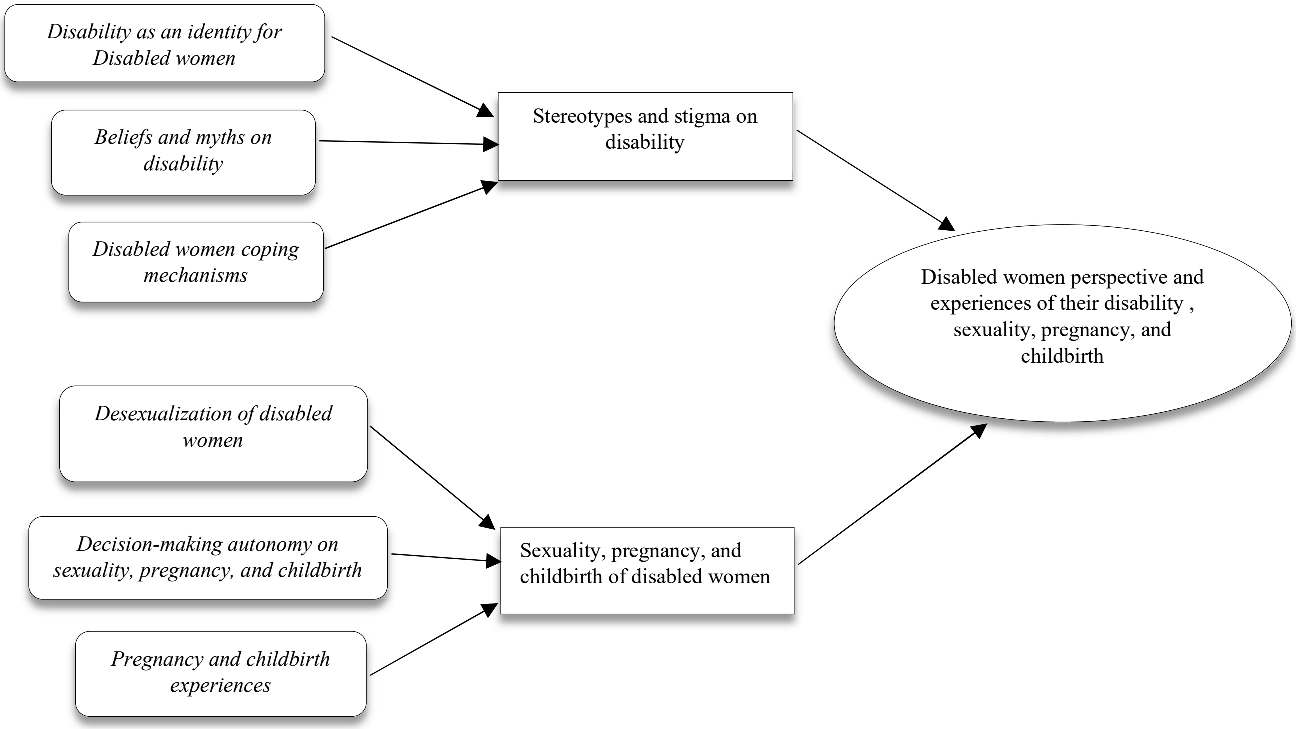
4.1 Research Question One: Perspective and Experiences of Disabled Women of their Disability, Pregnancy And Childbirth

The first research question explored disabled women's perspectives and experiences regarding their disability, pregnancy, and childbirth. Data for the study was gathered through personal interviews using an interview guide.

The study employed the pure inductive thematic analysis approach described by Selvam (2017) to analyze qualitative data. This method prioritises open coding at first and then axial coding before generating themes. Open coding involves carefully analyzing each line of data and extracting phrases while keeping their original words intact for later usage as nodes. Axial coding reduces the number of available nodes by combining related information into distinct codes used for further analyses thereafter. Eventually, closely similar codes from datasets get integrated into specific themes, with identifiable characteristics being highlighted accordingly.

Figure 4

Schematic Representation of Themes



The study's findings are presented under two main themes based on pure inductive thematic analysis of the interview transcripts: stereotypes and stigma on disability and sexuality, pregnancy, and childbirth of disabled women (Figure 4). The analysis was based on the following research question: *What are the perspectives and experiences of disabled women regarding their disability, pregnancy, and childbirth?*

4.1.1 Stereotypes and Stigma on Disability

One of the overarching themes that emerged from the thematic analysis of the interview transcripts was stereotypes and stigma about disability, which is connected to three other subthemes: misconceptions and beliefs about disability, disability as an identity for disabled women, and coping mechanisms for disabled women. The first subtheme discusses some deeply held beliefs and myths regarding disability and disabled women. The second subtheme focuses on how disability as an identity is frequently used to characterise disabled women. Finally, the third subtheme explores the strategies disabled women employ to manage their portrayal and treatment in society. These aspects are discussed in greater depth, along with evidence from the study's findings.

4.1.1.1 Beliefs and Myths about Disability. The study's findings have revealed the existence of prejudices and stereotypes about disability and disabled women in the community. They are seen as less human, and their presence is linked to unnatural occurrences such as bad omens and curses. This predicament is best described by Susan (not her real name), a 23-year-old single woman with Albinism and a university graduate from Kibra Ward, who recounts how she and her mother were treated unjustly because of her disability.

> My paternal uncles said terrible things about my mother and tried to get us to leave our homestead. First, they said that they had never had anyone with an impairment like me in their family before, and now I was giving them more trouble. They were afraid I would have another albino child who would bring more curses to the family, just like I did. They said that my birth brought a bad omen to the family and that I would give birth to something even stranger and more superstitious. They asked what would stop someone with albinism like me from having another albino child if my normal mother had an albino child.

23-year-old woman with albinism (Case #.14) – 22nd May 2022

The narratives and beliefs that associate impairments with supernatural forces or retribution for misdemeanours are reflected in the case of a second woman, a 23-year-old physically impaired woman. Jane (not her actual name) is also from Kibra Ward and has completed secondary school. She tells her story.

> The extended family blamed my parents for my impairment. There are claims that my parents are distant cousins and that their marriage was taboo. I have heard stories from some villagers that my impairment was a result of a curse on the family because of the sex of two close relatives. I do not believe in these stories and think they are unfair to my parents.

24-year-old physically impaired woman (Case #8) – 21st May 2022

In many societies, as evidenced in the study, disability is characterized in the context of superstition and moral judgment; disabled persons are viewed as bearers of misfortune, and this consequently breeds stigma and discrimination. This not only marginalizes disabled people but also reinforces barriers to social, economic, and personal development. Disabled women find themselves exposed to compound discrimination due to intersectionality between gender and disability.

While it is assumed that close family members would understand and accept disabled women without prejudice, the findings of this study indicate that this is not the norm. There are numerous occurrences and experiences in the study of disabled women reporting being subjected to discrimination by their family members on account of their disability. One such case is that of a 33-year-old single, physically impaired woman who narrates her painful childhood experience. She confided to the researcher that this discriminatory treatment wounded her heart since she had hoped for more acceptance and compassion from her family.

> I am viewed as an outsider because of my impairment. Within the family, I am treated differently, as if I am not a part of the family. When I was young, whenever we had visitors in the house, I was told to sit far away from the house. They seemed embarrassed about my impairment, and I felt hurt.
>
> *33-year-old physically impaired woman (Case #9) – 21st May 2022*

The family's behaviour towards disabled women, as documented in the study, is a testament to perpetuation of social values and norms. Attitudes held within society toward disability often get reflected and perpetuated through families as core units of society. Trying not to let others, especially visitors, see disabled children reflects an internalization by the family of broader societal expectations about physical normality and the idealized image of the family.

The other noteworthy finding from the study is that disabled women are seen as useless and incapable of caring for themselves. The women interviewed in the study were unhappy with their portrayal by community members as ‘beggars’ and ‘invalids.’ Disabled women believe that despite their disability, they are capable of fending for themselves and will not want to depend entirely on the rest of society for their livelihoods and needs. These perspectives are alive in the narrative of Margarita, a visually impaired 35-year-old woman in a polygamous marriage with vocational training as her highest level of education:

> The community is very judgmental; for example, when they see a disabled person, they always see beggars. They think we cannot work and take care of ourselves and our families. They only look down on us.
>
> *35-year-old visual impaired women (Case #11) – 20th May 2022*

Disabled women suffer a double burden due to their gender and disability, which are regarded by society as the constituent components of inadequacy and dependency. Such devaluation by society of the potential or capacities of disabled women can be located within a strongly held patriarchy that exalts male productivity and assigns traditional roles to women. By these standards, women have domestic roles, and the introduction of disability into this scheme produces a portrait of uselessness on the part of disabled women.

4.1.1.2 Disability as an Identity for Disabled Women. According to the study findings, a variety of dehumanizing labels are used to identify and characterize disabled women, some of which are insulting and demeaning. A summary of the labels is provided in *Table 15*. Disability as an identity is used to characterise disabled women. In this context, one of the women interviewed for the study complained that her children had been referred to as that 'sightless woman's children,' even though they knew her name and where she lived.

All the disabled women interviewed in the study reported that it really meant a lot to them if they were called by their real names. According to them, it not only gave them a sense of identity but was also crucial in breaking stereotypes and prejudices transmitted through impersonal labels. Some of the women did not mind being called with reference to children, such as being referred to as "Mama Jane." They felt this personalized address gave them an identity and presented them not just as disabled persons but as mothers and caregivers.

Table 15

Labels Used as Identity for Disabled Women

Type of disability	Derogatory label	English translation
Hearing/speech impaired	Bubu (Swahili)	Dumb and mute
	Maskio ziba (Swahili)	Blocked ears
Physically impaired	Okuome (Dholuo)	Hunchback
	Olingo (Dholuo)	Limping one
	Otiende (Dholuo)	One with a bad leg
	Kiwete (Swahili)	Cripple
	Kinundu (Swahili)	Hunchback
	Kaguru (Swahili slang)	One-legged
Visually impaired	Kipofu (Swahili)	Blind one
	Macho bovu (Swahili)	Useless eyes
Albinism	Mamillions (Swahili slang)	Worth much money
	Mzungu (Swahili)	White person
	Zeruzeru	White skinned

4.1.1.3 Disabled Women's Coping Mechanisms. When confronted with stigma, outright discrimination, and exclusion from mainstream society due to their impairments, disabled women frequently employ a variety of coping mechanisms. The findings of the study reveal that disabled women employ survival strategies that include aggressive behaviour, avoidance, self-stigma, and solidarity among themselves.

Aggressive behaviour is one of the responses of disabled women towards members of society with negative beliefs and attitudes. It could involve a physical or verbal altercation. In the study, several women disclosed to the researcher that they were compelled to engage in physical confrontation because of constant humiliation and harassment by community members due to their disability. Mary (not her real name), a 24-year-old hearing/speech-impaired woman, confided to the researcher that she had an unpleasant experience with one of the neighbours who insulted her without any provocation. In her own words, she ‘dealt with her decisively.’ Mary was educated up to the secondary school level and was currently single. She adds,

> But there was one time I pushed a neighbour while we were collecting water since she had removed my containers from the queue, and when I asked her why she did, she poked her ear at me and indicated that I was deaf and of unsound mind.
>
> *24-year-old woman with hearing/speech impairment (Case #2) – 19th May 2022*

Alice, a 25-year-old woman who is both unmarried and hearing and speech impaired, had a comparable encounter. In response to a community member who intentionally drew attention to her disability by poking his ears, Alice retaliated by biting his hand.

> I passed by one of the shops on my way home to get milk, but I couldn't tell the shopkeeper what I wanted due to a communication breakdown. Someone else in the shop kept putting their fingers in their ears and pointing at me. I was furious, and in an instant, I grabbed his right ear and bit it. This person had done the same thing to me more than once, and I could not stop myself from getting angry. I was mad.
>
> *25-year-old hearing/speech impaired woman (Case #3) – 20th May 2022*

These acts of aggression do not merely happen in spontaneous reactions to the world around them; rather, they result from constant frustration due to society's negative perception that belittles and stigmatizes them. Most disabled women develop defensive postures as a result of the internalization of these negative cultural attitudes. However, while seeking to regain dignity and establish existence, they turn to aggression in their struggle.

According to the study findings, self-stigma and self-hatred are additional ways disabled women cope with constant profiling and discrimination by the community. Some of the disabled women who were interviewed often thought of themselves as "odd" and "unworthy" because society has repeatedly taught them to believe that way. Self-stigma and self-hatred not only hurt their self-esteem but also keep them from accepting their impairment. Florence, a 42-year-old physically impaired single woman, shared that the use of derogatory names about her impairment has drained her emotionally. She adds that she preferred to be called by her name:

> The use of labels such as ‘crooked-legged woman’ impacted my self-esteem, and I felt as if I was not worthy to be a human being. I even questioned why God created me in this manner to face humiliation. Some community members continually negatively refer to my impairment, yet they know my name. It hurts very much.
>
> *42-year-old woman with physical impairment (Case #6) – 19th May 2022*

A second visually impaired woman, 35-year-old Margarita (not her actual name), who was in a monogamous marriage, shared that the community's negative perception of her disability had a significant impact on her personality and sense of belonging.

> These labels and other negative descriptions affect me negatively as they lower my self-esteem. I am trying to overcome my impairment and try to live a 'normal' life as much as possible when such names are used. If I am called the blind one, this affects my sense of belonging and my acceptance of my impairment. At times it makes me question if I am useful to society.
>
> *35-year-old woman with visual impairment (Case #11) – 20th May 2022*

Such labelling time and again de-personalizes and dehumanizes disabled women. These labels amount to significant psychological damage in the form of reduced self-esteem and self-worth. Disabled women burdened with such labelling may perceive themselves most of all through the prism of disability and 'abnormality'. This scenario leads to a feeling of unworthiness and inadequacy that pervades their private and social identities.

The study also found that disabled women in Kibra Sub County navigated the difficulties associated with exclusion, discrimination, and degradation in society through solidarity with each other. The women interviewed in the study were incredibly positive about their collective efforts to change their societal predicament. They also shared how meeting and discussing their disability with other women in similar circumstances had helped their cause. Susan (not her real name), a 23-year-old single woman with albinism and a university graduate from Kibra Ward, shared with the researcher some of the effects of their monthly solidarity meetings.

> Other disabled women do encourage me and tell me that they have faced the same problems as me and that I need to accept that not everyone will like me or treat me with respect. People tell me I will have to learn how to live with those who do not accept me because you cannot make them see things differently. They ask me to keep going and not give up because God will make up for all the wrongs done to me.
>
> *23-year-old woman with albinism (Case #14) – 20th May 2022*

The support from people going through similar situations provides a nurturing network that validates lived experiences and gives emotional nourishment. Therefore, disabled women affirm their identities and experiences collectively on the basis of solidarity. The act of collective resistance and challenge to the ableist narratives provides the necessary mental and emotional strength for disabled women to face the discriminating society.

4.1.2 Disabled Women's Sexuality, Pregnancy, and Childbirth

The second central theme that emerged from the thematic analysis was the sexuality, pregnancy, and childbirth of disabled women. It has three subthemes: Desexualization of disabled women, disabled women's pregnancy and childbirth experiences, and disabled women's decision-making autonomy on sexuality, pregnancy, and childbirth. The findings on the first subtheme concentrate on how society perceives the sexuality of Disabled women, specifically in terms of sexual desires and sexual activity. The second subtheme focuses on the lived experiences of disabled women before and during pregnancy and childbirth. The third subtheme emphasises women's autonomy in making decisions regarding their pregnancy. The findings from the three subthemes have been discussed alongside relevant quotes from study participants.

4.1.2.1 Desexualization of Disabled Women. Some of the study's interviewees revealed that the rest of the community does not expect disabled women to engage in sexual activity. It emerged from the interviews that the most common reaction to a pregnant woman was profound surprise, followed by the remark, "How did she even get pregnant?". Mary (not her actual name), a 24-year-old single hearing- and speech-impaired woman, was unhappy with the treatment she received from the community after it became apparent that she was expecting. She believed that she was profiled based on her disability.

> Some were telling me, ‘If you are impaired, why couldn’t you control your sexual urge? You were not supposed to have sexual feelings like ordinary people. They seemed to think that people like me have more control over sexual desires. Some were also asking who that man was who was merciless and insensitive enough to make somebody like me pregnant.

24-year-old woman with hearing/speech impairment (Case #2) – 19th May 2022

Monica, a 38-year-old physically impaired woman, was also subjected to similar humiliation when derogatory comments were made about her sexuality. Due to her disability, the community expected her to suppress her sexual desires to prevent the embarrassment of being pregnant.

> For the community, my pregnancy became a sensation and lots of harmful things were said about me. People were glancing at me and making bad comments and some even saying, 'Even that limping one, the crippled can have sex and become pregnant, we wonder' and 'This one is in crutches; how did she even open her legs?' I used to hide in the house during my pregnancy due to this mistreatment.

38-year-old woman with physical impairment (Case #5) – 19th May 2022

Another hearing- or speech-impaired woman endured the same humiliating treatment, including vile remarks about her sexual activity. The antenatal care (ANC) nurses who cared for her repeatedly made references to her impairment. Alice, a 25-year-old unmarried woman with a primary level of education, described her experiences at the clinic.

> At the hospital, things were not different as they would wonder why I didn't close my legs, given that I was impaired. Some even joked and asked how I communicated with my partner before and during sex to the point of getting pregnant. One of them even had the guts to use derogative hand signs to show how I asked for sex from my partner. They humiliated me, and I felt worthless.

25-year-old hearing/speech impaired woman (Case #3) – 20th May 2022

These research findings, in effect, reflect the extensive desexualization of disabled women in society, so much so that deep-rooted beliefs and prejudices grossly undermine their dignity and autonomy. Scepticism and shocking reactions towards the pregnancy of disabled women reveal how society narrowly perceives them solely based on their disability, stripping them of their sexual agency and humanity.

4.1.2.2 Pregnancy and Childbirth Experiences of Disabled Women. The findings of the study reveal that disabled women fear disclosing or discussing their pregnancy due to the anticipated hostile reception and response from other community members. There is a feeling of concern among them that their pregnancy will be met with considerable scepticism and suspicion because they are already deemed "abnormal." Martha (not her real name), a 37-year-old university graduate and divorced woman with Albinism, exemplifies the general sentiment among disabled women that their pregnancy is undesirable. She intimated to the researcher that she kept her pregnancy a secret from her family and community because she had been treated harshly owing to her disability, and some people even made comments about her infertility (due to her impairment), which caused her to doubt her pregnancy until the final month.

> When I had my son, they were surprised, and some of them even asked me why I had not told them I was pregnant. Even though they seemed worried, I know they were not because of how they treated my Albinism. They must have been surprised that a woman like me could get pregnant and have a baby. I did not tell anyone I was pregnant because I was still in denial and did not feel ready to be a mum. I also thought that people would judge me harshly for being pregnant because I am 'albino,' so I just kept it to myself. I felt terrible that I was pregnant before I was married and that this would bring shame to our family.
>
> *37-year-old Woman with Albinism (Case #13) – 20th May 2022*

The research findings bring out more deep-seated social and psychological barriers that exist regarding the pregnancy and childbirth of disabled women. The case of Martha illustrates the spectrum through which societal norms and stigma drive the personal choices of disabled women. Her fear of being judged by the members of the community, and most probably embarrassed due to her disability and pre-marital pregnancy, mirrors the dilemma of many disabled women.

Attendance at the antenatal clinic is essential for all expecting women since useful information and preventative interventions are provided for the mother and unborn child. The antenatal default rate among disabled women interviewed for this study was high, especially for public health institutions (at least 60% reported default), and it was attributed to previous negative experiences. The narratives of three disabled women reveal the level of contempt shown by healthcare workers and how it contributes to ANC defaults. The first one, Monica (not her real name), a 38-year-old physically impaired woman, was humiliated at the health facility.

> The reception at this health facility was not very welcoming, and they all seemed shocked that I was pregnant despite my impairment. The disdain was so open, and I could hear the discussion in hushed tones among the nurses. They openly showed contempt towards me because of my impairment. It made me wonder if I had made a mistake in coming to the ANC clinic, and I even defaulted on some visits.

38-year-old woman with physical impairment (Case #5) – 19th May 2022

During her first ANC appointments, the second person, Florence (not her real name), a 42-year-old physically impaired woman, was also humiliated by the health workers, and she decided to discontinue her visits. She recounts her own experience to the researcher and highlights a high degree of unprofessionalism and insensitivity on the part of the healthcare workers:

> I had my fears and initially hesitated to go to the clinic because I imagined people would laugh at me. However, when I eventually went to the nearby public health facility for my clinic, I remember there was a doctor who asked, ‘You are crippled, and yet you have decided to become pregnant and eventually give birth? Surely, some people don’t feel pity for themselves. If this one gives birth, who will care the baby for her?’ He told me this while laughing and conversing with the nurse. The doctor upset me, and I did not go to my next clinic the following month.
>
> *42-year-old woman with physical impairment (Case #6) – 19th May 2022*

Lastly, Susan (not her real name), a 23-year-old single woman with Albinism and a university graduate from Kibra Ward, also recounted the humiliating treatment she had at her first antenatal session and vowed never to return to a subsequent clinic again. She has defaulted on all antennal clinics after the unpleasant experience.

> They would wonder how someone like me would come for ANC visits since they had never seen someone like me (a person with Albinism) give birth. "Haka kakitu" (this thing) is what they called me. On one of my visits, there was a male doctor there. He told me I should not bother going to the hospital so much and should just let the baby die. Besides that, he did something I will never forget. Instead of helping me, he punched me in the stomach and told me that the baby and I should both die.
>
> *23-year-old woman with Albinism (Case #14) – 22nd May 2022*

This kind of hostile reception and open contempt for disabled women seeking ANC services at health facilities, as documented by the study findings, not only violates the principle of non-maleficence, which binds health professionals to do no harm or breach respect for human dignity concerning the care of patients. Specifically, the conduct of the doctor in the case of Florence, where he rebukes her in the presence of the nurse for her decision to become pregnant despite her disability, clearly shows insensitivity and complete disregard for professional ethics. This behaviour indicates serious pointers toward underlying issues within the healthcare system, more so the failure to enforce professional ethics and protocols of behaviour for healthcare workers. The extreme manifestation of degrading and dehumanizing behaviour by healthcare workers is thus a direct threat to the physical and emotional well-being of disabled women, entrenching their mistrust of health facilities and, therefore, their boycott of antenatal and postnatal services.

Some of the women interviewed for this study were concerned about how they would manage the responsibilities of motherhood. For instance, Mary (not her actual name), a 24-year-old single hearing- and speech-impaired woman, was worried that her infant would die of suffocation if she were unable to hear her cries for attention.

> I felt bad and had some fears because I thought I had made a mistake by becoming pregnant. I was always worried about taking care of the baby, or even hearing her cry because I have trouble hearing. I imagined what would happen to them if the baby swallowed something, and I was unable to hear her cry. It would be a disaster.
>
> *24-year-old woman with hearing/speech impairment (Case #2) – 19th May 2022*

According to the findings of the study, several disabled women who were interviewed indicated that healthcare workers often assume that, due to their disability, they were unable to give birth naturally. As a result, there was a tendency to refer them for emergency caesarean sections, even when it was not necessary. Two women recounted being pushed into the delivery room without their consent or that of their partners and that the decision to take them to the operation room was based entirely on their disability. The first woman, Lucy, a 41-year-old hearing- and speech-disabled woman in a monogamous marriage, reckoned that the communication barrier played a significant part in her predicament.

> Even though they couldn’t understand my sign language they figured I was pregnant and in labour and rushed me directly to the theatre. By this time, my partner had already arrived at the health facility and suggested that I be able to undergo normal delivery, but they ignored him. This was unusual for me since I know that only emergency cases were taken for operation. My partner, who was present, had not signed the consent form and wondered how they would take me in for the procedure.
>
> *41-year-old hearing/speech impaired woman (Case #1) – 19th May 2022*

The second individual, a visually impaired 29-year-old woman called Josephine (pseudonym), had similar experiences. Because of her impairment, Josephine was subjected to profiling and was immediately led to the operating theatre upon her arrival at the healthcare facility with labour pains.

> What really bothered me was when I went to the health facility to deliver my child. I wanted to give birth in a normal way and can still remember what the nurse said. She said that "hawa vipofu" (these blind people) should be taken in for CS (caesarean section), and the male doctor immediately jumped on that. I told him I should not have CS because I was able to push out my first child, but they just ignored me and rushed to the operating room. It occurred to me that many Disabled people have had to undergo caesarean section even though they are able to push.
>
> *29-year-old hearing/speech impaired woman (Case #12) – 19th May 2022*

Accounts of disabled women about forced caesarean sections raise serious concerns over consent and patient autonomy. Informed consent is paramount so far as healthcare is concerned, more so in surgical procedures. The findings show that consent from disabled women was either inadequately obtained or bypassed, both of which are ethically problematic and legally indefensible. Recurrence of unwarranted medical intervention for disabled women through emergency CS procedures draws attention to a potential medicalization of disability.

This study revealed that many disabled women were mistreated in a completely unethical manner by health facility staff, especially in the delivery room, where their right to privacy was violated. The experience of Martha (not her real name), a 37-year-old woman with albinism who endured humiliation while giving birth at a local health facility, illustrates the magnitude of the problem.

> As I was giving birth, I noticed a lot of people in the room. I figured that they had never seen a woman with Albinism giving birth before. I thought this was weird and that my privacy was being invaded because I think that when someone is giving birth, only the doctor and a nurse should be in the room, not a large group of people. Even though the curtain was closed, I could sometimes see people peeping in who had nothing to do with the delivery.
>
> *37-year-old woman with Albinism (Case #13) – 20th May 2022*

As the respondents recounted, the fact that curious onlookers usually surround the delivery room during childbirth for disabled women is enough to highlight outright disregard for a patient's right to privacy. This unpalatable behaviour lowers the dignity of disabled women and their right to a safe and conducive space during delivery. It projects the stigmatization of and ‘thingification’ of disabled women, who often become objects of curiosity rather than patients worthy of compassion and confidentiality. The inadequate training and sensitization of healthcare personnel on the needs and rights of disabled persons may be one of the reasons for this state of affairs. Measures must be instituted to make certain that only critical medical personnel are present during such intimate moments for all women, particularly disabled women, and all employees should be sensitized on the importance of absolute patient confidentiality and privacy.

4.1.2.3 Disabled Women's Decision-Making Autonomy on Sexuality, Pregnancy, and Childbirth. All the women interviewed for this study had extremely low incomes. Yet, they frequently paid out of pocket to visit private health facilities, which they perceived to be more accommodating than public institutions. The women cited healthcare workers at public health institutions for humiliation, rudeness, derogatory comments about pregnant, disabled women, and indifference towards their disability.

The narratives of two women who are physically impaired and visually impaired, respectively, reveal their preference for private health facilities over public ones. The first woman, a 24-year-old physically impaired woman called Nancy (pseudonym), who is a single mother with a secondary level of education, gives an insight into these choices.

> I went to the nearby public health centre for the first time during my second pregnancy. There, I met a nurse who seemed nice based on how she talked to me. When I returned for the second visit, I found someone else who treated me contemptuously. Her attitude was so bad, forcing me to look for an alternative facility for my other visits. I opted to pay for private health services due to the horrible experience at the government facility.
>
> *24-year-old woman with physical impairment (Case #8) – 21st May 2022*

The experience of Margarita, the second woman, who is 35 years old, visually impaired, and married, sheds further light on disabled women's preference for private health facilities over government-run facilities.

> As shared earlier my first ANC visit was to a public health facility, and it was an unpleasant experience. I was not treated well; the person accompanying me was denied entry into the consultation room and the nurse's station. My problems started at the reception as the reception wondered aloud, asking me ''even you, you are pregnant?'' Within a short time, another nurse came and loudly asked ''And why has this one come to the Hospital in her state (disability)? Do you mean she is also pregnant? This is a mystery''. Based on this negative experience, I went to a private health facility during my second pregnancy and was treated with respect, and they were not judgmental.
>
> *35-year-old woman with visual impairment (Case #11) – 20th May 2022*

The results suggest that among the major forces that drive disabled women to private health facilities, rather than public ones, is the series of undesirable experiences disabled women face in public health institutions. Among these experiences are rude, insensitive, and judgemental remarks concerning their pregnancy, coupled with unfair treatment. As such, even though private health institutions are more expensive, these women prefer them since they give them appropriate care, dignity, and respect. The inherent deficiency in public health institutions could be addressed through the application of zero-tolerance policies against non-discrimination, sensitization of health personnel on disability-sensitive practices, and engendering a cultural shift toward the inclusion and respect of all patients, regardless of their status.

The research also revealed the preference of disabled women for male healthcare workers and doctors over their female counterparts and nurses, respectively. All the women interviewed indicated that they would feel more at ease if they were cared for by male healthcare providers because they perceived them as more empathetic and less judgmental. One interviewee's narrative, Lucy, a 41-year-old hearing- and speech-disabled woman in a monogamous marriage, recounts her experiences with both female and male healthcare workers, with a preference for the former.

> I had a better experience at my ANC visits when the male healthcare workers attended to me. The females were very rude and uncaring in my encounter with them. The male worker handled me very professionally and allowed me to communicate on paper since we could not use sign language. He was very patient.
>
> *41-year-old woman with hearing/speech impairment (Case #1) – 19th May 2022*

The same was said to be true for doctors, who were also recognised as more sympathetic than nurses to the situation of disabled women. This is corroborated by the disclosure of Margarita, a 35-year-old visually impaired woman who is in a polygamous marriage and has a secondary level of education, who shares her positive experiences with a doctor.

> A doctor in the public health facility treated me in a very humane manner. I was bitter with the treatment I received at the reception and triage, and when I entered the consultation room, I was already fuming with rage. He noticed my displeasure and calmed me down, whispered and listened to my grievances and concerns… Doctors were more receptive to me compared to nurses.
>
> *35-year-old woman with visual impairment (Case #11) – 20th May 2022*

The perceptions of disabled women about their negative interactions with female health professionals are mediated by gender norms. Caregiving women are often held to even higher standards regarding care and compassion; deviating from these expectations is judged more harshly. On the other hand, characteristics typically considered very feminine — being empathic and patient — when exhibited by male healthcare professionals tend to be more tolerated and appreciated. It is further perceived by disabled women that doctors, mostly men, are more empathic towards them in comparison with nurses, mostly women. This difference may mean increased complexity in the patient-provider relationship, something that could be explained by professional hierarchies in healthcare facilities. Whereas doctors generally hold senior positions and are more qualified, they are arguably better positioned to show empathy to patients whose emotional and physical needs are very complex. The situation of the nurses may be different since they are burdened with many routine tasks and have limited time left to attend to patients individually, which could be misconstrued as cold and uncaring.

4.2 Research Question Two: Perception and Attitude of Non-Disabled Women and Men towards Disability, Sexuality and Pregnancy of Disabled Women

The second research question investigated the perceptions and attitudes of non-disabled women and men concerning disability, sexuality, and pregnancy of disabled women. This section discusses a variety of perceptions, including how respondents in the study viewed the causes and inheritance of impairment as well as the sexuality (sexual feelings, sexual organs, and sexual activity), fertility, and pregnancy of Disabled women. The study employed a perception survey questionnaire to gather data on perceptions. A Chi-Square Test of Independence was conducted to examine the relationship between perceptions and various demographic variables such as sex, age, religious affiliation, educational background, and encounters with Disabled people. The relationship was considered significant with p = < 0.05.

Additionally, the second research question focussed on the attitudes of non-disabled women and men toward Disabled women. Using the ATDP Form B questionnaire (discussed in detail in the methodology chapter), the researcher gathered data on attitudes. Mann–Whitney U and Kruskal Wallis tests assessed the relationship between demographic characteristics and the ATDP mean rank scores. The relationship was also considered significant with p = < 0.05.

4.2.1 Causes of Impairment as Perceived by Non-Disabled Women and Men

This section examines the perceptions of non-disabled women and men about what causes impairment. A close-ended question was posed to the study's participants: In your opinion, what causes impairment? They were given many alternatives from which they were required to choose only one: Accidents, birth complications, curses, evil spirits, heredity, God's punishment, sickness, and witchcraft were all possibilities. The study's findings (Table 16) indicate that non-disabled women and men identified heredity (40.3%) and birth complications (37.%) as the primary factors contributing to impairment. In comparison, evil spirits (2%) and God’s punishment (1%) were the least mentioned reasons for impairment. Statistical analysis using the Chi-Square Test of Independence was performed to examine the association between respondents’ perceptions of the causes of impairment and a range of demographic factors, including sex, age, religious affiliation, educational background, and encounters with disabled people. The results of the Chi-square test (Table 16) demonstrate a statistically significant association between the perceptions of non-disabled women and men regarding the causes of impairments and all the demographic factors examined (sex, $\chi2$ (7, N = 420) = 17.31, p = .016); age category, $\chi2$ (28, N = 420) = 60.74, p = < 0.001); religious affiliation, $\chi2$ (8, N = 420) = 44.40, p = .002); educational background, ($\chi2$ (35, N = 420) = 61.31, p = .004) and type of encounter with Disabled people, $\chi2$ (14, N = 420) = 36.53, p = < 0.001). This correlation implies that individual backgrounds and social settings may affect how people perceive the causes of impairment.

The research findings indicate that there are only slight variations in the beliefs of the respondents regarding the causes of impairment and their sexual orientation. The primary factors contributing to disability, as indicated by both female and male respondents, are evenly split between heredity and birth complications. More precisely, 41% of females and 39% of males ascribe the cause of impairment mostly to heredity. Conversely, 44% of females and 31% of males believe that birth complications are the most probable source of impairment.

The findings of the study revealed some interesting insights into the religious background of the respondents and their perception of the causes of impairment. Given the assumed deep integration of their faith into general life events, one would expect such individuals with deep religious beliefs to attribute such causal factors to supernatural forces. The results, however, paint a more complex picture: 41 % of both Muslims and Christians said heredity was a significant factor, as did 25 % of practitioners of African traditional religion. Birth complications were identified by 41 % of Muslims, 38 % of Christians, and 25 % of practitioners of African Traditional Religion as another significant factor for the existence of impairment. It also follows from the analysis that contact with disabled people influences perceptions of the causes of impairments. Those who have close contact with disabled people tend to attribute impairments mainly to heredity, as indicated by 49% of the sample. On the other hand, a fair proportion of caregivers of disabled people (47%) and those having no contact at all (42%) think that the leading cause could be complications during birth.

The findings also show remarkable differences in perceptions among the various age groups regarding what causes impairments. Older people, in particular, have been found to attribute impairments to human factors. Empirical data show that 44% of the respondents aged 36 to 45 years, 54% aged 46 to 55 years, and 56% of those aged 56 years and above attributed the presence of an impairment to birth complications. In contrast, younger participants were likelier to attribute impairments to non-human-caused factors. To this end, 52% of young adults between 18 and 25 and 45% of those between 26 and 35 attributed impairments to heredity.

The results of this study indicate that the perceptions of what causes impairments among the respondents are significantly different based on their level of education. More specifically, 48% of those with a university degree, 60% with some college education, and 59% with vocational training identified heredity as the leading cause of impairment. On the other, 42% of those with secondary education, 44% of those with primary education, and 30% of those without any formal education mentioned birth complications as the leading cause of impairment.

Table 16

Demographic Characteristics and Perceptions of Causes of Impairment

		In your opinion, what causes impairment?									
		Accidents	*Birth complications*	*Curses*	*Evil spirits*	*Heredity*	*God's punishment*	*Sickness*	*Witchcraft*		
Variable	*N*	*%*	*%*	*%*	*%*	*%*	*%*	*%*	*%*	**χ2**	**P - value**
Sex	**420**										
Female	208	2.4	43.8	3.4	0.5	41.3	4.3	1.0	3.4	17.31	0.016
Male	212	4.7	30.7	8.0	2.8	39.2	8.0	1.4	5.2		
Age category	**420**										
18-25	125	1.6	34.4	2.4	1.6	52.8	3.2	0	4.0	60.74	< 0.001
26-35	165	6.1	30.3	6.7	1.2	44.9	6.1	0.6	4.2		
36-45	73	4.1	43.8	11	1.4	21.9	8.2	4.1	5.5		
46-55	48	0	54.2	4.2	4.2	25	10.4	0	2.1		
56+	9	0	55.6	0	0	11.1	11.1	11.1	11.1		
Religious affiliation	**420**										
Christian	359	3.6	37.6	5.6	1.7	41	4.7	1.4	4.5	44.40	0.002
Muslim	44	2.3	41	0	0	41	16	0	0		
African Traditional Religion	12	0	25	16.7	8.3	25	8.3	0	16.7		
Not religious	5	20	0	40	0	20	20	0	0		
Educational background	**420**										
Bachelor's degree or higher	21	4.8	42.9	0	0	47.6	0	0	4.8	61.31	0.004
Some college	82	2.4	23.2	2.4	3.7	59.8	6.1	0	2.4		
Secondary school	164	3.7	41.5	6.1	0.6	38.4	3.1	1.8	4.9		
Vocational training	39	2.6	28.2	2.6	2.6	59	5.1	0	0		
Primary school	104	3.9	44.2	8.7	1.9	21.2	12.5	1.9	5.8		
No formal schooling	10	10	30	20	0	20	10	0	10		
Encounter with disabled people	**420**										
Casual Contact	216	3.2	29.6	5.6	2.3	48.6	6.9	0.9	2.8	36.53	0.001
Caregiver of a disabled person	127	3.2	47.2	3.9	0.8	34.7	7.1	0	3.2		
No contact at all	77	5.2	41.6	9.1	1.3	26	2.6	3.9	10.4		

Pearson chi-square test of independence

4.2.2 Sexuality of Disabled Women as Perceived by Non-Disabled Women and Men

This sub-section highlights findings on the perceptions of non-disabled women and men on the sexuality of disabled women. The analysis focuses on three key aspects: sexual feelings, sexual organs, and sexual activity. The study utilized a Chi-Square Test of Independence to investigate the potential relationships between demographic variables, including sex, age category, religious affiliation, educational background and encounters with disabled people, and perceptions of sexual feelings, sexual organs, and sexual activity. The relationship was considered significant with $p = < 0.05$.

4.2.2.1 Sexual Feelings of Disabled Women as Perceived by Non-Disabled Women and Men. The research gathered the perceptions of non-disabled women and men regarding the sexual feelings of disabled women. Study participants were asked a closed-ended question: “What is your opinion about the sexual feelings of disabled women?” They were asked to choose one of two possible answers: Have sexual feelings or lack sexual feelings. As shown in Table 17, a great majority of both non-disabled women and men (95%) believe that disabled women have sexual feelings. Only a minority of 5% had contrary views.

The study utilized a Chi-Square Test of Independence to investigate the potential relationships between demographic variables, including sex, age, religious affiliation, education level, encounters with disabled people, and perceptions of sexual feelings of disabled women. The relationship was considered significant with $p = < 0.05$. The test results (Table 17) show that there exists no statistically significant association among all the demographic variables examined and perceptions of non-disabled women and men pertaining to the sexual feelings of disabled women ($p = > 0.05$).

4.2.2.2 Sexual Organs of Disabled Women as Perceived by Non-Disabled Women and Men. The study examined the perceptions of non-disabled women and men on the sexual organs of disabled women about various demographic variables, such as sex, age, religious affiliation, educational background, and encounters with disabled people. Study participants were asked a closed-ended question: "What is your opinion about the sexual organs of disabled women?" They were asked to choose one of two possible answers: They have normal sexual organs or abnormal sexual organs. The study findings (Table 18) indicate that an overwhelming percentage of non-disabled women and men (99%) believe that disabled women have normal sexual organs just like any other women. Only a mere 1% were of the opinion that disabled women have abnormal sexual organs.

The study utilized a Chi-Square Test of Independence to investigate the potential relationships between demographic variables, including sex, age, religious affiliation, education level, encounters with disabled people, and perceptions of the sexual organs of disabled women. The relationship was considered significant with $p = < 0.05$. The test results (Table 18) show that only religious affiliation was found to be statistically significant among all demographic factors examined in relation to the perceptions of non-disabled women and men regarding the sexual organs of disabled women, $\chi 2$ (3, N = 420) = 13.06, p = .005. The results indicate that all the respondents who identified as Muslims or African traditional religion practitioners agreed that disabled women have normal sexual organs. Conversely, a small proportion of Christians (1%) and a fairly large proportion of individuals who declared they were non-religious (20%) doubted if these women had normal sexual organs. The findings suggest that individual motivation, attitudes and behaviours, rather than religious teachings and practices, are what mainly contribute to the negative perceptions about the sexuality of disabled women.

4.2.2.3 Sexual Activity of Disabled Women as Perceived by Non-Disabled Women and Men. The study investigated the perceptions of non-disabled women and men regarding the sexual activity of disabled women in relation to demographic variables such as sex, age, religious affiliation, educational background, and encounters with disabled people. The research gathered the perceptions of non-disabled women and men regarding the sexual activity of disabled women. Study participants were asked a closed-ended question: "What is your opinion on the sexual activity of disabled women?". They were asked to choose one of two possible answers: They are sexually active or sexually inactive. The study findings (Table 19) show that the majority of non-disabled women and men (98%) were of the opinion that they do engage in sexual activities, while a mere 2% believed otherwise.

The study utilized a Chi-Square Test of Independence to investigate the potential relationships between demographic variables, including sex, age, religious affiliation, education level, encounters with disabled people, and perceptions of sexual activity of disabled women. The relationship was considered significant with $p = < 0.05$. The test results (Table 19) show that there exists no statistically significant association among all the demographic variables examined and perceptions of non-disabled women and men pertaining to the sexual activity of disabled women ($p = > 0.05$).

Table 17

Demographic Characteristics and Perceptions of Sexual Feelings of Disabled Women

		What is your opinion on the sexual feelings of disabled women? They...			
		Have sexual feelings	*Lack sexual feelings*		
Variable	***N***	***%***	***%***	**χ2**	***P - value***
Sex	**420**				
Female	208	95.2	4.8	0.15	0.695
Male	212	94.3	5.7		
Age category	**420**				
18-25	125	92.0	8.0	3.39	0.495
26-35	165	96.4	3.6		
36-45	73	94.5	5.5		
46-55	48	95.8	4.2		
56+	9	100	0		
Religious affiliation	**420**				
Christianity	359	94.7	5.3	0.55	0.907
Islam	44	95.5	4.5		
African Traditional Religion	12	91.7	8.3		
Not religious	5	100	0		
Educational background	**420**				
Bachelor’s degree and above	21	95.2	4.8	3.51	0.622
Some college	82	92.7	7.3		
Secondary school	164	94.5	5.5		
Vocational training	39	100	0		
Primary school	104	94.2	5.8		
No formal schooling	10	100	0		
Encounters with disabled people	420				
Casual Contact	216	95.4	4.6	3.02	0.221
Caregiver of a disabled person	127	92.1	7.9		
No contact at all	77	97.4	2.6		

Pearson chi-square test of independence

Table 18

Demographic Characteristics and Perception of Sexual Organs of Disabled Women

		What is your opinion on the sexual organs of disabled women? They have…			
		Normal sexual organs	*Abnormal sexual organs*		
Variable	***N***	*%*	*%*	**χ2**	***P - value***
Sex	**420**				
Female	208	98.1	1.9	0.72	0.398
Male	212	99.1	0.9		
Age category	**420**				
18-25	125	96.8	3.2	8.92	0.063
26-35	165	100	0		
36-45	73	100	0		
46-55	48	95.8	4.2		
56+	9	100	0		
Religious affiliation	**420**				
Christianity	359	98.6	1.4	13.06	0.005
Islam	44	100	0		
African Traditional Religion	12	100	0		
Not religious	5	80	20		
Educational background	**420**				
Bachelor’s degree and above	21	100	0	8.38	0.137
Some college	82	97.6	2.4		
Secondary school	164	98.2	1.8		
Vocational training	39	100	0		
Primary school	104	100	0		
No formal schooling	10	90	10		
Encounters with disabled people	420				
Casual Contact	216	98.6	1.4	0.31	0.985
Caregiver of a disabled person	127	98.4	1.6		
No contact at all	77	98.7	1.3		

Pearson chi-square test of independence

Table 19

Demographic Characteristics and Perceptions on Sexual Activity of Disabled Women

		What is your opinion on the sexual activity of disabled women? They are…			
		Sexually active	*Sexually inactive*		
Variable	***N***	***%***	***%***	**χ2**	***P - value***
Sex	**420**				
Female	208	98.6	1.4	0.13	0.722
Male	212	98.1	1.9		
Age category	**420**				
18-25	125	98.4	1.6	1.59	0.811
26-35	165	97.6	2.4		
36-45	73	98.6	1.4		
46-55	48	100	0		
56+	9	100	0		
Religious affiliation	**420**				
Christianity	359	98.2	1.8	1.21	0.751
Islam	44	100	0		
African Traditional Religion	12	100	0		
Not religious	5	100	0		
Educational background	**420**				
Bachelor's degree and above	21	100	0	1.93	0.859
Some college	82	98.8	1.2		
Secondary school	164	97.6	2.4		
Vocational training	39	100	0		
Primary school	104	98.1	1.9		
No formal schooling	10	100	0		
Encounters with disabled people	420				
Casual Contact	216	98.1	1.9	1.05	0.591
Caregiver of a disabled person	127	99.2	0.8		
No contact at all	77	97.4	2.6		

Pearson chi-square test of independence

4.2.3 Fertility and Pregnancy of Disabled Women as Perceived by Non-Disabled Women and Men

This subsection presents findings from the study pertaining to the perceptions of non-disabled women and men towards the fertility and pregnancy of disabled women. The study utilized a Chi-Square Test of Independence to investigate the potential relationships between demographic variables, including sex, age, religious affiliation, educational background, encounters with disabled people, and perceptions of fertility and pregnancy of disabled women. The relationship was considered significant with $p = < 0.05$.

4.2.3.1 Fertility of Disabled Women as Perceived by Non-Disabled Women and Men. The research gathered the perceptions of non-disabled women and men regarding the fertility of disabled women. Study participants were asked a closed-ended question: “ Do you agree or disagree that disabled women cannot become pregnant?”. They were asked to select only one option on a 5-point Likert scale: “Strongly agree”, “agree”, “neutral”, “disagree”, and “strongly disagree”. The findings in Table 20 indicate that a substantial majority of non-disabled women and men (88%) hold the belief that disabled women are capable of becoming pregnant. This prevailing perception contrasts with another 4% of these respondents, who held a different view, while the remaining 8% were neutral.

The study utilized a Chi-Square Test of Independence to investigate the potential relationships between demographic variables, including sex, age, religious affiliation, education level, encounters with disabled people, and perceptions of non-disabled women and men regarding the fertility of disabled women. The relationship was considered significant with $p = < 0.05$. The results of the chi-square test of independence indicate a statistically significant association between the perceptions of non-disabled women and men regarding the fertility of the disabled, and only two of the demographic variables examined: sex ($\chi2$ (4, N = 420) = 11.18, p = .025) and age ($\chi2$ (16, N = 420) = 28.42, p = .028).

Study findings in Table 20 show a slightly increased propensity of belief in the fertility of disabled women among older people (46-55 years: 94%; 56+ years: 89%) and females (90%) compared to younger people (18-25 years 87%; 26-35 years: 88%; 36-45 years: 85%) and males (89%). This might be because the elderly respondents would have more experience with life and a better understanding of disability and reproductive health issues. Female respondents may demonstrate more empathy and identification with the reproductive experiences of a disabled woman.

Table 20

Demographic Characteristics and Perceptions on The Fertility of Disabled Women

		Do you agree or disagree with the statement that disabled women cannot become pregnant?						
		Strongly Agree	*Agree*	*Neutral*	*Disagree*	*Strongly disagree*		
Variable	***N***	*%*	*%*	*%*	*%*	*%*	**χ2**	*P - value*
Sex	**420**							
Female	208	3.8	1	5.3	11.5	78.4	11.18	0.025
Male	212	1.9	1.4	10.8	18.9	67		
Age category	**420**							
18-25	125	1.6	2.4	8.8	24	63.2	28.42	0.028
26-35	165	1.8	1.2	9.1	15.2	72.7		
36-45	73	6.8	0	8.2	6.8	78.2		
46-55	48	2.1	0	4.2	8.3	85.4		
56+	9	11.1	0	0	0	88.9		
Religious affiliation	**420**							
Christianity	359	2.8	1.1	8.1	15	73	7.22	0.843
Islam	44	2.3	2.3	4.5	15.9	75		
African Traditional Religion	12	8.3	0	16.7	25	50		
Not religious	5	0	0	20	0	80		
Educational background	**420**							
Bachelor's degree and above	21	0	0	0	14.3	85.7	24.38	0.579
Some college	82	2.4	1.2	8.5	18.3	69.5		
Secondary school	164	4.3	0.6	6.1	15.2	73.8		
Vocational training	39	2.6	2.6	12.8	30.8	51.3		
Primary school	104	1.9	1.9	9.6	7.7	78.8		
No formal schooling	10	0	0	20	10	70		
Encounters with disabled people	**420**							
Casual Contact	216	2.3	0.5	8.3	14.4	74.5	12.11	0.146
Caregiver of a disabled person	127	3.9	1.6	5.5	11.8	77.2		
No contact at all	77	2.6	2.6	11.7	23.4	59.7		

Pearson chi-square test of independence

4.2.3.2 Abnormality of Pregnant Disabled Women as Perceived by Non-Disabled Women and Men. The study investigated the perceptions of non-disabled women and men regarding the abnormality of pregnant, disabled women. Study participants were asked a closed-ended question: “Do you agree or disagree with the statement that it is abnormal to find pregnant disabled women in the community?”. They were asked to select only one option on a 5-point Likert scale: “Strongly agree”, “agree”, “neutral”, “disagree”, and “strongly disagree”. The results presented in Table 21 indicate that an overwhelming majority of the non-disabled women and men (84%) perceive that seeing a pregnant, disabled woman in the community is a normal occurrence. This dominant view contrasts with that of 8% of the respondents who believe it is an abnormality, while the remaining 8% were neutral.

The study utilized a Chi-Square Test of Independence to investigate the potential relationships among demographic variables, including sex, age, religious affiliation, education level, encounters with disabled people, and perceptions of non-disabled women and men regarding the abnormality of pregnant, disabled women in the community. The relationship was considered significant with p = < 0.05. The findings from the test (Table 21) reveal that among the various demographic factors examined, only sex ($\chi 2$ (4, N = 420) = 10.68, p = .030) and educational background ($\chi 2$ (20, N = 420) = 36.60, p = .013), show statistical significance as regards perceptions of non-disabled women and men regarding the abnormality of pregnant, disabled women.

Further analysis of the results indicates a remarkable difference in perceptions among the respondents of different sexes on the presence of pregnant, disabled women in the community. Specifically, while 87.1% of female respondents do not find the presence of pregnant, disabled women unusual, only 80.7% of male respondents shared this perception. In addition, the tendency towards neutrality is more pronounced in male respondents at 12.3%, compared to 4.3% among female respondents. Data analysis on educational background perceptions indicates significant differences, especially between university degree holders and those with no formal education. The great majority of those with a university degree (81%)

believe it is normal to have pregnant, disabled women in the community. In sharp contrast, only 30% of those without formal education believe so. The perceptions of the rest of the respondents fall between these two extremes. Specifically, 76% of those with primary education, 69.5% with secondary education, 68.3% with tertiary education, and 56.4% with vocational training hold the opinion that the presence of pregnant disabled women is nothing unusual. These findings highlight the role of educational and sex-related factors in shaping community perceptions towards pregnant, disabled women.

Table 21

Demographic Characteristics and Perceptions on Pregnancy of Disabled Women

		Do you agree or disagree that it is abnormal to find pregnant, disabled women in the community?						
		Strongly Agree	*Agree*	*Neutral*	*Disagree*	*Strongly disagree*		
Variable	***N***	**%**	**%**	**%**	**%**	**%**	**χ2**	***P - value***
Sex	**420**							
Female	208	6.3	2.4	4.3	13.5	73.6	10.68	0.030
Male	212	3.8	3.3	12.3	15.1	65.6		
Age category	**420**							
18-25	125	3.2	2.4	9.6	22.4	62.4	22.62	0.123
26-35	165	5.5	3.6	9.7	13.3	67.9		
36-45	73	4.1	4.1	8.2	5.5	78.1		
46-55	48	8.3	0	2.1	12.5	77.1		
56+	9	11.1	0	0	0	88.9		
Religious affiliation	**420**							
Christianity	359	5.3	2.8	7.8	15	69.1	19.51	0.077
Islam	44	0	4.6	4.5	11.4	79.5		
African Traditional Religion	12	8.3	0	25	8.3	58.4		
Not religious	5	20	0	40	0	40		
Educational background	**420**							
Bachelor’s degree and above	21	4.8	4.8	0	9.4	81	36.60	0.013
Some college	82	2.4	2.4	9.8	17.1	68.3		
Secondary school	164	3.7	3.7	9.1	14	69.5		
Vocational training	39	2.6	2.6	12.8	25.6	56.4		
Primary school	104	7.7	1	4.8	9.6	76.9		
No formal schooling	10	30	10	20	10	30		
Encounters with disabled people	**420**							
Casual Contact	216	5.6	3.2	8.8	14.8	67.6	6.93	0.544
Caregiver of a disabled person	127	4.7	2.4	4.7	11.8	76.4		
No contact at all	77	3.9	2.6	13	16.9	63.6		

Pearson chi-square test of independence

4.2.4 Attitude of Non-Disabled Women and Men towards Disabled Women

This section examines the attitudes of non-disabled women and men towards disabled women. The ATDP Form B was employed to evaluate attitudes towards disabled persons. The ATDP score is an overall algebraic sum of the respondents' rating scores and ranges between 0 and 180. A higher ATDP score is indicative of a positive attitude towards disabled persons.

Due to the non-normal distribution of ATDP scores among non-disabled women and men, the study used non-parametric statistical tests, notably the Mann-Whitney U and Kruskal Wallis tests, for hypotheses testing. The combined ATDP mean score for non-disabled women and men was 117.55 (SD = 24.18), with minimum and maximum values of 26 and 174, respectively. The mean ATDP score for non-disabled women was 118.76 (SD = 25.94), with the highest and lowest scores of 30 and 174, respectively. For non-disabled men, the mean score was 116.36 (22.39), with the most significant and lowest scores of 169 and 26. The study examined demographic characteristics to ascertain their influence on the ATDP scores of non-disabled women and men. The relationship was considered significant with $p = < 0.05$. *Table 22* presents an analysis of the total attitude score distribution among non-disabled women and men concerning their sex, age, religious affiliation, educational background, and encounters with disabled people.

The Mann-Whitney U and Kruskal Wallis tests indicate that there exist statistically significant differences in the mean rank of the ATDP scores for non-disabled women and men towards Disabled women with respect to their religious affiliation ($H = 16.84$, $p <.001$), educational background ($H = 21.50$, $p <.001$), and encounters with disabled people ($H = 18.61$, $p <.001$). The results suggest that individuals who identify with the Islamic faith (ADTP score:125.20), have completed secondary education (ATDP score:122.80) or are caregivers of disabled people (ATDP score: 124.33) are far more likely to display more positive attitudes towards disabled women than their counterparts. The results suggest that religious beliefs, level of education and contact with disabled persons are key factors that determine attitudes towards disabled women.

Table 22

Bivariate Analysis of ATDP Scores and Demographic Characteristics of Non-Disabled Women and Men

Variable	*N*	*Mean*	*SD*	*Mean Rank*	*U/H*	*df*	*P - value*
Sex*							
Female	208	118.76	25.94	217.50	20592.50	-	0.242
Male	212	116.36	22.39	203.63			
Age category**							
18-25	125	116.65	21.57	202.06	1.68	4	0.794
26-35	165	118.42	23.55	215.71			
36-45	73	117.34	25.31	208.51			
46-55	48	119.31	28.71	221.93			
56+	9	106.33	36.47	187.33			
Religious affiliation**							
Christianity	359	117.65	24.08	211.37	16.83	3	<.001
Islam	44	125.20	20.23	244.84			
African Traditional Religion	12	98.00	15.56	99.54			
Not religious	5	89.80	41.05	112.40			
Educational background**							
Bachelor's degree and above	21	119.81	18.32	216.69	21.50	5	<.001
Some college	72	117.96	21.27	204.93			
Secondary school	164	122.80	22.97	237.35			
Vocational training	39	114.10	17.60	185.53			
Primary school	104	112.08	28.98	191.82			
No formal schooling	20	93.70	21.33	94.50			
Encounters with disabled people**							
Casual Contact	216	114.00	21.74	189.56	18.61	2	<.001
Caregiver of a disabled person	127	124.33	27.17	248.02			
No contact at all	77	116.34	23.58	207.35			

**Mann–Whitney U test employed for analysis*

***Kruskal Wallis H test employed for analysis*

4.3 Research Question Three - Perceptions and Attitude of Healthcare Workers toward Disability and Pregnancy of Disabled Women

The third research question examined the perceptions of healthcare workers toward the impairment, sexuality, and pregnancy of disabled women. This section provides an analysis of the diverse perceptions of participants in the study towards the impairment, sexuality (comprising sexual feelings, sexual organs, and sexual activity), fertility, pregnancy, and childbirth of disabled women. The research utilized a perception survey questionnaire to collect data pertaining to perceptions. The study employed a Chi-Square Test of Independence to investigate the association between perceptions and demographic factors, including sex, age, health facility type, professional cadre, exposure to disability training, years of service and encounters with disabled people. The relationship was considered significant with $p = < 0.05$.

Furthermore, the third research question also aimed to examine the attitude of healthcare workers regarding disabled women. The researcher collected data on attitude by administering the ATDP Form B questionnaire. Mean comparison and statistical significance were evaluated using one-way ANOVA statistics to gain insight into the relationship between the variables. The relationship was considered significant with $p = < 0.05$.

4.3.1 Perceptions of Healthcare Workers towards the Sexuality of Disabled Women

This section provides research findings regarding the perceptions of healthcare workers towards the sexual feelings, sexual organs, and sexual activity of disabled women. The study utilized the Chi-Square Test of Independence to investigate relationships between demographic variables, including sex, age, health facility type, professional cadre, exposure to disability training, years of service, encounters with disabled people, and their perceptions. The relationship was considered significant with $p = < 0.05$.

4.3.1.1 Sexual Feelings of Disabled Women as Perceived by Healthcare Workers. The research gathered the perceptions of healthcare workers regarding the sexual feelings of disabled women. Study participants were asked a closed-ended question: “What is your opinion about the sexual feelings of disabled women?” They were asked to choose one of two possible answers: Have sexual feelings or lack sexual feelings. As shown in Table 23, generally, a very large proportion of healthcare workers (96%) were of the view that disabled women have sexual feelings, while 4% of them had a contrary perspective.

The study utilized a Chi-Square Test of Independence to investigate the potential relationships between demographic variables, including sex, age, health facility type, professional cadre, exposure to disability training, years of service and encounters with disabled people with perceptions of sexual feelings of disabled women. The relationship was considered significant with $p = < 0.05$. The test results (Table 23) show that there exists no statistically significant association among all the demographic variables examined and the perceptions of healthcare workers of the sexual feelings of disabled women ($p = > 0.05$).

4.3.1.2 Sexual Organs of Disabled Women as Perceived by Healthcare Workers. The research gathered the perceptions of healthcare workers regarding the sexual organs of disabled women. Study participants were asked a closed-ended question: “What is your opinion about the sexual organs of disabled women?” They were asked to choose one of two possible answers: Have normal sexual organs or abnormal sexual organs. The results in Table 24 indicate that a significant percentage of healthcare workers (96%) of all agreed that disabled women do indeed have normal sexual organs like all other women. In comparison, 4% of healthcare workers believed otherwise.

The study utilized a Chi-Square Test of Independence to investigate the potential relationships between demographic variables, including sex, age, health facility type, professional cadre, exposure to disability training, years of service and encounters with disabled people with perceptions of sexual organs of disabled women. The relationship was considered significant with p = < 0.05. The test results (Table 24) show that there exists no statistically significant association among all the demographic variables examined and the perceptions of healthcare workers of the sexual organs of disabled women (p = > 0.05).

4.3.1.3 Perceptions of Healthcare Workers on Sexual Activity of Disabled Women.

The research gathered the perceptions of non-disabled women and men regarding the sexual activity of disabled women. Study participants were asked a closed-ended question: "What is your opinion on the sexual activity of disabled women?". They were asked to choose one of two possible answers: They are sexually active or sexually inactive. The results in Table 25 show that the majority of the healthcare workers (95%) agreed that disabled women do indeed have normal sexual organs like all other women. In comparison, only 5% had a contrary opinion.

The study utilized a Chi-Square Test of Independence to investigate the potential relationships between demographic variables, including sex, age, health facility type, professional cadre, exposure to disability training, years of service and encounters with disabled people with perceptions of sexual organs of disabled women. The relationship was considered significant with p = < 0.05. The test results (Table 25) show that there exists no statistically significant association among all the demographic variables examined and the perceptions of healthcare workers of the sexual organs of disabled women (p = > 0.05).

Table 23

Healthcare Worker's Demographic Characteristics and Perceptions on Sexual Feelings of Disabled Women

		What is your opinion on the sexual feelings of disabled women? They...			
		Have sexual feelings	*Lack sexual feelings*		
Variable	***N***	***%***	***%***	**χ2**	***P - value***
Sex	**145**				
Female	99	98	2	1.91	0.167
Male	46	93.5	6.5		
Age category	**145**				
18-25	9	100	0	4.76	0.313
26-35	58	96.6	3.4		
36-45	42	95.2	4.8		
46-55	30	100	0		
56+	6	83.3	16.7		
Health facility type	**145**				
Public	111	97.3	2.7	2.26	0.520
Private	8	87.5	12.5		
NGO	24	95.8	4.2		
FBO	2	100	0		
Professional cadre	**145**				
Doctor	6	100	0	0.99	0.803
Nurse	27	96.3	3.7		
Clinical Officer	17	100	0		
Community Health Volunteer	95	95.8	4.2		
Exposure to disability training	**145**				
Yes	73	97.3	2.7	0.22	0.638
No	72	95.8	4.2		
Years of service	**145**				
1-5	61	96.7	3.3	2.08	0.721
6-10	45	97.8	2.2		
11-15	26	92.3	7.7		
16-20	9	100	0		
21+	4	100	0		
Encounters with disabled people	**145**				
General services	71	97.2	2.8	2.03	0.362
Specialized services	25	100	0		
Casual contact	49	93.9	6.1		

Pearson chi-square test of independence

Table 24

Healthcare Worker's Demographic Characteristics and Perceptions on Sexual Organs of Disabled Women

		What is your opinion on the sexual organs of disabled women? They have...			
		Normal sexual organs	*Abnormal sexual organs*		
Variable	***N***	***%***	***%***	**χ2**	***P - value***
Sex	**145**				
Female	99	97	3	0.16	0.686
Male	46	95.7	4.3		
Age category	**145**				
18-25	9	88.9	11.1	1.95	0.746
26-35	58	96.6	3.4		
36-45	42	97.6	2.4		
46-55	30	96.7	3.3		
56+	6	100	0		
Health facility type	**145**				
Public	111	97.3	2.7	2.26	0.520
Private	8	87.5	12.5		
NGO	24	95.8	4.2		
FBO	2	100	0		
Professional cadre	**145**				
Doctor	6	100	0	0.99	0.803
Nurse	27	96.3	3.7		
Clinical Officer	17	100	0		
Community Health Volunteer	95	95.8	4.2		
Exposure to disability training	**145**				
Yes	73	95.9	4.1	0.19	0.660
No	72	97.2	2.8		
Years of service	**145**				
1-5	61	96.7	3.3	0.62	0.961
6-10	45	95.6	4.4		
11-15	26	96.2	3.8		
16-20	9	100	0		
21+	4	100	0		
Encounters with disabled people	**145**				
General services	71	97.2	2.8	0.17	0.920
Specialized services	25	96	4		
Casual contact	49	95.9	4.1		

Pearson chi-square test of independence

Table 25

Healthcare Worker's Demographic Characteristics and Perceptions on the Sexual Activity of Disabled Women

	What is your opinion on the sexual activity of disabled women? They are…				
		Sexually active	*Sexually inactive*		
Variable	***N***	***%***	***%***	**$\chi 2$**	***P - value***
Sex	**145**				
Female	99	96	4	0.42	0.516
Male	46	93.5	6.5		
Age category	**145**				
18-25	9	100	0	1.41	0.842
26-35	58	94.8	5.2		
36-45	42	92.9	7.1		
46-55	30	96.7	3.3		
56+	6	100	0		
Health facility type	**145**				
Public	111	95.5	4.5	1.17	0.759
Private	8	100	0		
NGO	24	91.7	8.3		
FBO	2	100	0		
Professional cadre	**145**				
Doctor	6	100	0	1.60	0.660
Nurse	27	92.6	7.4		
Clinical Officer	17	100	0		
Community Health Volunteer	95	94.7	5.3		
Exposure to disability training	**145**				
Yes	73	93.2	6.8	1.31	0.253
No	72	97.2	2.8		
Years of service	**145**				
1-5	61	95.1	4.9	1.05	0.903
6-10	45	93.3	6.7		
11-15	26	96.2	3.8		
16-20	9	100	0		
21+	4	100	0		
Encounters with disabled people	**145**				
General services	71	94.4	5.6	1.55	0.461
Specialized services	25	100	0		
Casual contact	49	93.9	6.1		

Pearson chi-square test of independence

4.3.2 Perceptions of Healthcare Workers on Fertility and Pregnancy of Disabled Women

The perceptions of healthcare workers towards the fertility, pregnancy and childbirth of disabled women are presented in this section. The Chi-Square Test of Independence examined potential relationships between demographic factors, including sex, age, health facility type, professional cadre, exposure to disability training, years of service, encounters with Disabled people, and perceptions. The relationship was considered significant with $p = < 0.05$.

4.3.2.1 Perceptions of Healthcare Workers on Fertility of Disabled Women. The research investigated the perceptions of healthcare workers towards the fertility of disabled women. Study participants were asked a closed-ended question: “Do you agree or disagree with the statement that disabled women can become pregnant?”. They were asked to select only one option on a 5-point Likert scale: “Strongly agree,” “agree,” “neutral,” “disagree,” and “strongly disagree.” The findings in Table 26 indicate that a substantial majority of healthcare workers (82%) believe that disabled women are capable of becoming pregnant. This prevailing perception contrasts with another 14% of these respondents, who held a different view, while the remaining 4% were neutral.

The study utilized a Chi-Square Test of Independence to investigate the potential relationships between demographic variables, including sex, age, health facility type, professional cadre, exposure to disability training, years of service and encounters with disabled people with perceptions of sexual organs of disabled women. The relationship was considered significant with $p = < 0.05$. The test results (Table 26) show that there exists no statistically significant association between all the demographic variables examined and the perceptions of healthcare workers of the fertility of disabled women ($p = > 0.05$).

4.3.2.2 Abnormality of Pregnancy of Disabled Women as Perceived by Healthcare Workers. The study investigated the perceptions of non-disabled women and men regarding the abnormality of the presence of pregnant, disabled women at the health facility. Study participants were asked a closed-ended question: Do you agree or disagree that the image of pregnant women with disability at the healthcare facility is abnormal?”. They were asked to select only one option on a 5-point Likert scale: “Strongly agree”, “agree”, “neutral”, “disagree”, and “strongly disagree”. As shown in Table 27, a slight majority of healthcare workers (59%) generally agreed that the image of a pregnant, disabled woman at the health facilities is not out of the ordinary. Another substantial portion (30%) think this is abnormal, while the remaining healthcare workers (11%) were neutral.

The study utilized a Chi-Square Test of Independence to investigate the potential relationships between demographic variables, including sex, age, health facility type, professional cadre, exposure to disability training, years of service and encounters with disabled people with perceptions of sexual feelings of disabled women. The relationship was considered significant with $p = < 0.05$. The test results (Table 27) show that there exists no statistically significant association between all the demographic variables examined and the perceptions of healthcare workers of the abnormality of pregnancy among disabled women ($p = > 0.05$).

Table 26

Healthcare Worker's Demographic Characteristics and Perceptions on the Fertility of Disabled Women

	Do you agree or disagree with the statement that disabled women can become pregnant?							
		Strongly agree	*Agree*	*Neutral*	*Disagree*	*Strongly Disagree*		
Variable	***N***	***%***	***%***	***%***	***%***	***%***	***χ2***	***P - value***
Sex	**145**							
Female	99	62.6	27.3	3.0	1.0	6.1	6.92	0.140
Male	46	56.5	17.4	4.3	0	21.7		
Age category	**145**							
18-25	9	44.4	22.2	22.2	0	11.1	24.21	0.085
26-35	58	53.4	31	3.4	0	12.1		
36-45	42	64.3	23.8	2.4	0	9.5		
46-55	30	70	13.3	0	3.3	13.3		
56+	6	83.3	16.7	0	0	0		
Health facility type	**145**							
Public	111	61.3	24.3	2.7	0	11.7	7.39	0.831
Private	8	62.5	25	0	0.	12.5		
NGO	24	62.5	25	4.2	4.2	4.2		
FBO	2	50	50	0	0	0		
Professional cadre	**145**							
Doctor	6	50	16.7	0	0	33.3	12.70	0.391
Nurse	27	55.6	25.9	11.1	0	7.4		
Clinical Officer	17	52.9	35.3	5.9	0	5.9		
Community Health Volunteer	95	64.2	22.1	1.1	1.1	11.6		
Disability training	**145**							
Yes	73	60.3	24.7	1.4	1.4	12.3	2.60	0.626
No	72	61.1	23.6	5.6	0	9.7		
Years of service	**145**							
1-5	61	50.8	31.1	4.9	0	13.1	14.37	0.571
6-10	45	62.2	22.2	2.2	2.2	11.1		
11-15	26	76.9	15.4	3.8	0	3.8		
16-20	9	55.6	22.2	0	0	22.2		
21+	4	100	0	0	0	0		
Encounter with disabled people	**145**							
General services	71	66.2	18.3	1.4	0	14.1	14.80	0.063
Specialized services	25	36	36	12	0	16		
Casual contact	49	65.3	26.5	2	2	4.1		

Pearson chi-square test of independence

Table 26

Healthcare Worker's Demographic Characteristics and Perceptions on Abnormality of Pregnant Disabled Women

		Do you agree or disagree with the statement that the image of pregnant women with disability at the healthcare facility is abnormal?						
		Strongly agree	*Agree*	*Neutral*	*Disagree*	*Strongly disagree*		
Variable	***N***	***%***	***%***	***%***	***%***	***%***	$\chi2$	*P - value*
Sex	**145**							
Female	99	12.1	18.2	10.1	12.1	47.5	1.39	0.847
Male	46	15.2	15.2	10.9	15.2	43.5		
Age category	**145**							
18-25	9	33.4	0.0	22.2	0	44.4	21.15	0.173
26-35	58	12.1	24.1	12.1	17.2	34.5		
36-45	42	7.2	21.4	7.1	11.9	52.4		
46-55	30	16.7	6.7	10	6.7	60		
56+	6	16.7	0.0	0	33.3	50		
Health facility type	**145**							
Public	111	14.4	18.9	9.9	10.8	45.9	13.93	0.305
Private	8	12.5	12.5	0	25	50		
NGO	24	8.3	12.5	12.5	16.7	50		
FBO	2	0	0	0	50	50		
Professional cadre	**145**							
Doctor	6	0	0	33.3	16.7	50	16.38	0.174
Nurse	27	3.7	22.2	18.5	14.8	40.7		
Clinical Officer	17	5.9	23.5	11.8	23.5	35.3		
Community Health Volunteer	95	17.9	13.7	6.3	11.6	50.5		
Disability training	**145**							
Yes	73	13.7	13.7	5.5	11.0	56.2	7.48	0.113
No	72	12.5	20.8	15.3	15.3	36.1		
Years of service	**145**							
1-5	61	13.1	19.7	13.1	13.1	41	11.05	0.806
6-10	45	15.6	17.8	8.9	13.3	44.4		
11-15	26	11.5	15.4	0	11.5	61.5		
16-20	9	11.1	11.1	22.2	22.2	33.3		
21+	4	0	0	25	0	75		
Encounter with disabled people	**145**							
General services	71	9.9	19.7	8.5	11.3	50.7	7.96	0.438
Specialized services	25	16	4	16	24	40		
Casual contact	49	16.3	20.4	10.2	10.2	42.9		

Pearson chi-square test of independence

4.3.3 Attitude of Healthcare Workers towards Disabled Women

This section examines healthcare workers' attitudes towards disabled women. The ATDP Form B was used to assess attitudes, and ATDP scores were obtained. ATDP scores range from 0 to 180 and are the algebraic sum of the health workers' attitude ratings. A higher ATDP score indicates a positive attitude toward disabled women, whereas a lower score suggests a negative attitude. The mean ATDP score for healthcare workers was 117.77, with a standard deviation 19.25. The lowest and highest scores recorded were 54 and 165, respectively. The average ATDP score for female healthcare workers was 118.22 (SD = 19.34), ranging from 54 to 165. In comparison, the average ATDP score for male healthcare workers was 119.93 (SD = 19.14), with the highest and lowest scores being 78 and 153, respectively

A one-way analysis of variance (ANOVA) was conducted to assess the influence of demographic variables (sex, age, health facility type, professional cadre, exposure to disability training, years of service, and encounters with Disabled people) on ATDP scores. The means, standard deviations, minimum and maximum values for the ATDP scores, and the F-value and P-value of the ANOVA tests are presented in *Table 28* below.

The statistical analysis revealed that only health facility type had a significant effect on ATDP scores at a 0.05 significance level (F (3, 141) = [3.517], p = 0.017). The post hoc tests conducted using Tukey's Honestly Significant Difference (HSD) test indicate a statistically significant difference in ATDP scores between healthcare workers from private and public health facilities (p = 0.017, 95% C.I. = [38.38, 2.66]). As a result, the null hypothesis stating that there is no significant difference in ATDP values between different health facility types (public, private, NGO and FBO) is rejected.

Table 27

Bivariate Analysis of Healthcare Workers' Demographic Variables and ATDP Scores

Variable	*n*	*Mean*	*SD*	*Min*	*Max*	*df*	*F*	*P - value*
Gender	**145**							
Female	99	118.22	19.34	54	165	(1,143)	0.247	0.620
Male	46	119.93	19.14	78	153			
Age category	**145**							
18-25	9	121.78	16.20	95	149	(4,140)	0.766	0.549
26-35	58	117.83	21.50	54	165			
36-45	42	122.17	17.18	87	152			
46-55	30	114.63	17.42	70	144			
56+	6	120.17	24.00	89	155			
Health facility type	**145**							
Public	111	117.11	18.93	54	165	(3,141)	3.517	0.017
Private	8	137.63	15.98	111	155			
NGO	24	121.33	18.93	87	158			
FBO	2	104.50	14.85	94	115			
Professional cadre	**145**							
Doctor	6	121.67	5.82	114	128	(3,141)	0.649	0.585
Nurse	27	119.63	20.04	63	155			
Clinical Officer	17	124.06	15.61	94	147			
CHV	95	118.77	20.14	54	165			
Disability training	**145**							
Yes	73	120.03	19.31	70	165	(1,143)	0.630	0.429
No	72	117.49	19.24	54	158			
Years of service	**145**							
1-5	61	117.26	20.19	54	149	(4,140)	1.136	0.342
6-10	45	120.82	18.69	84	165			
11-15	26	115.85	16.48	87	144			
16-20	9	119.67	23.30	70	146			
21+	4	135.50	15.59	119	155			
Encounters with disabled people	**145**							
General services	71	119.06	20.57	54	165	(2,142)	0.267	0.766
Specialized services	25	120.72	20.89	70	158			
Casual contact	49	117.35	16.51	87	152			

One-way analysis of variance (ANOVA)

4.4 Summary of Chapter Four

The study presented several findings on the individual experiences and perspectives of disabled women, the perceptions and attitudes of non-disabled women and men, and the perceptions and attitudes of health workers. Below is a brief overview of the results:

- Disabled women are systematically humiliated by society, leading to misconceptions, mistreatment, and labels.
- The stereotyping of disabled women as asexual and infertile is widespread.

- Disabled women tend to engage in aggressive behaviour, avoidance, self-stigmatization, and solidarity to deal with these negative prejudices.
- The most common causes of disability, as mentioned by the respondents, are heredity (40.2%) and birth complications (37.1).
- Most respondents believe that disabled women have sexual feelings and normal sexual organs and are sexually active.
- Many respondents believe that disabled women are often pregnant but do not give birth to disabled children.
- The combined average ATDP score for non-disabled women and men was 117.55. All demographic characteristics except gender and age showed positive attitudes toward disabled women.
- Healthcare workers had an average combined ATDP score of 118.77. The type of healthcare facility had a significant impact on the attitudes of healthcare workers. The ATDP mean differed significantly between public and private healthcare facilities (p = 0.017, 95 C.I. = [-38.38, -2.66]).

CHAPTER FIVE: DISCUSSION

5.0 Introduction

This chapter discusses the study findings in connection with the three research questions in light of past empirical investigations. What are the perspectives and individual experiences of disabled women regarding their disability, pregnancy, and childbirth? What are the perceptions and attitudes of non-disabled women and men towards disability, pregnancy, and childbirth of disabled women? What are the perceptions and attitudes of healthcare workers towards disability, pregnancy, and childbirth of disabled women? The comparisons, or lack thereof, have been utilized in Chapter 6 to reach conclusions and provide recommendations for policy formulation and execution, as well as for future studies about the disability, pregnancy, and childbirth of disabled women. Lastly, we explore Utu philosophy as a potential framework for reducing the stigma surrounding disability concerning pregnancy and childbirth among disabled women.

5.1 Perspectives and Experiences of Disabled Women of their Disability, Sexuality, Pregnancy and Childbirth

This section presents an examination of the results of the first research question. The focus is on perspectives and individual encounters of disabled women concerning their disability, sexuality, pregnancy, and childbirth. The primary emphasis of this discussion will be on the misconceptions, mistreatment, prejudicial behaviour, and labelling directed towards disabled women, as well as disability and sexual stereotypes against them. Furthermore, we also discuss the reactions of disabled women towards societal negative perceptions, attitudes, and behaviours, encompassing aggressive behaviour, avoidance, and self-stigmatization.

The findings of this study have revealed a high prevalence of prejudices and stereotypes in the community towards disability and disabled women. Not only are these women excluded from mainstream society, but they are also made targets of ridicule and blamed for misfortunes in society. The conviction that disability may be a result of punishment from higher beings for violating social norms such as forbidden sexual relationships emphasizes how deeply ingrained cultural taboos can cause discriminatory treatment of disabled women. Reducing the stigma faced by disabled women could be achieved with the help of initiatives inside communities aiming at raising awareness about the reality of disability. These findings corroborate previous studies that prejudices and stereotypes against disabled individuals and disabled women are deeply rooted in society. As Brittain (2004) noted, the broad negative attitudes are the greater cause of the disabled's exclusion from social activities alongside the internalization of such attitudes among the disabled, including those with more severe disabilities. In like manner, Meer and Combrinck (2015) discussed how misconceptions and negative attitudes cause not only victimization but also the internalization of negative perceptions among disabled people. The present research, in addition, elaborates that the suffering of disabled women is even pronounced with the exacerbation of exclusion, ridicule, and blame for societal misfortunes for disabled women. This, therefore, calls for societal transformation and raising awareness through community initiatives to reduce stigma and improve the social integration of disabled women.

The study additionally revealed explicit instances of discrimination and prejudice exhibited by family members towards disabled women solely based on their disability. Instances of discrimination and bias displayed by family members towards disabled women bring into focus an aspect of ableism within close social circles. It highlights manifest contradictions where family members, usually seen as sources of support and care, contribute to exclusion and prejudice towards disabled women. In the family setting, disabled women may face discriminative behaviour and attitude from those closest to them and such familial bias hinder their integration of into mainstream society. The results of this study are in line with those by Friedman (2019), whose research especially points out that family members showed an unconscious preference for non-disabled people. However, they differ from the findings by Braathen and Kvam (2008), who described a supportive family environment toward disabled women in Malawi. While advocacy efforts on disability rights and inclusion often focus on large-scale societal changes, these findings suggest that attention should also be directed towards and the private domain of family life.

The results of the study show an extensively entrenched societal narrative that identifies disabled women as beggars, therefore mirroring more general discriminating views on disability. Being labelled as beggars exposes disabled women to a limited identity forced upon them by societal prejudices, therefore undermining their inherent dignity and potential. The belief that disability translates into economic ineffectiveness drives the characterization of disabled persons as social liabilities. It ignores the many ways in which disabled people could and do benefit society as well as their varied abilities. These findings of the study are supported by other existing evidence, including the research by Adam et al. (2017), which associated negative attitudes regarding disabled individuals with their portrayal in public discourses as a financial and social burden. On the same breadth, Opuko et al. (2017) found out that most disabled people were viewed as unable to make meaningful contributions to society and, more importantly, as people who capitalized on the goodwill of other members of society for personal gain. The current study, focusing on the specific situations of disabled women in this broader discriminatory framework, further supports the argument that societal attitudes, perceptions, and associated behaviour influence, to a greater extent, the characterization of disabled people as unproductive members of society.

The findings of the research indicate that disabled women often face mockery, shaming and negative labels due to their disability. The study observed the use of terms like "mzungu" (white one) and "macho bovu" (useless eyes) to refer to women with Albinism and visually impaired women, respectively. These insulting labels display society's lack of regard for the identity and dignity of women. Such derogatory terms can make women feel inadequate, affecting their well-being and self-worth over time. Furthermore, the study points out how the stigma around disabilities not only impacts disabled women but also extends to their families. The children of women also experience discrimination and bias, encountering derogative comments about their mothers' disabilities. The research underscores the importance of reassessing norms and language usage to communicate about disability and disabled persons. The findings of this current study are very similar to the investigation by Dlodlo and Moyo (2022), who document the use of derogatory terms in pinpointing the perceived abnormalities of disabled people among the Ndebele people of Zimbabwe, and Green et al. (2005), who discuss the role of labelling and stereotyping in the perpetuation of stigma and exclusion of disabled persons within the same community. This research provides additional evidence on the impact of disability-induced labelling not only on disabled women but also on the members of their families. For instance, children of disabled women are exposed to secondary discrimination in view of their disabled mothers, which emphasizes the deep-rootedness and entrenchment of societal prejudice against disability across generations. This intergenerational aspect of negative labelling, especially regarding disability, is overlooked by researchers most of the time.

The research provides insights into how disabled women manage challenges such as discrimination and prejudice. Their coping strategies differ, illustrating the complexity of responses by marginalised populations. The study findings show that some women opt for confrontation, while others withdraw or internalize negative perceptions about themselves from the wider society. Engaging in confrontations reflects frustration and an immediate response to mistreatment. While it may offer relief, it also carries the risk of escalating conflicts and legal repercussions. Solidarity among disabled women demonstrates an empowering approach that draws on shared experiences and support for each other and the collective sense of self-worth. Self-stigmatization and isolation may, in the long run, contribute to mental health challenges and alienation. The findings of this study are supported by Kassah et al. (2014), who observe that some disabled persons adopt coping strategies such as avoidance, confrontation, and the exchange of sympathy in reaction to social, physical, verbal, and sexual abuse. The study findings also relate to the research by Acheampong and Aziato (2018), which revealed the existence of suicidal thoughts among physically impaired women due to stigma, discrimination, and mistreatment from society. They mention self-reflections by disabled women on the effect of suicide on their children, spiritual guidance from religious leaders and solidarity from family and peer networks as some of the coping strategies they applied to navigate seemingly adverse situations. The current study places more emphasis on the debilitative effect of self-stigmatization among disabled women, in particular, the deepening of alienation and further strengthening of the discriminating barriers that complicate their mental health.

The findings of the study depict some of the stereotypes and myths used in connection to the sexuality of disabled women, which include widespread desexualization. The perception that disabled women do not have sexual organs or sexual desire at all or are sexually inactive brings to the fore the lack of recognition of their humanity and the outright denial of the depth of varied sexual experiences. Moreover, sexually demeaning comments toward pregnant, disabled women reflect societal doubts about their potential for motherhood, extending desexualization into broader life roles and abilities. The findings of this study are quite similar to those of Hunt et al. (2018), who observed that most non-disabled people perceived disabled persons as asexual or less sexually desirable. Such perceptions, they argue, are driven by strongly held imageries linking physical disability to deficient sexual capability or a lack of sexual agency. Moreover, a study by Bahner et al. (2024) on the way intellectually disabled individuals are desexualized in Sweden also found that most representations of disabled people revolve around their presumed asexuality or hypersexuality. From the findings of the study, we additionally argue that the desexualization of disabled women is more than a mere stereotype; it is a deliberate approach used to diminish their humanity, identity, and rightful social roles. By stripping disabled women of their sexuality, society effectively denies them the opportunity to fulfil important roles in the family and community as mothers. Motherhood is fundamental to the human experience for most women, and the exclusion of disabled women from such experiences, merely on account of their disability, undermines their full participation in society.

The results of the research provide insights into the challenges that disabled women encounter when trying to access antenatal and prenatal care. The study recorded a high default rate of 60% for follow-up appointments on ANC services among disabled women users at public health facilities but none in private medical establishments. This may not primarily be due to a number of reasons including the unpreparedness of healthcare workers in public institutions to meet the unique needs of disabled women. It is, however, a structural problem occasioned by the high volume of patients in public institutions, which limits opportunities for personalized care or extra support disabled women may require, as well as major resource constraints and competing interests. When disabled women visit the healthcare facility and are criticized for getting pregnant, it undermines their right to make reproductive decisions. Labelling of pregnancy by disabled women by healthcare workers as 'recklessness' not only diminishes their self-worth but also prompts them to boycott maternal health services altogether, exposing them to considerable health risks. It is essential to promote cultural shifts and adopt approaches that address negative perceptions and behaviours by healthcare professionals towards disabled women seeking maternal healthcare services. In comparison to the findings of this study, Edna et al. (2022) have also observed a lower incidence of antenatal visits for disabled women in Uganda, which they attribute in part to the stigma associated with disability and initial negative experiences. However, studies by Hameed et al. (2023), DeBeaudrap et al. (2019), and Murthy et al. (2014) did not show any significant differences between disabled and non-disabled women in the utilization of ANC (antenatal care) services. The contribution of this study to the existing discourse emanates from its analysis of the differences between public and private health institutions in terms of antenatal care default rates among disabled women. Therefore, the present study calls for cultural change towards disabled women and increased investment in public health institutions, primarily for training healthcare workers to be sensitive to disabled women, especially those seeking antenatal care.

The results of this study reveal that a large majority of disabled women are usually profiled for unnecessary caesarean deliveries, reflecting underlying biases within the healthcare system. These actions violate the inherent rights of disabled women in decision-making and remaining in charge of their lives. They also raise questions about the blatant disregard for professional ethics and patient rights by healthcare providers, who often make decisions for CS based on stereotypes rather than personalized evaluations of patients. The findings presented in this study are consistent with existing research; for instance, Biel et al. (2020) established that disabled women were disproportionately subjected to caesarean section surgeries, even when they were not medically justified. On the same breadth, the research by Darney et al. (2017) indicated that caesarean births for disabled women doubled that of non-disabled women. This study establishes the need for formal protocols in dealing with prejudice against disabled women and making decisions about caesarean delivery based on evidence. The institutionalization of these protocols will ensure that disabled women are treated with equity and respect before, during, and after delivery. Furthermore, it is very crucial to make evidence-based decisions regarding caesarean delivery for the safeguarding of the health of the mother and her child. Caesarean sections should not be pursued unless there is an evidence-based clear rationale for such; though medically inevitable, they are risky procedures.

The invasion of disabled women's privacy during prenatal visits and childbirth was another significant finding of the study. Many of the women interviewed for this study complained about the lack of respect for their personal space when they arrived at the healthcare facility to give birth. This was notably true for one woman with albinism, whose presence in the labour ward was regarded as a spectacle. The delivery room was crowded with healthcare workers who were not necessarily there to assist with the delivery. Some of them made derogatory remarks about her pregnancy and their anticipation of the birth of a child with albinism. These conditions fail to provide safe spaces for women with disabilities and are likely to discourage them from utilising skilled birth attendants in the future. It is also unethical and unprofessional, as healthcare professionals are typically expected to provide a secure, dignified, and memorable childbirth experience for all women, irrespective of their social status. These findings of the study are consistent with those of Rugoho and Maphosa (2017), who identified invasion of privacy as the most significant barrier to access and utilisation of antennal services and skilled birth attendance by disabled women. Wudneh et al. (2022) also highlight the intrusion into the private space of disabled women by healthcare workers during childbirth. They provide graphic details of how such women's dignity and privacy are constantly abused in Ethiopia.

The research results also revealed that some disabled women were worried about the safety of their pregnancies and childbirth. This apprehension stemmed from biases and medical conversations that tend to highlight the dangers linked to disabled women. Repeated warnings regarding the nature of danger associated with pregnancy and childbirth for disabled women, as well as the possibility of delivering disabled children, contribute to a narrative that paints disability as something undesirable and risky. This narrative is self-sustaining, and disabled women who absorb these stereotypes may be less motivated to seek out empowering information or challenge these beliefs. Disabled women who buy into these misconceptions may limit their choices and might opt out of pregnancy altogether. These results are comparable to those of Walsh-Gallagher et al. (2012), who have indicated that the perceptions and beliefs of community and healthcare workers regarding the transmission of impairments through childbirth caused disabled to worry about what would happen to their unborn children and offered little support for their affirmation of motherhood. The study by Thomas (1997) also discusses the potential for the medical 'risk' discourse to instil fear in disabled women about the risks of their pregnancy and delivery, especially when seen in the context of the dominant narrative on the probability of giving birth to disabled children. This research additionally depicts the intersection of societal stereotypes, medical discourse, and psychological effects concerning the pregnancy and childbirth experiences of disabled women. The internal assimilation of societal stereotypes by disabled women, in connection with the perceived medical hazards of pregnancy and childbirth, combined with the apprehension regarding the possibility of delivering disabled offspring, instils self-doubt and anxiety. This would inevitably influence their reproductive health choices and overall well-being, and they may decide to abstain from sex completely and possibly avoid pregnancy despite nurturing the desire for motherhood.

The findings of the study show that quite a good number of disabled women prefer private health facilities over public ones despite the added financial burden. This preference underscores certain critical deficiencies related to quality, inclusivity, responsiveness, and apathy in matters of disability and disabled women in the public healthcare system. The study has documented many instances of mistreatment and lack of respect by healthcare staff towards disabled women in public health institutions and none in private health facilities. These negative experiences of disabled women completely diminish their trust in the public healthcare system and motivate them to seek services elsewhere, particularly where they would be treated with compassion, care, and personalized attention. This preference for dignity and respect underlines an important choice. For many disabled women, the quality of care and how it is delivered overshadows financial considerations. Public health facilities need urgent policy reforms to make them more accommodative, fairer, accessible, and dignified for disabled women. These findings are supported by the results of research conducted in Nepal by Devkota et al. (2017), who found that disabled women preferred private health facilities. They cite negative experiences with public healthcare workers and inadequate systems for identifying and attending to them promptly as the primary reasons for their choice. They also concur with the study by Zuurmond et al. (2019), which reports that despite the free services being provided by the Indian government, most people from poor households opted to pay to get services elsewhere. Some of the reasons for their decisions included mistrust of the public healthcare system, perceived poor quality of service, and previous bad experiences. The defining characteristic of this research is the illustration of the agency of disabled women; their capacity to make informed choices that serve their best interests. This agency is particularly evident in selecting health facilities that demonstrate the potential to accord them dignity, compassion, and fundamental human rights, among other things. Such choices are made in the face of societal misconceptions regarding their humanity, including doubts about their ability to make informed decisions and questions about their sexuality.

5.2 Perceptions and Attitudes of Non-Disabled Women and Men towards Disability, Sexuality and Pregnancy of Disabled Women

This section discusses the findings related to the second study question, which is the perceptions and attitudes of non-disabled women and men about disability, sexuality, and pregnancy among disabled women. This section will concentrate on evidence about the causes of impairment and the inheritance of impairment, as well as sexuality, pregnancy, and childbirth in Disabled women. Furthermore, the discussion will discuss data on the attitudes of non-disabled women and men towards disabled women. The findings will also be compared to previous empirical investigations.

The study's findings indicate that non-disabled women and men identified heredity (40.3%) and birth complications (37.%) as the primary factors contributing to impairment. In comparison, evil spirits (2%) and God's punishment (1%) and evil spirits were the least mentioned reasons for impairment. Moreover, the data demonstrates a statistically significant association between the perceptions of non-disabled women and men regarding the causes of impairments and all the demographic variables: sex, age, religious affiliation, educational background and encounter with disabled people. The correlation implies that both personal experiences and social environments may influence public perceptions about the cause of impairments. The findings of the study revealed some interesting insights among respondents who indicated they were religious about the causes of impairment. Given the assumed deep integration of their faith into general life events, one would expect such individuals to attribute causal factors to supernatural forces. The results, however, paint a more complex picture: 41 % of both Muslims and Christians said heredity was a significant factor, as did 25 % of practitioners of African traditional religion. Birth complications were identified by 41 % of Muslims, 38 % of Christians, and 25 % of practitioners of African Traditional Religion as another significant factor for the existence of impairment.

Prior research has identified similar causal factors for impairment as those observed in the current study. In the study by Bunning et al. (2017) undertaken in a rural setting in Kenya, some of the probable causes of impairment mentioned include curses resulting from human transgressions, the action of supernatural forces, the will of God and biomedical reasons. Their study was qualitative and did not compare the prevalence level of each factor. On the other hand, the study by Akasreku, Habib, and Ankomah (2018), which was also conducted in a rural setting in Ghana, reveals that the most prevalent causes of disability are spiritual

(88.8%), accidents (85.9%), and medical conditions (46.0%). The researchers employed a mixed methods approach, allowing the participants to choose multiple and mutually inclusive responses. The findings of the study by Tigere and Makhubele (2019) singled out witchcraft as the most common cause of disability among the rural population in Limpopo Province, South Africa. Their findings contradict those of the current study, which found that witchcraft was the least common cause of impairment. The current study represents a novel contribution to the literature on how non-disabled people in urban Kenya understand the causes of impairment. Compared with earlier studies that were mostly rural-based and emphasized supernatural or spiritual explanations, the study found that city respondents strongly believe in hereditary and birth-related factors as the probable cause of impairments, even if they might be religious. The research questions the assumption that religious people automatically attribute impairment to supernatural causes and shows a much more complex relationship between personal beliefs and societal influences.

The findings from the research reveal how non-disabled women and men view the sexuality of disabled women. Most of them recognize that disabled women have sexual desires, possess sexual organs, and engage in sexual relationships, indicating a shift towards a more positive societal outlook on disability and sexuality. This is significant for dispelling misunderstandings and stereotypes that often depict disabled women as lacking sexual agency. The study challenges standing prejudices about sexuality, advocating for an inclusive discussion on sexual rights and self-determination of disabled women. Sexual desires and needs are universal and not constrained by abilities. This study's findings on the sexuality of disabled women contradict those of Esmail et al. (2010), who observed the stigmatisation and labelling of disabled people as asexual. They also note that non-disabled people are typically reluctant to initiate relationships with disabled people. Furthermore, they contend that the socialisation process tends to reinforce prevailing narratives that encourage disabled people to seek out sexual relationships with others of their kind. The portrayal of disabled people as lacking sexual agency and the perpetuation of misconceptions about their bodies, which also contradicts the findings of the current study, has similarly been observed in other studies conducted in Nigeria and Northern Ireland (Afolayan, 2015; Anderson & Kitchin, 2000). The current study makes a significant scholarly contribution by revealing a notable shift in the perceptions of non-disabled individuals regarding the sexuality of disabled women. In contrast to most of the previous research that highlighted the portrayal of disabled individuals as asexual and lacking sexual agency, the present study demonstrates a growing recognition among non-disabled individuals that disabled women are sexual beings entitled to the same recognition, respect, and fulfilment of their sexual identities as anyone else.

The results of the study show that a substantial proportion (87.8%) of non-disabled women and men believe that disabled women can conceive. These findings are promising and show a shift in societal attitudes toward the reproductive capabilities of disabled women. They challenge all those negative historical biases and misconceptions that have often marginalized their sexual and reproductive health and rights. Such widespread recognition is a potential catalyst for progressive changes in health practices and policies that would allow for a more inclusive and supportive environment for the reproductive health needs of disabled women. The present study's findings, however, contrast with those of Akasreku, Habib and Ankomah (2018), who observed that educational status was the single factor that had the most significant effect on negative attitudes towards the pregnancy of disabled women. The findings of this study also contradict those of Iezzoni et al. (2015), who reported societal scepticism by non-disabled individuals about the capability of Disabled women to become pregnant and care for their newborns. The results of this study reflect a significant shift in societal perceptions towards the reproductive capabilities of disabled women. Markedly in contrast to the previous research demonstrating negative attitudes and scepticism against the childbearing and parenting capabilities of disabled women, this research has clearly shown that many nondisabled persons believe they can become pregnant. This change in perception defies the pervasive marginalization of disabled women concerning their sexual and reproductive health and rights. The results point to the necessity of overcoming negative stereotyping and misconceptions to work toward an equal society sensitive to the reproductive choices of disabled women.

The research results also highlight how society reacts to the presence of pregnant, disabled women. The findings indicate that the majority of non-disabled women and men see pregnancy in women as common or normal, suggesting a shift in societal acceptance of pregnancy among disabled women. Moreover, the findings underscore the importance of demographic factors, particularly sex and educational background, in shaping perceptions regarding pregnancy among disabled women. It reveals underlying social dynamics that inform individual attitudes. Specifically, the findings indicate that males and individuals with limited formal education are more likely to view pregnancy among disabled women as abnormal. This suggests that gender roles and educational attainment play critical roles in influencing societal norms and prejudices. The intersection of gender and education in shaping perceptions calls for targeted educational interventions that address and deconstruct stereotypes surrounding disability and reproductive health. These findings and observations can guide the development of policies, educational approaches, and community awareness initiatives focused on enhancing inclusiveness for disabled women on matters related to sexual and reproductive health and rights. The findings presented in this study differ from those of Bassoumah and Mohammed (2020), who examined the socio-cultural obstacles faced by disabled women in Ghana. They noted the existence of a prevailing perception within the community and among disabled men that disabled women should refrain from becoming pregnant. Furthermore, they add that in cases where disabled women do become pregnant, their capacity to care for their children adequately is often called into question. Similarly, Chisale (2018) examines the experiences of disabled women through the lens of feminist theology, emphasising how they face and resist societal and ableist prejudices and impediments to their roles as mothers. She argues that disabled women use different means of protest, such as carrying a pregnancy and giving birth, to challenge the judgmental and discriminatory behaviours and opinions of society. This study offers an important contribution to increasing our understanding of perceptions of pregnant, disabled women among non-disabled people in Kenyan society. The results also point to a great deal of change away from prejudices and misconceptions against disabled women, which often suppress their sexual and reproductive health and rights. The findings have far-reaching implications for future research, pointing to the need for more investigation into the interplay between gender, disability, and education and their impact on shaping various perceptions and behaviours around disability in society.

The general attitude of non-disabled women and men toward disabled women is very positive, represented by the high scores on the ATDP scale. Further analysis of data brings out clear evidence of the role that religious belief, educational level, and personal contact with disabled people play in the determination of attitudes. There is a possibility that religious beliefs might often foster the demonstration of positive attitudes toward disabled persons through the stimulation of acts of sympathy, compassion, and acceptance. It means that religious communities can become strong actors in the process of social change in regard to disability and thus promote a better acceptance and integration of disabled persons. Education is essential as the findings indicate that it can tackle myths and misunderstandings about disabled people. This means the educational system could address stigma by promoting inclusive attitudes for children early on. Another important variable that may affect positive attitudes is personal contact with disabled persons. Such contact can create more profound understanding and empathy by familiarizing other people with the predicament of disabled persons.

Several previous studies have shown results similar to those of the current research regarding the attitude of community members towards disabled persons. Chen et al. (2002) reported that individuals with a disabled family member or friend had higher ATDP scores (112.60) than those who did not (105.71) in a comparative study on the attitudes of Taiwanese, American, and Singaporean students towards disabled people. They also observed that the ATDP scores of female students (111.81) were higher than male students (105.94). However, the ATPD scores recorded in their investigation for both females and males were lower than the recommended threshold by Yuker et al. (1970) for positive attitudes. In another study, Perry et al. (2008) determined that the mean ATDP score of undergraduate students towards disabled people was 115.89. The study's ATDP scores of female and male students were 119.40 and 111.60, respectively. Female ATDP scores were higher than the suggested levels by Yuker, Block and Young (1970).

The current study adds to the growing literature within the context of disability and attitudes toward disabled women. It uncovers high ATDP scores for nondisabled Kenyan women and men, indicating very positive attitudes toward disabled women. This could be evidence of cultural change or other factors unique to the Kenyan setting that allow acceptance and inclusivity more than before. Specifically, it identifies religious beliefs, education level, and personal contact with disabled people as statistically significant factors for these positive attitudes. Although earlier literature acknowledged the role of these variables in influencing attitude formation toward disabled persons, this study underlines their particular relevance within the Kenyan context. For instance, religious leaders could marshal their influence to propagate acceptance and inclusiveness messages. Opportunities for disabled and non-disabled persons to intermingle, such as community events or conversations about disability, could foster empathy and reduce stigma. Moreover, the educational curriculum can be overhauled to introduce children at an early age to positive values regarding disability.

5.3 Perceptions and Attitudes of Healthcare Workers towards Disability, Sexuality and Pregnancy of Disabled Women

This section discusses the data related to the second study question, which explores the perceptions and attitudes of healthcare workers about disability, pregnancy, and childbirth in the context of disabled women. Specifically, this addresses study findings about the perceptions of sexual feeling, sexual organs, sexual activity, pregnancy, and childbirth among disabled women. Furthermore, it discusses data on the attitudes of healthcare workers towards disabled women. The study findings are compared to those of previous empirical investigations.

These findings suggest a shift in the perception of healthcare workers concerning the sexuality of disabled women. The majority of healthcare workers in the study acknowledged that disabled women experienced sexual feelings, had normal sexual anatomy, and were sexually active. This contrasts with perpetuated stereotypes that traditionally view them as asexual. These findings have important implications for healthcare policy and practice. They underline the need for recognition and attention to be given to the sexual health of disabled women through the provision of disability-sensitive healthcare services that are inclusive, respectful, and responsive toward their needs. It should be noted, however, that the very same findings also document a small minority of healthcare workers who think that disabled women are indeed asexual and are devoid of sexual agency. This calls for disability-sensitive education and training to ensure all healthcare professionals have the cultural competence to effectively care for all patients, including disabled persons.

The current study's findings contrast with those of prior studies done by Joseph, Saravanabavan, and Nisker (2018), as well as Sharma and Sivakami (2019), in Canada and India, respectively. They observe the use of terminology such as 'asexual' and 'celibate' about the sexuality of disabled women. A study conducted in Türkiye by Tugut et al. (2016) that examined nursing students' perceptions similarly found prevalent prejudices towards Disabled people. A majority of the nursing students surveyed (79%) held the view that sexuality was not a significant aspect of the lives of disabled people. Furthermore, they saw them as less desirable sexual partners. The findings from this study challenge the prevailing narrative of asexuality that has been historically imposed on disabled women. It disrupts dominant discourse by its documentation of recognition—at least among health professionals—that, indeed, disabled women have sexual feelings and normal sexual anatomy and are sexually active. It has emphasized the necessity of access to disability-friendly health services, encompassing comprehensive sexual health education, counselling, and support to help disabled women make self-determined choices about their sexuality.

These study findings also greatly enrich the understanding of perceptions of healthcare workers of reproductive potential among disabled women. Notably, these findings report that a considerably high proportion of healthcare workers considered the possibility of pregnancy among disabled women, reflecting some degree of awareness and openness, a desired characteristic of a disability-friendly healthcare environment. The results imply that interaction with disabled persons can affect the opinion of health workers, most probably because such exposure may lead to a more understanding, empathetic, and appreciative attitude towards disabled women. Moreover, this research suggests that when health professionals encounter disabled women outside of the clinical setting, they are likely to start thinking about them as human beings as opposed to objects of medical curiosity and begin to appreciate that they lead complete, active lives beyond disability.

The findings of this study contrast studies done in Uganda, Ghana, and Zambia, which document negative perceptions towards disabled women in healthcare settings (Emoru et al., 2022; Ganle et al., 2016; Smith et al., 2004). The studies noted cases of open disapproval, disbelief, and even public humiliation by health workers regarding the pregnancy of disabled women. The results of the study also go contrary to another study by Nguyen et al. (2022), which reported that many health workers still have a negative attitude towards pregnant, disabled women, especially concerning perceived abnormalities in their pregnancies and birth experiences. By highlighting the transformative power of personal interaction, this research makes an excellent case for including opportunities for meaningful interaction between health professionals and disabled persons in healthcare education and practice. It further states that these interactions are not matters of courtesy but are important in mainstreaming a culture of equitable and compassionate care.

The findings show that, generally, there was a relatively high positive attitude toward disabled women among health workers, evidenced by an overall ATDP mean score of 117.77 with a standard deviation of 19.25 out of a maximum of 180. This may indicate an implicit culture of acceptance and inclusiveness within the health fraternity, which may be exploited to instigate the delivery of quality and more inclusive healthcare for disabled women. This study also finds health facility type to be a statistically significant factor for the determination of attitudes. The findings show that healthcare workers in private health facilities display more positive attitudes toward disabled women compared to their counterparts in public health institutions. They suggest the influence of work environment and organizational culture on attitudes toward disabled women. There is the possibility that private facilities may probably have more resources available to afford training in disability awareness and a greater focus on the delivery of patient-centered care, and as such, generally, positive attitudes are more common. These findings underline the interaction of organizational culture, resources, and individual factors in influencing healthcare workers' attitudes toward disabled women. Undoubtedly, the significant implications of the findings on policy and practice justify multi-level interventions to influence attitude change at both institutional and individual levels. This would most certainly lead to greater inclusivity for disabled women and enhanced quality of care.

5.4 Utu and the Destigmatization of Disability, Sexuality, Pregnancy and Childbirth of Disabled Women for Social Transformation

We have already discussed the origins and significance of critical disability theory (Chapter Two), focusing on its emancipatory potential in the context of disability and disabled people. Critical disability theory has made significant contributions, most notably in the de-medicalization of disability and its emphasis on transforming the social structures and situations that perpetuate and sustain disability-related oppression. This is a significant contribution that should be noticed. Nonetheless, due to its conceptual foundations in the Western world, there are concerns that critical disability theory (and other Western disability theories) may inadvertently or intentionally project hegemonic and Eurocentric perspectives on disability while silencing marginalized and subdued voices of disabled people from the global south (Mutanga; 2023; Gwaravanda, 2021; Naude, 2019).

We have also analyzed how the Utu philosophy emphasizes the interdependence of all people and the need to show compassion and respect for others (Chapter 2). Utu offers a solid basis for recognizing and integrating marginalized people in society. Some scholars have explored the possibility that Utu restores disability in terms of identity, social status, and human rights. Etieyibo (2022), a Nigerian scholar, has highlighted some aspects of the traditional African worldview on disability. He points out that unlike most Western theories of disability, which focus solely on the physical representations of disability, any understanding of disability must be conceptualized in its diverse social, cultural, and spiritual contexts. Furthermore, he believes that disability should not be limited to physical limitations only but that the concept needs to be expanded to include spiritual, psychological, and social dimensions. In addition, he places greater emphasis on the role of the entire community in providing experiences to people with disabilities. Contrary to the widespread belief that disabled people should be viewed as passive recipients of care, he argues that it is an important responsibility of communities and societies to ensure that these people are supported, included, and facilitated to participate in society.

Ojok and Musanze (2019) posit that African culture inherently respects disabled people and their identities, with disabled people enjoying enormous respect in their respective communities. They cite examples from ancient Egypt in which people of low social status were shown respect and given elaborate burial traditions that were also extended to other important people in society. They also reinforce the mythical origin story of the Yoruba people and their relevance to disability, as well as the Yoruba god Obatala's promise to care for all people with disabilities everywhere in the universe, as clues to how to accept people with disabilities. They argue that the dehumanization and marginalization experienced by people with disabilities today is not a reflection of African cultural values, but rather the prevailing socio-economic inequalities within society. The obstacles that people with disabilities face are due to socially constructed factors, as well as prejudices and collective actions of people that violate accepted cultural values, commonly referred to as respect, humanity, compassion, and solidarity.

Given the previous discussion on decolonization and decoloniality and the examination of utu as a philosophical construct, values-based system, and human-existential approach, what implications arise for critical disability theory and the social model of disability? What possibilities exist for the (re)conceptualization of disability based on Utu philosophy? From the perspective of critical disability theorists, it is not primarily the impairment that contributes to disability in society but rather the attitudes, beliefs, perceptions, practices, and policies exhibited by non-disabled individuals. These manifest as discriminatory behaviours or prejudicial treatment towards disabled people. Critical disability theorists and advocates of the social model contend that disability is not solely a physical condition but rather one constructed by societal norms and power relations. This contradicts proponents of the medical model who view impairments as innate to an individual's biology, necessitating medical intervention for correction. Despite their contrasting philosophical perspectives, critical disability theory and the Utu conceptualization of disability share a central feature. Rather than viewing disability as a purely personal problem, both approaches highlight the importance of social, cultural, political, and economic elements in the persistence of disability injustice. Fundamentally, both approaches emphasize that the community must make the necessary adjustments to address and accommodate potential barriers arising from disability and emphasize the need to treat disabled people with dignity, respect, and compassion.

In most African cultures, the role of the extended family in the socialization and integration of the individual into society is as significant as it is an inherent element of the Utu philosophical paradigm. The general changes at the broader societal level emphasize critical disability theory rather than this particular aspect. The sense of closeness, solidarity and camaraderie generated by the extended family and clan helps to recognize, accept, and integrate disabled members into the larger community. Utu prioritizes micro-level reforms by focusing on the extended family and the family unit. In conclusion, it can be stated through observation that Utu has a value-based component in that it acts as a basis for the equal and impartial treatment of all individuals of the society, regardless of their position in society, gender, racial difference, etc. or any other consideration. This is because respect, compassion, solidarity, care, trust, and selflessness are key components that ensure such connectedness, interdependence, and shared prosperity among community members. These principles are instilled in individuals through socialization, creating the attitudes that promote equal treatment of disabled people as they would treat other members of the community. Such a value system is missing from critical disability theory.

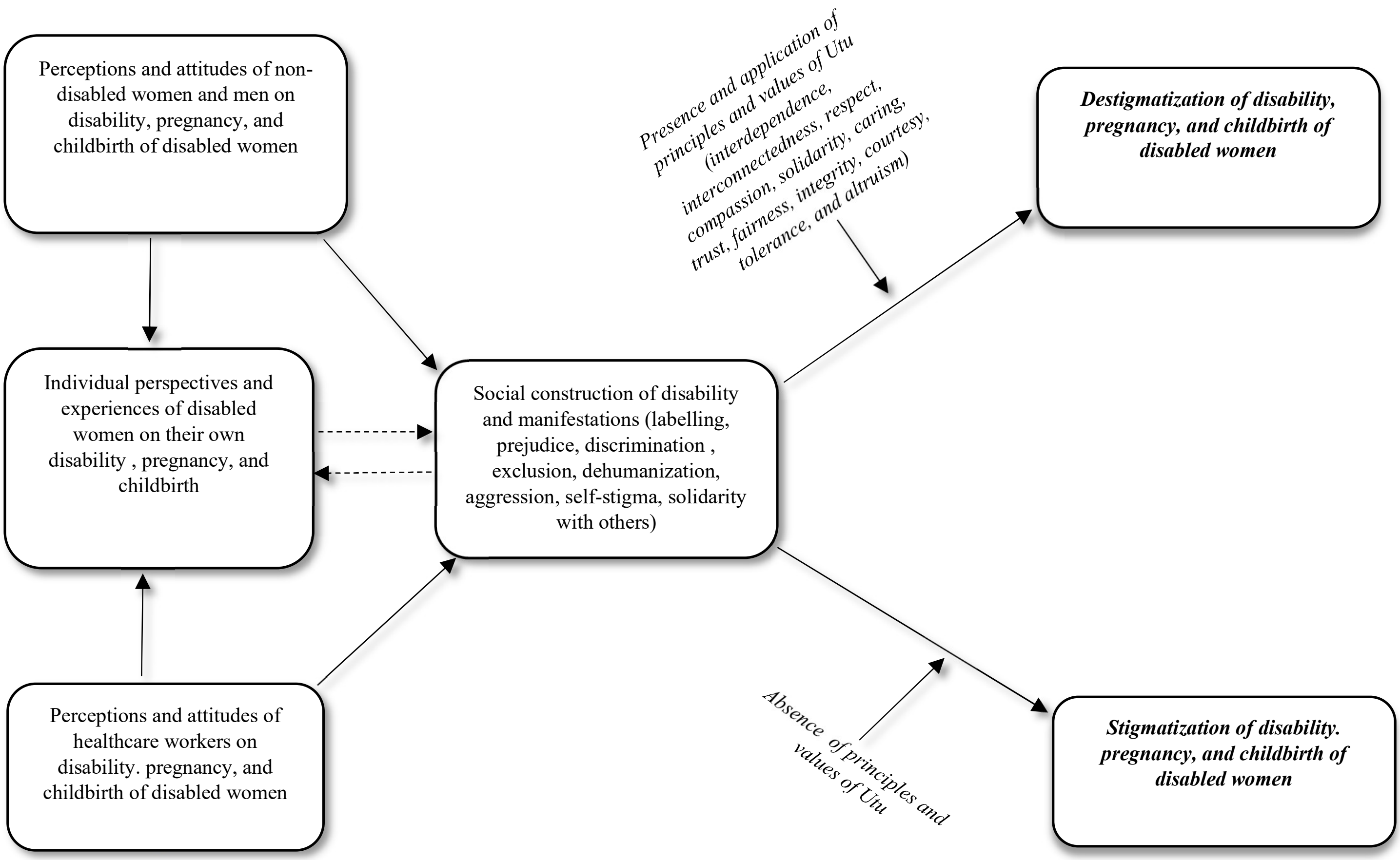
The prevalence of marginalization and stigmatization experienced by disabled women is fundamentally intertwined with the erosion and disregard for the Utu value system. The tenets of Utu offer a crucial foundation to advance progressive societal shifts, particularly in addressing formidable obstacles that disabled women encounter, such as adverse attitudes and perceptions towards their disability status, sexuality, pregnancy, or childbirth experiences, alongside misconceptions regarding disability heredity. In an environment predicated on Utu principles, everyone receives equal treatment irrespective of their background, including disability status, gender identity, religious beliefs, or social status. Incorporating the values of Utu can have a transformative impact on societal norms, institutions, and policies. It has the potential to create an inclusive and responsible community. Nevertheless, implementing these principles demands unwavering dedication and structural adjustments to rectify power disparities. This reality informs the reconfiguration of our initial conceptual framework, and this is discussed in the next sub-section

5.5 Revisiting and Reconfiguration of the Conceptual Framework

The conceptual framework has been modified in light of the analysis and discussion of the study's findings and an exploration into the *Utu* philosophical paradigm and its conception of disability, with the potential implications for the destigmatization of the disability, sexuality, and pregnancy of disabled women (*Figure 6*). The findings from the study underscore the intricate ways in which the individual perspectives and experiences of disabled women, along with the attitudes and perceptions of both non-disabled individuals and healthcare workers, converge to influence the social construction of disability. This confluence of perspectives acts as a fundamental framework within which disabled women face labelling, prejudice, discrimination, exclusion, and dehumanisation.

Figure 5

Revised Conceptual Framework



The revised conceptual framework suggests that the Utu philosophical framework could change how we see disability, shifting the focus from the narrow view of limitations imposed by physical or mental conditions to a more embracing and integrative practice towards disabled women. It can play a crucial role in breaking down deep-rooted stereotypes around disability, especially when it comes to the sexual and reproductive health and rights of disabled women. The Utu approach prioritizes relationships and mutual respect advocating for the recognition of the value and dignity of all individuals regardless of their social identity, including disability. The revised conceptual framework additionally indicates that embracing Utu principles such as interdependence, interconnectedness, respect, compassion, solidarity, care, trust, fairness, integrity, politeness, tolerance, and altruism can help reduce the stigma surrounding disability, sexuality, and pregnancy of disabled women. Without these values, disabled women might be unfairly judged based on their disability status and face stigma.

5.6 Summary of Chapter Five

The chapter aimed at discussing the research results, comparing them with existing empirical evidence, and identifying the scholarly contribution of the study. We have observed that in this chapter, there exists pervasive discrimination and stereotypes disabled women face in Kenya, more so regarding their sexuality, pregnancy, and childbirth. We have noted that women with a disability are often marginalized, ridiculed, or even victimized by the community and family members; negative perceptions and labelling further marginalize or lower their self-esteem and well-being. The discussion also identifies a shift in society's views to a large extent, with most people displaying positive perceptions and attitudes. However, there are differences among demographic groups. Moreover, only a small minority displayed negative perceptions and attitudes. This chapter has also discussed and acknowledged the potential of Utu philosophy and its value-based characteristic in reducing stigma and prejudice with regard to disability.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

The concluding chapter of this study presents the key findings obtained from the analysis and discussion of both qualitative and quantitative data. Additionally, this chapter highlights the conclusions and recommendations as well as theological considerations related to the disability, pregnancy, and childbirth of disabled women. These findings, recommendations and proposed ministerial action can enhance the conditions related to how disability is perceived, treated, and approached. Specifically, emphasizing women with disabilities could help encourage a more inclusive society.

The main objective of the study was to explore societal attitudes and perceptions regarding the disability, pregnancy, and childbirth of disabled women in Kibra. The first research question addressed the perspectives and individual experiences of disabled women concerning their disability, pregnancy, and childbirth. The second and third research questions focused on the perceptions and attitudes of non-disabled women and men, on the one hand, and healthcare workers, on the other hand, regarding the disability, pregnancy, and childbirth of disabled women.

6.1 Summary of Findings

Qualitative data for the study was gathered through in-depth interviews with fourteen disabled women to get their individual experiences and perspectives on their disability, pregnancy, and childbirth through the use of an interview guide. Quantitative data was obtained through survey methodology; specifically, the perception survey and ATDP tool were administered to 420 non-disabled people and 145 healthcare workers. The qualitative data in the study were subjected to thematic analysis, whereas the quantitative data were analysed using statistical methods. The researcher used the Cronbach alpha model to evaluate the internal consistency of the ATDP scale. The resulting Cronbach's alpha value of 0.717 for the 30-item ATDP scale indicated a satisfactory level of internal consistency. The following subsection summarises the results for each of the three study objectives.

6.1.1 Individual Experiences and Perspective of Disabled Women

The study revealed explicit instances of discrimination and prejudice exhibited by family members towards disabled women solely based on their disability. Instances of discrimination and bias displayed by family members towards disabled women bring into focus an aspect of ableism within close social circles. It highlights manifest contradictions where family members, usually seen as sources of support and care, contribute to exclusion and prejudice towards disabled women.

The findings of the research indicate that disabled women often face mockery, shaming and negative labels due to their disability. The study observed the use of terms like "mzungu" (white one) and "macho bovu" (useless eyes) to refer to women with Albinism and visually impaired women, respectively. These insulting labels display society's lack of regard for the identity and dignity of women. Such derogatory terms can make women feel inadequate, affecting their well-being and self-worth over time. Furthermore, the study points out how the stigma around disabilities not only impacts disabled women but also extends to their families.

The findings of the study depict some of the stereotypes and myths used in connection to the sexuality of disabled women, which include widespread desexualization. The perception that disabled women do not have sexual organs or sexual desire at all or are sexually inactive brings to the fore the lack of recognition of their humanity and the outright denial of the depth of varied sexual experiences. Moreover, sexually demeaning comments toward pregnant, disabled women reflect societal doubts about their potential for motherhood, extending desexualization into broader life roles and abilities.

The study recorded a high default rate of 60% for follow-up appointments on ANC services among disabled women users at public health facilities but none in private medical establishments. This may not primarily be due to a number of reasons, including the unpreparedness of healthcare workers in public institutions to meet the unique needs of disabled women. It may also be a structural problem occasioned by the high volume of patients in public institutions, which limits opportunities for personalized care or extra support disabled women may require.

The results of this study reveal that a large majority of disabled women are usually profiled for unnecessary caesarean deliveries, reflecting underlying biases within the healthcare system. These actions violate the inherent rights of disabled women in decision-making and remaining in charge of their lives. They also raise questions about the blatant disregard for professional ethics and patient rights by healthcare providers, who often make decisions for CS based on stereotypes rather than personalized evaluations of patients.

The invasion of disabled women's privacy during prenatal visits and childbirth was another significant finding of the study. Many of the women interviewed for this study complained about the lack of respect for their personal space when they arrived at the healthcare facility to give birth. This was notably true for one woman with albinism, whose presence in the labour ward was regarded as a spectacle. The delivery room was crowded with healthcare workers who were not necessarily there to assist with the delivery. Some of them made derogatory remarks about her pregnancy and their anticipation of the birth of a child with albinism.

The study's findings show that quite a few disabled women prefer private health facilities over public ones despite the added financial burden. This preference for dignity and respect underlines an important choice. For many disabled women, the quality of care and how it is delivered overshadows financial considerations. This preference underscores certain critical deficiencies related to quality, inclusivity, responsiveness, and apathy in matters of disability and disabled women in the public healthcare system. The study has documented many instances of mistreatment and lack of respect by healthcare staff towards disabled women in public health institutions and none in private health facilities.

6.1.2 Perceptions and Attitudes of Non-Disabled Women towards Disability and Disabled Women

The second research question examined the perceptions of non-disabled women and men regarding disability, sexuality, pregnancy and childbirth of disabled women and their attitudes towards them.

The study's findings indicate that non-disabled women and men identified heredity (40.3%) and birth complications (37.%) as the primary factors contributing to impairment. In comparison, evil spirits (2%) and God’s punishment (1%) and evil spirits were the least mentioned reasons for impairment. Moreover, the data demonstrates a statistically significant association between the perceptions of non-disabled women and men regarding the causes of impairments and all the demographic variables. The correlation implies that personal experiences and social environments may influence public perceptions about the cause of impairments.

Most of the non-disabled women and men surveyed in the study indicated that they recognize that disabled women have desires, possess organs, and engage in sexual relationships, indicating a shift towards a more positive societal outlook on disability and sexuality. This assertion, however, contradicts the perspectives of disabled women who felt that they were victims of desexualization. The study challenges standing prejudices about sexuality, advocating for an inclusive discussion on sexual rights and self-determination. Sexual desires and needs are universal and not constrained by abilities.

The results of the study show that a substantial proportion (87.8%) of non-disabled women and men believe that disabled women can conceive. These findings are promising and show a shift in societal attitudes toward the reproductive capabilities of disabled women with disabilities. They challenge all those negative historical biases and misconceptions that have often marginalized their sexual and reproductive health and rights.

The findings indicate that the majority of non-disabled women and men see pregnancy in women as common or normal. Additionally, the findings indicate that males and individuals with limited formal education are more likely to view pregnancy among disabled women as abnormal. This suggests that gender roles and educational attainment play critical roles in influencing societal norms and prejudices.

The general attitude of non-disabled women and men toward disabled women is very positive, represented by the high scores on the ATDP scale. Further analysis of data brings out clear evidence of the role that religious belief, educational level, and personal contact with disabled people play in the determination of attitudes. Religious beliefs might often stimulate the demonstration of positive attitudes toward disabled persons by stimulating sympathy, compassion, and acceptance. Education is essential as the findings indicate that it can tackle myths and misunderstandings about disabled people. This means the educational system could address stigma by promoting inclusive attitudes for children early on.

6.1.3 Perceptions and Attitudes of Healthcare Workers towards Disability and Disabled Women

The third research question focussed on healthcare workers' attitudes toward disabled women and their perceptions of their sexuality, disability, pregnancy, and childbirth.

These findings reflect a huge shift in the perception of healthcare workers concerning the sexuality of disabled women. The majority of healthcare workers in the study acknowledged that disabled women experienced sexual feelings, had normal sexual anatomy, and were sexually active. This contrasts with perpetuated stereotypes that traditionally view them as asexual. The findings are, however, inconsistent with the experiences narrated by disabled women interviewed in the study, who reported blatant instances of desexualization in the community.

The study findings report that a considerably high proportion of healthcare workers agreed on the possibility of pregnancy among disabled women. The results imply that interaction with disabled persons can affect the opinion of health workers since such exposure leads to the development of a more understanding, empathetic, and appreciative attitude towards disabled women. Moreover, this research suggests that when health professionals encounter disabled women outside of the clinical setting, they are likely to start thinking about them as human beings as opposed to objects of medical curiosity and begin to appreciate that they lead complete, active lives beyond disability.

The findings of this study show that, generally, there was a relatively high positive attitude toward disabled women among health workers. The findings suggest that private facilities slightly have more positive attitudes toward disabled women compared to public facilities among health workers. It just goes to prove the influence of work environment and organizational culture on attitudes toward disabled women. Private facilities may probably have more resources available to afford training in disability awareness and a greater focus on delivering patient-centred care. As such, generally, positive attitudes are more common.

6.2 Overall Conclusions

In Kibra and throughout Kenya disabled women face obstacles due to stigma and bias. Within their families, these women often experience neglect, discrimination and even mistreatment because their disabilities are seen as burdens. This family-based stigma can hinder their access to education, job opportunities and social interactions leading to a cycle of dependence and isolation. In the community disabled women are frequently left out of life and decision-making processes. Cultural misconceptions, about disabilities can result in exclusion where these women are not given the chance to participate in or benefit from development initiatives in the community. This exclusion reinforces stereotypes and deepens their disadvantaged status.

The optimistic perceptions, attitudes and behaviour of healthcare workers highlighted by the study findings could be leveraged to ensure that the healthcare system is sensitive, to disability, and to provide respectful care for all disabled women. This effort would help drive progress towards achieving development goal 5 on gender equality and women empowerment. The commitments made by world leaders in 2015 demonstrating their dedication to inclusivity and prioritizing support, for marginalized individuals should not remain mere slogans. Instead, it should be translated into implementable policies that lead to substantial and enduring transformations.

The tendency to marginalize and stigmatize disability, sexuality, and pregnancy, of disabled women is driven by power dynamics in society. Non-disabled individuals often take it upon themselves to define what is considered abnormal, acceptable, or unacceptable and set expectations for disabled persons. Various agents of socialization such as family, religion, media, and education relegate disabled women to the periphery of society, continuously perpetuating norms that prioritize non-disabled individuals. To uphold the rights of disabled women and create an inclusive society, we must dismantle ingrained biases and discriminatory behaviours that impede the empowerment of these women. The rights of disabled women outlined in the Convention on the Rights of Persons with Disabilities must be universally acknowledged, applicable and enforced across all aspects of society.

Revitalizing the principles of Utu, a philosophy centered on unity, mutual reliance, acceptance, justice, unity, respect, empathy, and sacrifice, for others offers a foundation for promoting empowerment and equality for disabled women. Utu, deeply ingrained in the communal perspective on life goes beyond individualism and underscores the importance of community well-being. When applied to disability issues it has the potential to nurture an atmosphere that acknowledges the interconnectedness and interdependence, among all members of society. By dismantling the barriers that marginalize disabled women, Utu can offer guidance towards their acceptance, inclusion, and integration in society.

6.3 Limitations of the Study

Researching a sensitive topic about a stigmatized population presents numerous obstacles, including researcher bias, methodological complexity, and respondent-related issues such as social desirability. The qualitative data for the study was collected from only 14 disabled women from Kibra, which presents several difficulties, including the complexity of extrapolating the study results to disabled women outside the Kibra region. In addition, the study was explicitly aimed at women who are physically impaired, visually impaired, hearing and speech impaired and with albinism. Therefore, the results cannot be extrapolated to include the experiences and perspectives of other disabled women with distinct categories of disability.

The positionality of the researcher as an outsider-insider may have hindered the interview process with disabled women. The researcher has previous experience working with disabled women in Kibra, including organizing maternal health rights clinics and is familiar with some respondents. Given this reality, the researcher entered the study with certain assumptions and beliefs regarding disability and disabled women. The researcher showed self-awareness and openness about pre-existing biases in research and was careful not to influence respondents with these biases. To promote objectivity, mutual trust, and truthful dealings, it was essential to subject the research process to peer review, provide appropriate and unsolicited information to research participants, and create a conducive and open environment for interviews.

Furthermore, the prevalence of social desirability may have influenced the perceptions and attitudes of healthcare workers, as well as non-disabled women and men, towards disability and disabled women. Participants were allowed to complete the surveys anonymously to ensure they felt comfortable sharing their information to reduce the influence of social desirability on the research results. In addition, the researcher ensured that the research assistants were not placed in areas where they were familiar with the local community or where they usually lived.

The researcher interviewed hearing and speech-impaired women, for the study with the help of a sign language interpreter as they were not proficient in sign language and had literacy in that area. However, this approach raised concerns, about the possibility of the interpreters imposing their subjective views on the issues under discussion. To address this potential challenge, two different interpreters were used interchangeably to minimize bias and ensure accuracy. The interviews were scheduled on different days to minimize interpreter fatigue and transcriptions were done promptly after each interview to capture details accurately. Follow-up calls were made to clarify any exaggerated parts of the interview.

6.4 Suggestions for Further Research

The research findings were associated with three distinct objectives outlined in the study. Nevertheless, several significant matters have arisen that necessitate additional examination and deliberation. Pregnant disabled women demonstrated a significant disparity in their use of prenatal care services according to the study findings. A minimum of eight women with disabilities in the study indicated a failure to attend pre-natal sessions. The study's sample size was deemed inadequate, and it is recommended that the research be supplemented with more qualitative investigations or surveys with a more specific scope. This approach would yield more comprehensive data and significant insights into the underlying causes of the observed high default rate. It would be of greater significance to ascertain the impact of this issue on women, irrespective of their disability status.

Another intriguing finding that deserves further investigation is the claim that those who have never interacted with impaired persons are more prone to believe that impairment is passed down through generations. To investigate diverse issues, we advocate empirical investigations involving individuals with varying degrees of experience to impaired people. The nature of contact with disabled people, the nature of the relationship with disabled people, and the respondents' religious orientation are all considerations to examine.

The results of the study also suggest that people who follow the Islamic faith have a greater tendency to have positive attitudes towards pregnancy and childbirth among disabled women than those who identify as Christians or followers of the traditional African religion. This represents another matter that requires more research, focusing primarily on the interplay between religious values, personality, and morality, which can manifest and impact individual or societal behaviour, including perceptions and attitudes towards people with disabilities.

The reasons why healthcare professionals from private health facilities seem to have or are perceived to have more positive attitudes towards disabled women than their counterparts from public health institutions is another critical issue that needs more investigation. Several factors would be considered, such as the type of training provided, the working environment, the value system, the pay scale, and the patient care guidelines for both public and private healthcare facilities.

The study also highlighted Utu's significant role in enforcing human dignity and rights, underlining its core values such as integrity, respect, decency, compassion, solidarity, and tolerance as the basis for ethical behaviour. These values emphasize the interconnectedness and interdependence between individuals and their communities. Further research on *Utu* values, particularly their impact on people with disabilities, should focus on a homogeneous ethnic community, paying particular attention to the normative and non-normative representation, interpretation, and application of these values. A more nuanced inquiry would examine whether these normative and non-normative representations, interpretations, and applications of *Utu* values would manifest differently for a heterogeneous ethnic community.

6.5 Recommendations for Policy Accountability, Reform and Action

The study's findings have significant policy implications, particularly concerning the disability, pregnancy, and childbirth of disabled women. The issue of disability stigma and prejudice is a significant challenge within healthcare settings and requires a concerted effort at cultural transformation within the healthcare system. This endeavour should be supported by implementing policies, guidelines and practices prioritising dignity, respect, inclusion, and equality for women with disabilities. The study documented several cases where women with disabilities experienced humiliation and had limited options for redress. Healthcare facilities need to establish and enforce strict rules and standards that prohibit any form of dehumanization and degradation of women with disabilities. These protocols should be accompanied by explicit sanctions to ensure accountability and deterrence.

It has been shown by the study findings that disabled women often tend to forego prenatal care or have high failure rates due to unpleasant experiences in the past, particularly in public health settings. Therefore, it is advisable to restructure or redesign maternal health policies to increase disability awareness among the healthcare workforce and promote a more inclusive environment. One solution to this problem is providing healthcare workers with specialized disability training. Equipped with such training, professionals would be better able to understand and meet the unique needs of diverse groups of pregnant women with disabilities, thereby improving their effectiveness in providing care. It is possible to integrate disability education content into the in-service training module or the formal training curriculum for health workers.

The study results show that a significant challenge for hearing and speech-impaired women is the lack of knowledge that many healthcare workers display about their unique communication methods. The limited availability of healthcare workers with sign language proficiency poses challenges in identifying and addressing the unique needs of these women. In situations where hearing and speech-impaired women require assistance, such as during childbirth, their needs may be overlooked or consistently ignored due to a lack of interpreters to communicate effectively. This situation leaves individuals vulnerable to significant potential harm. To address this policy deficiency, it is strongly recommended that healthcare facilities implement strategies to ensure the presence of certified sign language interpreters. Sign language interpreting can be done in person or through remote audiovisual technology such as video interpreting services.

The findings of the study also revealed occurrences of coerced or non-consensual caesarean sections among disabled women, which deviated from established medical protocols. It is crucial to underscore that these medical interventions ought to be exclusively carried out in cases of emergencies and contingent upon the informed consent of the patient, including disabled women. The utilization of coercion in such circumstances raises concerns regarding the attitudes and perceptions of healthcare workers on hypothetical risks associated with the childbirth of these women, often lacking medical justification. When identifying, assessing, and managing cases requiring caesarean section, healthcare facilities must apply a set of defined protocols that apply to all women, regardless of whether they are disabled or not. We recommend that disabled women not be selected as potential candidates for caesarean delivery based solely on their disability; Rather, any decision to take them to the operating room for delivery should be underpinned by a transparent and consultative process.

6.6 Theological Reflection and Ministerial Action towards the Destigmatization of Disability, Pregnancy, and Childbirth of Disabled Women and Impetus for Social Transformation.

This study is not an end in itself; Rather, it is the continuation of a long-term social transformation project that aims not only to change perceptions, attitudes, and behaviours towards disabled women at the personal, societal, and global levels but also influence sustainable mechanisms for inclusion of disabled persons into mainstream society. In this study, we have argued that the *Utu* value system has the potential to bring about social transformation by reducing the stigma surrounding disability, pregnancy, and childbirth of disabled women. We believe that by embracing Utu principles such as interconnectedness, interdependence, tolerance, justice, solidarity, and respect from the Utu system, we can make a difference in this regard.

In this section, we will revisit the narrative of Jane that was presented in the introductory chapter of this study, drawing parallels between her encounters and challenges and our study findings. In addition, we will highlight our understanding and perspective on the destigmatization of disability, pregnancy and childbirth of disabled women and its implications for social transformation and ministerial action. This research has used the pastoral circle, developed by Joe Holland and Peter Henriot as the foundation for theological reflection. The pastoral circle has four distinct and interrelated stages, namely insertion, social analysis, theological reflection, and pastoral action (Holland and Henriot, 1980).

6.6.1 Insertion and immersion into life and experiences of disabled women of Kibra

Insertion is the first stage of the pastoral circle. It requires complete immersion in the situation and personal experiences of people affected by a particular social problem. In the context of this study, mothers and pregnant disabled women face the challenge of stigma, discrimination, and exclusion due to disability. The researcher "immersed" in the community and built a relationship with them to better understand the underlying factors of the particular social problem of disability.

The entry point for this insertion and immersion was the encounter with Jane (not her real name) a physically impaired middle-aged woman who has lived in Kibra her entire life. Born to casual labourers, Jane never had the opportunity to attend school, and several factors contributed to this predicament. As a disabled child, her parents saw no need to send her to school. They viewed her disability as something unusual for the family and the community and believed that it would be better for them to stay at home. Furthermore, her parents were impoverished, and the family lived from hand to mouth, making it out of their reach to raise money for school fees and uniforms for her and her siblings. Even if there was money to send one of the children to school, her male siblings would get priority.

The initial step for me, in this process of insertion and immersion, began with the encounter with Jane (a pseudonym) physically impaired middle-aged woman who has lived in Kibra her entire life. Because of her disability, her parents felt it unnecessary to enrol her in school. They viewed her impairment as something abnormal and decided it would be better for her to stay at home. Additionally, the family faced hardship struggling to meet their needs, which made it impossible for them to afford the required fees and uniforms for both Jane and her siblings. Even if they had funds there was a preference given to sending her siblings rather, than Jane to school.

My paths crossed with Jane during one of the human rights clinics organized by Amnesty International in Kibra. The focus of the clinic was on maternal health rights, bringing together community members to share their experiences and challenges. Jane was overtly quiet during most discussions but nodded in apparent agreement with the stories shared by other women. Most of these women were non-disabled, recounting harrowing tales of maternal health injustices. One narrative, in particular, seemed to strike a chord with Jane. A woman shared the gut-wrenching story of giving birth on the floor due to a delayed response from nurses. She was later blamed and verbally abused for circumstances beyond her control. As the woman spoke, Jane broke down in tears, her face drenched in sorrow and empathy. Her reaction triggered my curiosity, especially since I had noticed that she was physically impaired. Could her experiences be any different from those of the other women?

During one of the breaks, I approached Jane, gently suggesting that the story must have deeply affected her. Tears welled up in her eyes again as she confided that she had endured the worst of experiences. She began to narrate the humiliation she faced because of her pregnancy. She revealed how her parents blamed her for getting pregnant, considering her condition a disgrace. When she sought antenatal services, the healthcare staff ostracized her. During delivery, she was chastised for daring to get pregnant despite her disability. This interaction with Jane was not an isolated incident. Conversations with other disabled women from Kibra unveiled layers of similar experiences steeped in stigma and prejudice. These firsthand accounts were heartbreaking but also enlightening. They revealed that communal attitudes and perceptions were the primary forces behind the enormous barriers disabled women faced.

Inspired by these narratives, I felt a compelling need to delve deeper. The objective was not merely to understand but to investigate these specific societal perceptions and attitudes that perpetuated such stigma and discrimination. By concentrating on these aspects, the study aimed to uncover the root causes of the injustice and discrimination faced by disabled women in Kibra.

6.6.2 Social analysis: Unmasking stigmatization and discrimination of disabled women in Kibra

The second phase of the pastoral circle pertains to social analysis and entails a systematic exploration of the underlying structural, historical, and systemic factors contributing to a particular societal problem. This phase facilitates scrutiny of root causes, repercussions, linkages, and actors for the given social issue. Additionally, it provides a contextualized representation of the experiences of numerous individuals affected by the prevalent social issue within broader societal frameworks and establishes an interconnection between their personal encounters and society's actions or inactions. The research process, as well as the analysis and discussion of the findings in this study, represents the social analysis process.

The research focused on gathering insights from disabled women, non-disabled women, and men, as well as healthcare workers, regarding their experiences with disability, pregnancy, and childbirth. The findings of the study revealed myriads of issues such as manifest prejudice, dehumanization, and societal stigma towards disabled women. The situation of disabled women in society is precarious and uncertain, and they are systematically excluded from key aspects of society due to predetermined social norms, attitudes, and practices, which perpetuate ableism.

The study's findings have revealed the existence of prejudices and stereotypes about disability and disabled women in the community. They are seen as less human, and their existence is linked to unnatural occurrences such as bad omens and curses. Furthermore, the study found that several disabled women reported being discriminated against by family members because of their disability, even though they expected their family members to understand and accept them unconditionally. The research also shows that disabled women expressed displeasure with how community members portrayed them, labelling them as ‘beggars’ and ‘invalids.’

The study also found mixed results regarding how non-disabled women and men perceive the sexual orientation of disabled women. There is a belief among particular sections of society that disabled women lack sexual feelings and sexual organs and are not sexually active. This belief has a significant impact on how these women are treated in society when they express their sexual desires, become pregnant, or seek sexual and reproductive health services, such as family planning.

The inclination to abnormalize and stigmatize the disability, sexuality, and pregnancy of disabled women is influenced by power dynamics in society, where non-disabled persons assume the authority to determine what is considered normal or abnormal, acceptable, or unacceptable, and establish behavioural expectations for disabled individuals. The way people are socialized keeps this kind of situation going, and agents of socialization, like family, religion, media, and school, all play a role in not only pushing women to the edges of society but also strengthening the norms, beliefs and practice that prioritize non-disabled individuals, over disabled persons.

6.6.3 Theological Reflection: Utu values and the destigmatization of disability, sexuality, pregnancy, and childbirth for disabled women

The third phase of the pastoral circle primarily focuses on contemplating the relationship between the social analysis outcomes and the convictions or values of a specific religious orientation. In this study, the researcher utilized the Utu philosophical tradition as a framework for understanding and examining the existence of stigma and discrimination toward disabled women and ways to address it.

Utu defines expectations of how individuals should interact with one another and with others. The qualities and attributes desirable in Utu include justice, integrity, respect, courtesy, compassion, solidarity, and tolerance. These principles and values aim to create a culture of recognition, acceptance, and cohesion among members of society, not only to regulate behaviour but also to sanction discrimination and marginalization of vulnerable members of the community. Utu philosophy emphasizes the interdependence of all people and the need to show compassion and respect for others. It offers a solid basis for recognizing and integrating marginalized people in society.

In most African cultures, the role of the extended family in the socialization and integration of the individual into society is as significant as it is an inherent element of the Utu philosophical paradigm. The sense of closeness, solidarity and camaraderie generated by the extended family and clan helps to recognize, accept, and integrate disabled members into the larger community.

Although Utu promotes solidarity, non-discrimination, and the safeguarding of the dignity of every member of the community, disabled individuals nevertheless face prejudice and stigma. The insufficiency or ineffectiveness of the Utu value system is not the cause, but rather a result of a broader and long-term process that transcends it. Despite its enduring significance and pertinence as a fundamental philosophical framework and system of values, Utu has consistently faced suppression and subjugation at the hands of prevailing Western ideologies and intellectual paradigms throughout history. This process of dominance has persisted even beyond the era of colonialism. The Utu values, with their emphasis on communal existence and interdependence, as previously constituted in the pre-colonial era, are still useful elements for mainstreaming the integration and inclusion of disabled persons into all aspects of society.

6.6.4 Pastoral action: Ministerial action towards social transformation

The final component of the pastoral circle is pastoral action, which involves formulating specific strategies for individual and communal action, advocacy, or social change projects, while also addressing the underlying causes of social injustice. Summary of the proposed actions, objectives, period, and outcomes are highlighted in *Table 30*.

The study proposes actions to address the root causes of oppression experienced by women, with disabilities aiming to transform their social status. This involves confronting beliefs and perspectives that contribute to dehumanization and stigmatization. The action will target change at the community level and policy level as exploratory academic work on Utu values as a basis for addressing disability-related barriers.

The researcher intends to conduct policy conversations with policymakers and implementers as well as legislators and non-state actors to discuss and explore mechanisms for the inclusion of disabled women in the health sector as well as other social sectors. The first phase of this initiative includes a policy-focused meeting with the Nairobi County Health Management Team. During this meeting, key findings from the study will be presented, and strategies will be discussed to facilitate the provision of dignified, respectful, and disability-informed maternal health services to disabled women in health facilities across the county. The emphasis will be on discussing the differences in ATDP scores between healthcare workers in private and public health facilities. The objective of this study will be to identify entry points and opportunities for these professionals to participate in disability-sensitive training and sensitization programs.

In addition, the researcher will actively participate in community-level discussions and initiatives to reduce stigma and promote the integration of women with disabilities into society. The significant findings of the study from the community will be shared, and it is expected that the meetings will lead to the adoption of community-led interventions to address stigma and prejudice against disabled women. Finally, the researcher will conduct a further exploratory study on the Utu idea of disability, focusing on a selected ethnic community. This research will serve as a basis for identifying, analyzing, and interpreting vital disability-related constructs. A summary of the proposed actions, objectives, period, and outcomes are highlighted in *Table 29*.

Table 28

Proposed Plan of Action for Social Transformation

Action	Objective	Participants	Time Frame	Outcome
Policy conversations	To discuss and explore mechanisms transforming healthcare workers' perceptions and attitudes towards disabled women, particularly in the context of sexuality, pregnancy and childbirth	County Assembly County Executive Disabled Peoples Organizations Kenya National Commission on Human Rights County Health Management Team	January – March 2024	Clear policy guidelines and commitments toward disability inclusion and destigmatization
Community conversations	To discuss and adopt community-led interventions aimed at addressing stigma and prejudice towards disabled women	Opinion leaders Religious leaders Women leaders Local administrators Village elders Youth leaders, disabled people leaders	January – July 2024	Community-led interventions for addressing stigma and prejudice toward disabled women/people

Exploratory research on Utu and disability	Exploring and discussing key disability constructs within a selected ethnic community as a basis for strengthening the Utu concept of disability	Research respondents, academic colleagues	July – December 2024	Foundation for decolonization and decoloniality of disability

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APPENDICES

Appendix 1A: Consent Form for Disabled Women

Habari! My name is Brezhnev Otieno, a PhD candidate at Tangaza University College. I am undertaking academic research to explore societal attitudes and perceptions towards disability, pregnancy, and childbirth of Disabled women in Kibra.

This interview is expected to last between 30 minutes and an hour. The interview will ask personal questions about your experiences and perspectives on disability, pregnancy, and childbirth. Your identity will be kept confidential, and no direct link will be made between you and any information gathered during the interview. Please remember that participating in this interview is entirely voluntary, and you are free to decline to answer any questions that make you uncomfortable. Nevertheless, I hope you will participate fully. Your experiences and perspectives are critical to the success of this study. Kindly confirm if you have permitted us to continue with the interview. Tick the appropriate box below.

☐ *I agree to proceed with the interview but retain my right to decline to answer any questions that may cause discomfort. The researcher begins the interview process.*

☐ *I decline to participate in the interview and will not disclose the reasons for my decision. The researcher ends the interview process.*

Signature of Respondent: --

Interviewer Signature: --

Date Interviewed: --

Time Interview Begins: ----------------------------- Time Interview Ends: ------------------------

Appendix 1B: Interview Guide for Disabled Women

This interview guide will be used to gather perceptions and experiences of the disability, sexuality, pregnancy, and childbirth of disabled women

Instructions:

- Ask the questions in the order provided and probe for more responses and clarifications
- The interview should take between 30 – 45 minutes and should be done at the convenience of the interviewee
- Request consent to record on voice recorder the interview, and if this is not granted, please take notes
- Inform the interviewee that if they provide their real names, their identity will remain anonymous, and they will be assigned a unique number to maintain privacy.

SECTION A: SOCIODEMOGRAPHIC INFORMATION

1. Unique Code for Respondent: ____

2. Indicate your age group:
   18-25 ☐ 26-35 ☐ 36-45 ☐ 46-55 ☐ ≥ 56 ☐

3. Where do you live?
   Kibra ☐ Sarang'ombe ☐ Laini Saba ☐ Woodley ☐

4. What is your marital status?
   Married ☐ Single ☐ Separated ☐
   Divorced ☐ Widowed ☐ Other ☐ ________________________

5. Type of marriage: Monogamous ☐ Polygamous ☐ N/A ☐

6. What is your highest education level? - tick the most appropriate box

No schooling ☐ Primary ☐ Vocational training ☐

Secondary ☐ University ☐

7. Type of impairment: Tick the most appropriate box.

Hearing/speech impairment ☐ Albinism ☐ Visual impairment ☐

Physical impairment ☐ Other ☐

SECTION B: PERSPECTIVES AND EXPERIENCES

Part One: Questions around disability

1. Please tell us about yourself.
2. Share some of the challenges you experience as a disabled woman.
3. What has been the perception and attitude within your household regarding your impairment?
4. What has been the perception and attitude within your community regarding your impairment?

Probing questions

a. Share labels that community members assign you because of your impairment

b. Tell us how this labelling affects you and how you react.

c. What support, if any, do you get from other disabled women to confront such challenges? Kindly mention a few examples.

Part Two: Questions about pregnancy

5. Kindly share with us about your first/previous pregnancy experience.

   Probing questions

   a. Was the pregnancy planned?
   b. How did you personally feel about this pregnancy?
   c. What was your expectation of pregnancy?
   d. How did your close family members react when they found out about your pregnancy (siblings, spouse, mother-in-law)?
   e. How did they treat you after the pregnancy? Were there any reasons for this sort of treatment?
   f. Please share any unusual things that happened at home during the pregnancy.

6. Please share the reactions of your friends, neighbours, and community members to your pregnancy.

   Probing questions

   a. What was their expectation about you becoming pregnant?
   b. What was the behaviour of your friends, neighbours, and community members after and during your pregnancy?
   c. Please share any unusual things in the community during the pregnancy.

7. We would love to hear about your experiences with access to antenatal care services. Please share your thoughts on this.

   Probing questions

a. Please share your experience visiting the health facility during your last pregnancy. If you did not visit, what are the reasons for this?
b. How was the decision to attend the health facility arrived at? Who made the decision? (you, spouse, family member, health worker)? Why was the decision made?
c. c. How was the reception and reaction of the healthcare workers when you visited the health facility for a pregnancy check?
d. Was there any experience that made you uncomfortable during your visit to the health facility? Please explain.
e. Can you share memorable experiences with the healthcare workers during the pregnancy check?
f. What were the general behaviours and attitudes of the health worker towards you in the ANC clinic?
g. What would you want to see changed to provide a good experience for you when accessing ANC services?

Part Three: Questions on labour and childbirth

8. We will now discuss something extremely sensitive. Could you share your thoughts on labour and childbirth?

   <u>*Probing questions*</u>

   a. Please share with us where you delivered your child and the reasons for this decision.
   b. Who decided your place of delivery, and what was the basis for this?

c. Can you please share information on the person who accompanied you to the maternity and if they were allowed into the delivery room?
d. What was the general behaviour of the healthcare worker(s) who received and attended to you when you sought service to deliver your child? (respectful, kind, rude, etc.)
e. How did the healthcare workers communicate to you about the delivery and after the birth of your child? For women with hearing impairment, probe the mode of communication.
f. What is your comment about the general delivery ward experience in the context of your disability?

Appendix 2A: Consent Form for Non-Disabled Women and Men

Habari! My name is Brezhnev Otieno. I am a PhD candidate at Tangaza University College. I am conducting academic research to explore societal attitudes and perceptions toward disability, sexuality, and pregnancy among disabled women in Kibra, Nairobi.

The filling of this questionnaire is expected to last between 30 minutes and an hour. The researcher will ask very personal questions regarding your perspectives on disability, sexuality, and pregnancy of disabled women. Your identity will be kept confidential, and no direct link will be made between you and any information gathered during the survey. Please remember that participating in this survey is entirely voluntary, and you are free to decline to answer any questions that make you uncomfortable. Nevertheless, I hope you will participate fully. Your perspectives are critical to the success of this study. Kindly confirm if you have permitted us to continue with the survey. Tick the appropriate box below.

☐ *I agree to proceed with the interview but retain my right to decline to answer any questions that may cause discomfort. The researcher begins the survey.*

☐ *I decline and will not participate in the interview or disclose the reasons for my decision. The researcher ends the survey.*

Signature of Respondent: ---

Research Assistant Signature: ---

Date of Survey: ---

Appendix 2B: Perception Survey for Non-Disabled Women and Men

This questionnaire will be used to gather perceptions of non-disabled women and men on the disability, sexuality, and pregnancy of disabled women in Kibra

Instructions:

- Indicate the most appropriate answers by a tick (√) or a cross (×) in the box or spaces provided.
- Kindly use a blue or black pen
- The names provided in the questionnaire will remain anonymous, and you will be assigned a unique number to maintain your privacy.

SECTION A: SOCIODEMOGRAPHIC INFORMATION

1. Respondent unique code: ____

2. What is your sex?

   Male ☐ Female ☐ Binary ☐ Preferred not to answer ☐

3. Indicate your age category:

   18-25 ☐ 26-35 ☐ 36-45 ☐ 46-55 ☐ ≥ 56 ☐

4. What is your religious affiliation?

   Christianity ☐ Islam ☐ African Traditional Religion ☐

   No religious affiliation ☐ Other ☐

5. What is your highest education level?

   No formal schooling ☐ Primary school ☐ Vocational training ☐

   Secondary school ☐ Bachelor’s degree and above ☐

6. What is your level of contact with a disabled person?

No personal contact ☐ Caregiving of PWD ☐ Casual Contact ☐ Other ☐

SECTION B: PERCEPTIONS ON DISABILITY AND WOMEN WITH DISABILITY

7. In your opinion, what causes impairment?

Witchcraft ☐ God's punishment ☐ Birth complications ☐

Evil spirits ☐ Curse ☐ Other (specify) ☐

8. Do you concur or differ with the assertion that women with disabilities have a higher chance of passing on their disability to their offspring?

{ } Strongly disagree
{ } Disagree
{ } Neutral
{ } Agree
{ } Strongly agree

9. What is your opinion on the sexual feelings of disabled women? They…

Have sexual feelings ☐ Lack sexual feelings ☐

10. What is your opinion on the sexual organs of disabled women? They have…

Normal sexual organs ☐ Abnormal sexual organs ☐

11. What is your opinion on the sexual activity of disabled women? They are …

Sexually active ☐ Sexually inactive ☐

12. Do you agree or disagree with the statement that disabled women cannot become pregnant?

{ } Strongly disagree
{ } Disagree
{ } Neutral
{ } Agree
{ } Strongly agree

13. Do you agree or disagree with the statement that it is abnormal to find pregnant, disabled women in the community?

{ } Strongly disagree
{ } Disagree
{ } Neutral
{ } Agree
{ } Strongly agree

Appendix 2C: Attitude Towards Disabled Persons Scale (ATDP) For Non-Disabled Women and Men

(Adapted from Yuker, Block & Young 1970)

Please indicate whether you agree or disagree with the following statements.

#	***Statement***	***Your preferred response***					
1.	Disabled women have a more difficult time making new friends than others.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
2.	Disability is caused by immoral behaviour or sins	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
3.	Disabled women have difficulty participating in society	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
4.	Disabled women are unable to engage in normal social activities.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
5.	Disabled women burden the society.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
6.	Disabled women place a strain on their families.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
7.	Disabled women are more likely to be exploited (or subjected to mistreatment) than other individuals.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much

8.	Disabled women should not participate in sex-related discussions.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
9.	Sexual feelings are absent in disabled women.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
10.	Disabled women should refrain from having sex.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
11.	Disabled women expect to be treated differently.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
12.	Disabled women frequently require more sympathy than non-disabled women	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
13.	Disabled women should not be expected to perform many tasks.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
14.	Disabled women are not as productive as other women in society regarding work output.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
15.	Disabled women are unable to enjoy their sexual life as other women.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
16.	Because of their condition, pregnant, disabled women require special care.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
17.	Disabled women can have normal babies.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much

18.	Disabled women are more likely to transmit impairment to their children than other women	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
19.	Disabled women have a lower likelihood of receiving maternal healthcare services.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
20.	When compared to other women, disabled women face bias throughout pregnancy and childbirth.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
21.	Disabled women are not born with 'normal' sexual organs.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
22.	It is unethical for disabled women to become pregnant.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
23.	My close relatives having sexual encounters with Disabled women would be okay.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
24.	Disabled women can marry non-disabled individuals	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
25.	Disabled women can only have sexual relationships with other disabled persons.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
26.	I would be fine if a male relative married a disabled woman.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much

27.	Disabled women are unable to have normal labour and childbirth.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
28.	Pregnant, disabled women should not be allowed to mix freely with other expectant women.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
29.	Families with disabled persons should avoid socializing with other members of the community.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
30.	Disabled women are often more confrontational than non-disabled women.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much

Appendix 3A: Consent Form for Healthcare Workers

Habari! My name is Brezhnev Otieno, a PhD candidate at Tangaza University College. I am conducting academic research to explore societal attitudes and perceptions towards disability, sexuality, and pregnancy of disabled women in Kibra, Nairobi.

The filling of this questionnaire is expected to last between 30 minutes and an hour. The researcher will ask very personal questions, regarding your perspectives on disability, sexuality, and pregnancy of disabled women. Your identity will be kept confidential, and no direct link will be made between you and any information that is gathered during the survey. Please keep in mind that your participation in this survey is entirely voluntary, and you are free to decline to answer any questions that make you feel uncomfortable. Nevertheless, I hope you will participate fully. Your perspectives are critical to the success of this study. Kindly confirm if you have permitted us to continue with the survey. Tick the appropriate box below.

☐ *I agree to proceed with the survey but retain my right to decline to answer any questions that may cause me discomfort. The researcher begins the survey.*

☐ *I decline and will not participate in the survey nor disclose the reasons for my decision. The researcher ends the survey.*

Signature of Respondent: --

Research Assistant Signature: --

Date of Survey: --

Appendix 3B: Perception Survey for Healthcare Workers

This questionnaire will be used to gather perceptions of healthcare workers on the disability, sexuality, and pregnancy of disabled women in Kibra

Instructions:

- Indicate the most appropriate answers by a tick (√) or a cross (×) in the box or spaces provided.
- Kindly use a blue or black pen
- The names provided in the questionnaire will remain anonymous, and you will be assigned a unique number to maintain your privacy.

SECTION A: SOCIODEMOGRAPHIC INFORMATION

1. Respondent unique code: ____
2. What is your sex?

   Male ☐ Female ☐ Binary ☐ Preferred not to answer ☐
3. Indicate your age group:

   18-25 ☐ 26-35 ☐ 36-45 ☐ 46-55 ☐ 56+ ☐
4. What is your health facility type?

   Public ☐ Private ☐ FBO ☐ NGO ☐
5. Have you received any training or awareness forums on disability issues?

   Yes ☐ No ☐
6. How many years have you been in service?

   1-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 20+ ☐

7. What is your professional cadre?

Nurse ☐ Clinical Officer ☐ CHV ☐ Doctor ☐

8. What is your level of contact with a Disabled person?

Specialized Services ☐ Casual Contact ☐ General Services ☐ Other (specify) ☐

SECTION B: PERCEPTIONS ON DISABILITY AND WOMEN WITH DISABILITY

9. What is your opinion on the sexual feelings of disabled women? They…

Have sexual feelings ☐ Lack sexual feelings ☐

10. What is your opinion on the sexual organs of disabled women? They have…

Normal sexual organs ☐ Abnormal sexual organs ☐

11. What is your opinion on the sexual activity of disabled women? They are …

Sexually active ☐ Sexually inactive ☐

12. What is your opinion on the sexuality of disabled women? Choose one between the following contrasting pairs.

Have sexual feelings ☐	Lack sexual feelings ☐
Have normal sexual organs ☐	Have abnormal sexual organs ☐
Are sexually active ☐	Are sexually inactive ☐

13. Do you agree or disagree with the statement that disabled women can become pregnant?

{ } Strongly disagree
{ } Disagree
{ } Neutral
{ } Agree
{ } Strongly agree

14. Do you agree or disagree with the statement that the image of pregnant women with disability at the healthcare facility is abnormal?

{ } Strongly disagree
{ } Disagree
{ } Neutral
{ } Agree
{ } Strongly agree

Appendix 3C: Attitude Towards Disabled Persons Scale (ATDP) For Healthcare Workers

(Adapted from Yuker, Block & Young 1970)

Please indicate whether you agree or disagree with the following statements.

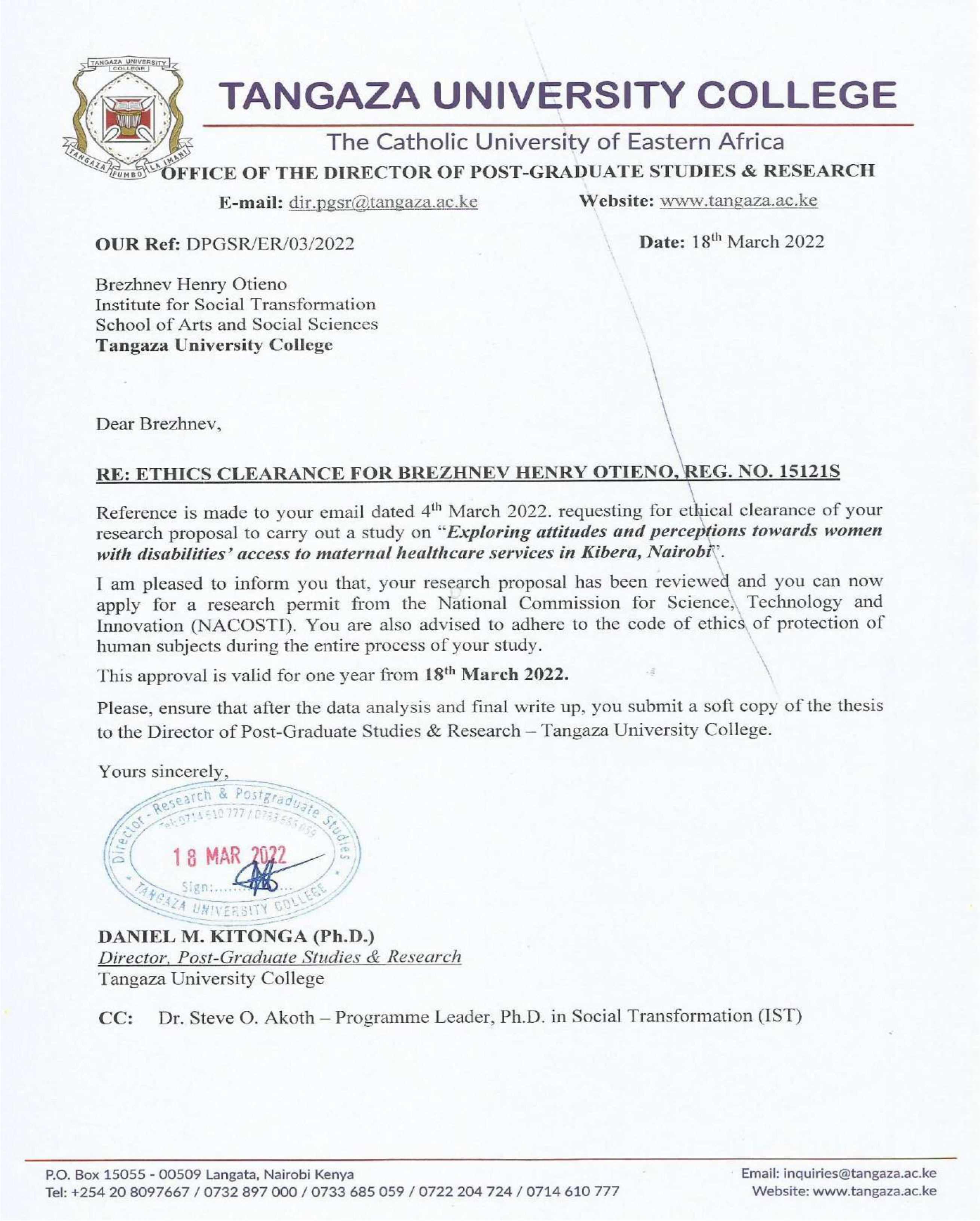
#	*Statement*	*Your preferred response*					
1.	Disabled women have a more difficult time making new friends than others.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
2.	Impairment is caused by immoral behaviour or sins	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
3.	Disabled women have difficulty participating in society	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
4.	Disabled women are unable to engage in normal social activities.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
5.	Disabled women burden society.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
6.	Disabled women place a strain on their families.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
7.	Disabled women are more vulnerable to exploitation (or mistreatment) than other persons.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
8.	Disabled women should not participate in sex-related discussions.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much

9.	Sexual feelings are absent in disabled women.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
10.	Disabled women should refrain from having sex.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
11.	The majority of disabled women expect to be treated differently.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
12.	Disabled women frequently require more sympathy than non-disabled women	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
13.	Disabled women are not productive in society in terms of work	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
14.	Disabled women are unable to enjoy their sexual life as other women.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
15.	Disabled women are unable to enjoy sexual life like other women.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
16.	Because of their condition, pregnant, disabled women require particular care.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
17.	Disabled women can have normal babies.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
18.	Disabled women are more likely to transmit impairment to their	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much

	children than other women.						
19.	Disabled women have a lower likelihood of receiving maternal healthcare services.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
20.	When compared to other women, disabled women face bias throughout pregnancy and childbirth.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
21.	Disabled women are not born with 'normal' sexual organs.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
22.	It is unethical for disabled women to become pregnant.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
23.	My close relatives having sexual encounters with disabled women would be okay.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
24.	Disabled women can marry non-disabled persons	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
25.	Disabled women can only have sexual relationships with non-disabled persons.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
26.	I would be fine if a male relative married a disabled woman.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
27.	Expectant disabled women are unable to have normal labour and childbirth.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much

28.	Pregnant, disabled women should not be allowed to mix freely with other expectant women.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
29.	Disabled women experience more complications during childbirth and labour than non-disabled women.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much
30.	Disabled women are often more confrontational than non–disabled women.	Disagree very much	Disagree pretty much	Disagree a little	Agree a little	Agree pretty much	Agree very much

Appendix 4: Ethical Clearance Letter



TANGAZA UNIVERSITY COLLEGE
The Catholic University of Eastern Africa
OFFICE OF THE DIRECTOR OF POST-GRADUATE STUDIES & RESEARCH
E-mail: dir.pgsr@tangaza.ac.ke **Website:** www.tangaza.ac.ke

OUR Ref: DPGSR/ER/03/2022 **Date:** 18th March 2022

Brezhnev Henry Otieno
Institute for Social Transformation
School of Arts and Social Sciences
Tangaza University College

Dear Brezhnev,

RE: ETHICS CLEARANCE FOR BREZHNEV HENRY OTIENO, REG. NO. 15121S

Reference is made to your email dated 4th March 2022. requesting for ethical clearance of your research proposal to carry out a study on "***Exploring attitudes and perceptions towards women with disabilities' access to maternal healthcare services in Kibera, Nairobi***".

I am pleased to inform you that, your research proposal has been reviewed and you can now apply for a research permit from the National Commission for Science, Technology and Innovation (NACOSTI). You are also advised to adhere to the code of ethics of protection of human subjects during the entire process of your study.

This approval is valid for one year from **18th March 2022.**

Please, ensure that after the data analysis and final write up, you submit a soft copy of the thesis to the Director of Post-Graduate Studies & Research – Tangaza University College.

Yours sincerely,

18 MAR 2022

DANIEL M. KITONGA (Ph.D.)
Director, Post-Graduate Studies & Research
Tangaza University College

CC: Dr. Steve O. Akoth – Programme Leader, Ph.D. in Social Transformation (IST)

P.O. Box 15055 - 00509 Langata, Nairobi Kenya
Tel: +254 20 8097667 / 0732 897 000 / 0733 685 059 / 0722 204 724 / 0714 610 777
Email: inquiries@tangaza.ac.ke
Website: www.tangaza.ac.ke

Appendix 5: NACOSTI Research Permit

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR
SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **558428**

Date of Issue: **25/March/2022**

RESEARCH LICENSE

This is to Certify that Mr.. Brezhnev Otieno of Tangaza University College, has been licensed to conduct research in Nairobi on the topic: Exploring Attitudes and Perceptions towards Women with Disabilities' Access to Maternal Healthcare Services in Kibra, Nairobi for the period ending : 25/March/2023.

License No: **NACOSTI/P/22/16497**

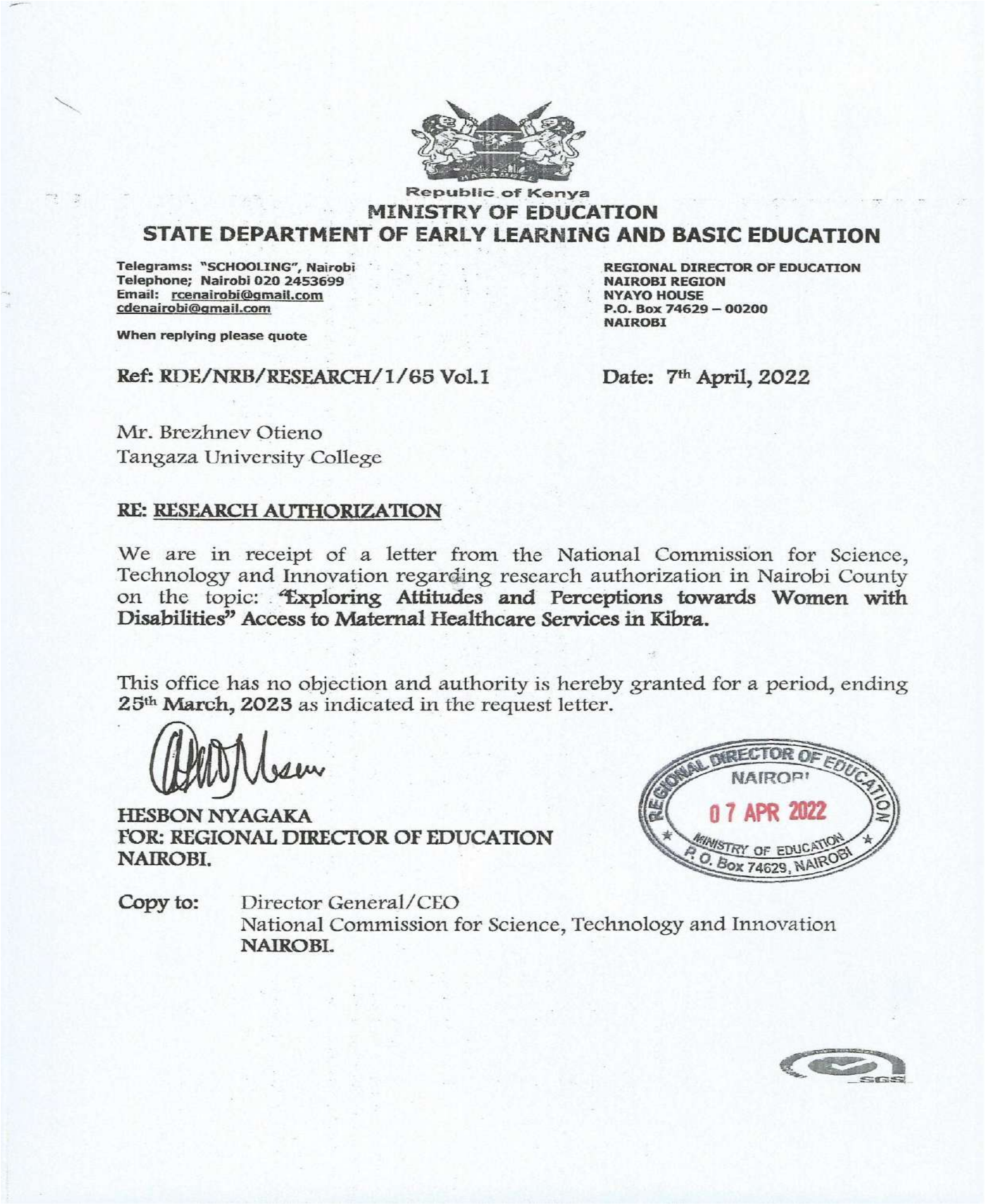
558428
Applicant Identification Number

Director General
NATIONAL COMMISSION FOR
SCIENCE,TECHNOLOGY &
INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document,
Scan the QR Code using QR scanner application.

Appendix 6: Ministry of Education Approval Letter



Republic of Kenya
MINISTRY OF EDUCATION
STATE DEPARTMENT OF EARLY LEARNING AND BASIC EDUCATION

Telegrams: "SCHOOLING", Nairobi
Telephone; Nairobi 020 2453699
Email: rcenairobi@gmail.com
cdenairobi@gmail.com

When replying please quote

REGIONAL DIRECTOR OF EDUCATION
NAIROBI REGION
NYAYO HOUSE
P.O. Box 74629 – 00200
NAIROBI

Ref: RDE/NRB/RESEARCH/1/65 Vol.1 **Date: 7th April, 2022**

Mr. Brezhnev Otieno
Tangaza University College

RE: RESEARCH AUTHORIZATION

We are in receipt of a letter from the National Commission for Science, Technology and Innovation regarding research authorization in Nairobi County on the topic: **"Exploring Attitudes and Perceptions towards Women with Disabilities" Access to Maternal Healthcare Services in Kibra.**

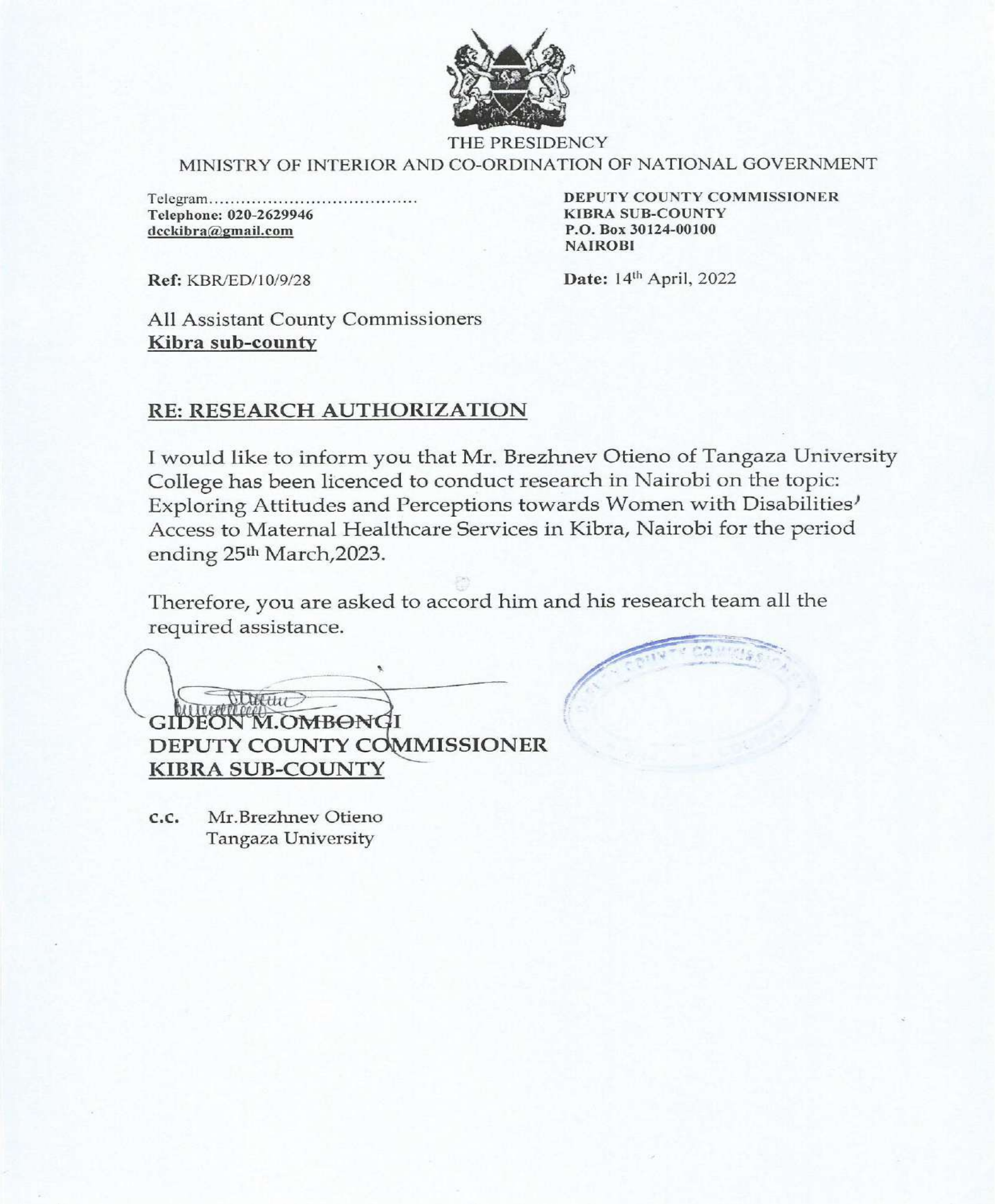
This office has no objection and authority is hereby granted for a period, ending **25th March, 2023** as indicated in the request letter.

HESBON NYAGAKA
FOR: REGIONAL DIRECTOR OF EDUCATION
NAIROBI.

REGIONAL DIRECTOR OF EDUCATION
NAIROBI
07 APR 2022
MINISTRY OF EDUCATION
P.O. Box 74629, NAIROBI

Copy to: Director General/CEO
National Commission for Science, Technology and Innovation
NAIROBI.

Appendix 7: Kibra Deputy County Commissioner Approval Letter



THE PRESIDENCY
MINISTRY OF INTERIOR AND CO-ORDINATION OF NATIONAL GOVERNMENT

Telegram.......................................
Telephone: 020-2629946
dcckibra@gmail.com

DEPUTY COUNTY COMMISSIONER
KIBRA SUB-COUNTY
P.O. Box 30124-00100
NAIROBI

Ref: KBR/ED/10/9/28

Date: 14th April, 2022

All Assistant County Commissioners
Kibra sub-county

RE: RESEARCH AUTHORIZATION

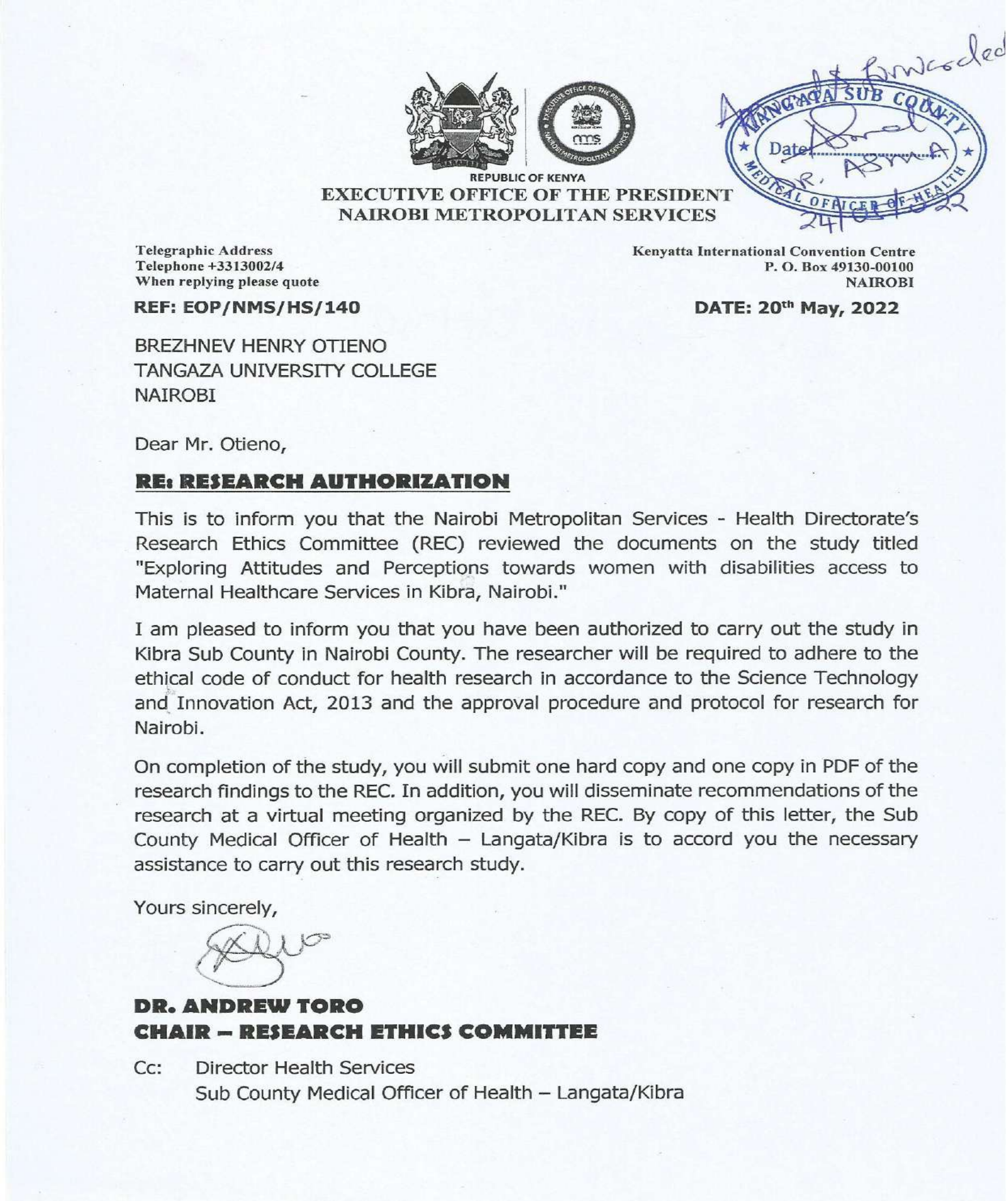
I would like to inform you that Mr. Brezhnev Otieno of Tangaza University College has been licenced to conduct research in Nairobi on the topic: Exploring Attitudes and Perceptions towards Women with Disabilities' Access to Maternal Healthcare Services in Kibra, Nairobi for the period ending 25th March,2023.

Therefore, you are asked to accord him and his research team all the required assistance.

GIDEON M.OMBONGI
DEPUTY COUNTY COMMISSIONER
KIBRA SUB-COUNTY

c.c. Mr.Brezhnev Otieno
Tangaza University

Appendix 8: Nairobi Metropolitan Services Approval Letter



Ack & forwarded

LANGATA SUB COUNTY
Date
DR. ASMA
MEDICAL OFFICER OF HEALTH
24/05/2022

REPUBLIC OF KENYA
EXECUTIVE OFFICE OF THE PRESIDENT
NAIROBI METROPOLITAN SERVICES

Telegraphic Address
Telephone +3313002/4
When replying please quote

Kenyatta International Convention Centre
P. O. Box 49130-00100
NAIROBI

REF: EOP/NMS/HS/140

DATE: 20th May, 2022

BREZHNEV HENRY OTIENO
TANGAZA UNIVERSITY COLLEGE
NAIROBI

Dear Mr. Otieno,

RE: RESEARCH AUTHORIZATION

This is to inform you that the Nairobi Metropolitan Services - Health Directorate's Research Ethics Committee (REC) reviewed the documents on the study titled "Exploring Attitudes and Perceptions towards women with disabilities access to Maternal Healthcare Services in Kibra, Nairobi."

I am pleased to inform you that you have been authorized to carry out the study in Kibra Sub County in Nairobi County. The researcher will be required to adhere to the ethical code of conduct for health research in accordance to the Science Technology and Innovation Act, 2013 and the approval procedure and protocol for research for Nairobi.

On completion of the study, you will submit one hard copy and one copy in PDF of the research findings to the REC. In addition, you will disseminate recommendations of the research at a virtual meeting organized by the REC. By copy of this letter, the Sub County Medical Officer of Health – Langata/Kibra is to accord you the necessary assistance to carry out this research study.

Yours sincerely,

DR. ANDREW TORO
CHAIR – RESEARCH ETHICS COMMITTEE

Cc: Director Health Services
Sub County Medical Officer of Health – Langata/Kibra

Appendix 9: Mbagathi District Hospital Approval Letter

REPUBLIC OF KENYA

NAIROBI
METROPOLITAN
SERVICES

Mbagathi Hospital, P.O Box 20725 – 00202
Email: mbagathihosp@gmail.com
Tel: 0721311808, 2724712, 2725791

Date: 21st July 2022

Brezhnev Henry Otieno
Institute for Social Transformation
School of Arts and Social Sciences
Tangaza University College

Dear Brezhnev

RE: RESEARCH AUTHORIZATION.

This is in reference to your application for authority to carry out a research, , on ***'Exploring Attitudes and Perceptions Towards Women With Disabilities' Access to Maternal Healthcare Services in Kibera, Nairobi."***

I am pleased to inform you that your request to undertake research in the hospital has been granted.

On completion of the research, you are expected to submit one hard copy and one soft copy of the research report/ thesis to this office.

21 JUL 2022

Dr. David Kimutai
For: Medical Superintendent
Mbagathi Hospital.

Kenyatta International Convention Centre P.O. Box 49130-00100, GPO, Nairobi, Kenya
Tel: +254 (0) 20 2217774/3
Email: transport@nms.go.ke | Web: www.nms.go.ke