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Social Cultural Factors Affecting Fertility Among Women Living with Disability in Bungoma County, Kenya

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This research aimed to explore the childbearing gap created by sociocultural challenges among disabled women in Bungoma County. Using a pronatalist approach, the study explores the extent to which the level of education, marital status and social status influence fertility attainment among WLWD. The research was directed by planned behaviour theory by Icek Ajzen (1991), which helped analyse the interaction of childbearing motivations, decision-making processes and fertility outcomes. Cross-sectional design was adopted and participants aged between 15 to 49 years old were selected using purposeful sampling. A pre-tested structured questionnaire, key informant guide and two focus groups were adopted to gather data. A sample size of 120 comprised women living with disability, health officials, administrators, and family members. The study area was mapped out with nine sites selected in Bungoma Central and Kimilili sub-counties in Bungoma County. A pilot study was done in the Kimilili subcounty to test reliability. Descriptive data underwent content analysis, themes coded using the framework analysis approach and transcribed, while quantitative data underwent logistic regression analysis using the SPSS package. Chi-square tests were used to link associations between sociocultural factors and fertility outcomes among WLWD in Bungoma County. Data results were represented using tables of frequencies, charts, graphs and percentages. These cultural barriers were identified as stigma, cultural beliefs and cultural attitudes. The study concludes that lack of education, low social status, overwhelming stigma and conservative mode of the patriarchal family system negatively depresses the fertility outcomes of disabled women in Bungoma County. The research recommended that disabled people ought to be helped to get an education and promote programmes against cultural biases towards fertility. Further, special hospital or home care units with well-trained personnel by the government were recommended to give specialised services to the WLWD.

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INTRODUCTION

According to a global health report by WHO and World Bank (2011), 15% of individuals globally are projected to have different types of disabilities. In Africa, an estimated 60 to 80 million people have a disability. Women with disabilities of childbearing age are estimated to be 10% (WHO, 2013). In Kenya, despite the use of Washington groups questions as the basis for disability measurement, the prevalence rate was still low. As reported (KNBS, 2019), the disability prevalence rate dropped from 2009 at 3.5% to a further low of 2.2% in 2019. Further studies in developing countries suggest a unique experience with more marginalised women than males living with disability (Osgood et al., 2005). Women living with disability experience double burden of social pressure, especially against their desires to have children. A study by Bloom & Mosher (2017) in the United States of America study on fertility needs and goals observed that women having disabilities were less certain of their fertility preferences and outcomes. Evidence pertaining to reproductive goals and fertility among women living with disabilities is sporadic despite having attained reproductive age.

In developing countries, many fertility studies have dwelt less on PWD, despite the increasing disability prevalence (Morton *et al.*, 2013). Furthermore, the high illiteracy and low social status have subjected Women Living with Disability (WLWD) to lost opportunities of access, availability, acceptance and dignity in society hence reducing their chances for exposure to pregnancies.

Marriage is highly associated with high fertility outcomes KNBS (2009). Kenyans are regarded as a marrying society; however, it is a challenge for WLWD who are perceived as asexual. The Kenya Constitution (2010) ushered in the new human rights-based approach to disability issues and further devolved the health system which also left Women with Disability largely fragmented and exposed to matters related to reproductive decisions. According to BCIDP (2013), many disabled women living in rural areas experience inherent adverse religion-cultural beliefs that negate their fertility outcomes in Bungoma County. The county has a higher number of persons living with a disability which limits their activities (28%) and participation (27%), respectively (KNSPD, 2008). Kenya census report (KNBS, 2019) states that the total fertility rate for Bungoma County is 4.8, which

could have been higher had fertility contribution from WLWD not been included.

This study takes note of the challenges facing the increasing number of disabled women desirous of having children in Bungoma County. Murthy et al. (2014), while comparing disabled women and those who are not in South India recognised that stigma, negative cultural attitudes and lack of knowledge about disabled women concerning fertility preference achievement remains hidden. It continuously damages their self-esteem and self-worth in pursuit of their fertility preferences hence widening the acceptance levels among potential heterosexual partners. The study conceptualises a model through which social and cultural factors influence policy design and practice in the Sexual and Reproductive Health sector for better fertility outcomes among WLWD.

LITERATURE REVIEW

A report by the World Health Organisation shows that approximately 15% of people globally have disabilities, and 2-4% have functional difficulties (WHO & World Bank, 2011). Further, this increase in disability rates occurs due to increased accidents, ageing, increased pandemic spread and improved approaches to measuring disabilities. Persons with disability are the world's utmost underprivileged and most deprived (WHO, 2013) and are projected at 10% among African nations and might be as high as 20% in the poorest African nations (WHO, 2011). In Africa, an estimated 60 to 80 million people have disabilities today (Tafadzwa & Maphosa, 2017). Disability is instigated by numerous factors for instance, birth defects, environmental factors, accidents, wars and conflicts (Jan & Jeanne, 2022). In the poorest parts of Africa, the percentage of disabled children in employment is as low as 1-3% (Maroto & Pettinicchio, 2014).

According to the KNBS (2019), disability rates stand at 2.2% which equals 918,270 people living with disabilities. Additionally, persons with disability face extensive hardships resulting in them

depending on their relatives for psychological, monetary and social (KNBS, 2019). However, the current state for persons with disability probably renders them to have minimal or no access to education, marriage and employment as other abled members of the same family and society.

WHO's report (2009) stated that persons with disability are noted as those experiencing mental, sensory and physical impairments which interfere with their daily functioning. According to Kraus *et al.* (2012), disability is recognised as a multidimensional status rooted in individual persons and the interaction of persons with their environments. Although about 10% of women of reproductive age report disabilities (Kraus *et al.*, 2017), very few studies have investigated the connection between disability and fertility attainment. According to Gül & Koruk (2019), most WWD having children are not affected by disability but by other factors.

According to Bloom & Mosher (2017), fertility attainment is defined as the number of children, desired family size, and desired birth intervals. Disabled women have not been common among women in maternity (Bremer et al., 2010). A study in the USA from 2006 to 2010 indicated that disabled and abled women have the same attitudes, needs, and goals when it comes to motherhood and bearing children (Shandra et al., 2014). Findings from a similar study in Ghana by Ganle et al. (2020) observed that disabled women had their first children while older and were probably lacking partners.

According to Querious et al. (2015), society connects ability with finances, fitness, sexuality and power. This value inclines to enhance and strengthen core key negative decisions about disabled individuals. The enhancement of persons with a disability's right to health services and fertility opportunities is not applauded globally (Johnstone, 2012). WHO's report (2011) confirmed that there is an increasing unfulfilled need in sexual and reproductive needs among women living with

disability, specifically desired fertility. A study by Bloom et al. (2017) in the USA on fertility desires and intentions observed that WWD have a high percentage of wanting a baby than the non-disabled. However, they were less likely to get within the desired time. Childbearing behaviour manifests in terms of the number of children, timing, and birth spacing (Rojas et al., 2014). According to Tarasoff (2013), women face a variety of social pressures to have children and to feel acceptable. (Steinmetz, 2006) stated that WWD had the same desire to be mothers just like other women, but what is questioned is their parenting capabilities. A study by Shandra et al. (2014) in the USA found that WWD who desired a baby were about (61%) against women without disabilities at (60%) indicating a higher fertility desire of 1%.

According to WHO (2018), the literacy rate for disabled adults is estimated to be 3%, while that for adult women with disabilities is as low as 1%. According to WHO (2011), it was noted that most respondents with a disability experienced a lower rate of school completion. Further, WHO (2009) noted that education for PWD is limited or non-existent and access to SRH information in school is also limited. United Nations (2011) also reported that many persons with disabilities around the world are illiterate and even those few who are literate are unaware of their proper roles in fertility discourses. Kroll et al. (2006) argued that education plays a critical role in the promotion of positive attitudes, especially among marginalised persons. In an extensive study about educational differences in fertility desires, Berrington and Pattaro (2014) posit that contrary to women without disabilities, educated WWD tends to have high fertility outcomes. Most fertility studies have suggested education is negatively correlated with fertility attainment (Ganle et al., 2020). Shandra and Chowdhury (2012) collaborating other studies suggested that the higher the education levels, the less the number of children ever born.

According to WHO and World Bank report (2011), 41.7% of disabled females completed primary education in contrast to 52.9% who are not disabled. Badu et al. (2016) stated that lack of education exposes WLWD to delays in delivery processes due to lack of understanding and discrimination. However, according to Etieyibo and Omiebie (2016), disabled women experience low attainment marks in life; hence this study explored the positive correlation between education levels and fertility attainment. Illiteracy is associated with poverty in adulthood hence trickles down into the reproductive life course of women (KDHS, 2014). Bungoma County has scanty data on education levels for PWD. However, it is estimated that the former Western province had less than 6% of PWD who had completed post-secondary education; this is among the highest in Kenya (KNSPD, 2007). In a highly patriarchal society like Kenya, WWDs experience obstacles more than those without disabilities because they are judged harshly more by their bodies (Ganle *et al.*, 2020).

This research was directed to the planned behaviour theory. This theory was used to predict fertility behaviour during any specific life course of WWD. The theory states that behaviour intentions are influenced by the attitude about the likelihood that the behaviour will have the expected outcome (Rojas *et al.*, 2014). The fertility behaviour outcomes depend on motivation (preferences), ability and behavioural control which are attitudinal in nature. According to Dommermuth & Klobas (2011), fertility intentions are classified into three groups of factors; attitudes towards, social approvals and perceived control of attaining positive fertility outcomes. The framework captures the social model substance among the disabled, which encompasses subjugation and social structure and system failure to fine-tune wants and desires for PWD (Etieyibo & Omiegebe, 2016), especially fertility attainment.

METHODOLOGY

Research Design

The researcher adopted a cross-sectional design where purposive and stratified sampling was applied. This design was used due to the short time intended for the study and the easiness of carrying out an all-time comparison across age sets.

Sampling Procedure

The sample was restricted to disabled women aged 15 to 49 years., who had children. About 36 Key informants and respondents were included, comprised of healthcare officials, local administrators, and family members. The sample was calculated based on the population of persons with disability in Kenya (KNBS 2019). The study took place in 9 sites across the two sub-counties that were selected using the poverty levels and administrative locations (BCDIP, 2013). Data was collected from a sample of 100 respondents. This was derived using Israel's (1992) formulae, which filled the structured qualitative questionnaires, audio recordings and in-depth interview guides from phone calls, face-to-face interviews, and two focused group discussions.

The study was modelled based on Tafadzwa & Maphosa's (2017) study in Zimbabwe, where participants were derived based on International Functioning Classification ranges in WHO (2001) and KNSPD (2008), percentages of persons with disability. The study had 46 participants for structured questionnaires, 36 participants for key informant interviews, and 18 participants for two focus group discussions split into nine members for each. The groups were selected from two sub-counties (1 rural sub-county and 1 peri-urban sub-county). Data was gathered within two months, from January 2020 to March 2020. Filling of questionnaires, one on one interviews, and two focused group discussions were conducted based on WLWD weekly meetings and household schedules. Using KNSPD (2008) data set, survey sample

participants were spread proportionally as follows; orthopaedic handicapped (34%), visual impairment (30%), hearing impairment (12%), and speech impairment (4%).

Using poverty index levels and social indicators (BCIDP, 2013), Bungoma Central and Kimilili sub-counties were selected, respectively. Proportional ratios on physical impairments were calculated based on disability derived from the International Classification Functioning (WHO, 2001) as reported in the status of disabilities report in KNBS (2019). Stratified sampling was used to choose representative households grounded on disability, level of education, and marital status. A pilot study was conducted in the Kimilili ward within Kimilili subcounty in the month of November 2019. Respondent-driven samples were undertaken to fill out the questionnaires. Follow up were made through home visits and phone calls as recommended by Agadjanian & Zotoya (2012). Mentally challenged and childless women were excluded. Proxies were appraised and allowed to help blind and deaf participants. Sampling clusters were spread.

Target Population and Sample Size

The target population was WLWD of childbearing age 15- 49 years who resided in Bungoma County six months before the study and were registered in different support organisations. Based on WHO (2011) estimates of 10% global disability prevalence using KDHS (2014). Bungoma County has an estimated population of about 1,375,000, and about 52% are females whose half were their childbearing age, making the target population about 35750. The target population was calculated as follows Disability prevalence (10% of 1,375,000) (female 52%) \times 50% = 35,750.

The targeted population for this research were 120 disabled women aged 15-49 years having physical disabilities for instance, hearing, speech, orthopaedic, and hearing impediments. All were registered with the National Council of People with

Disabilities. While the 36 key informants were systematically selected from hospitals, administrative stations, and families. The selection criteria for the study were women living with disability who have at one point been pregnant and experienced physical disability. The research targeted the population who responded to the survey, had been prepared early and had appointments made. All the participants were to benefit from the services of disability associations.

To improve the accuracy, and quality of data, minimise costs and save time, a study sample was done as opposed to the entire population. The participants were selected representing the types of disabilities as reported in KNSPD (2008). In order to come up with a suitable sample size, adopted a combination of the model by Tafadza & Maphosa (2017), where 10 % of the global estimates of disability were used as a baseline of Bungoma county estimates of WWD of childbearing age and formula by Israel (1992) giving a sample size of 99.41 which was approximated to 100 respondents.

Methods of Data Collection and Analysis

A semi-structured questionnaire and interview guide were derived from a standard child motivation using a Likert scale. Illiterate women with disabilities were allowed to speak in their mother tongue and a language interpreter was trained prior to assist. Caregivers were used to translating or interpret responses for the hard blind and deaf participants.

A series of multivariate logistic regression analyses was carried out on fertility variables in relation to education, marital status, and social-cultural factors. Themes were derived from coded questionnaires, analysed interview schedules, and transcript notes. Chi-square tests were done to test levels of cultural attitudes and the extent of desire for children based on education, marriage and cultural perceptions to ascertain significant levels of association in fertility attainment. Level of significance at 90%, with a p-value less than 0.1 was used to test the hypothesis.

A descriptive data collection form representing a semi-structured questionnaire was prepared after reviewing the literature. It included socio-demographic characteristics (age, place of birth, educational status, marital status), characteristics of disability (type, number, source, duration, and level of disability), fertility characteristics (age at first child, number of pregnancies, partner decisions, planning of pregnancy, pregnancy follow up, use of contraceptive methods) of women with a disability and consists of 40 questions in total.

A brief questionnaire for key informants including family members, health care providers, and local administrators, were administered. An Interview guide for two focused group discussions (rural and urban) were designed for use during the study. A phone recorder and notebook were also used during interviews. According to Agadjanian and Natalya (2012), a phone interview was scheduled in case of hard-to-reach respondents.

Respondents residing within the research areas for the past six months before data collection were recognised as key informants and thus were included in the study as established by trained research assistants through reference manual recorded and certificates given to persons with disability in Kenya via collaboration. Home visit interviews were done in two months (January 20 to March 20 2021) between 9 am and 4 pm on weekdays. A second appointment was made with WLWD for those who were not available during the home visits. Kimilili Sub County, WLWD registered with particular institutions were called and invited to the institutions where data were gathered via one-on-one interviews.

Content analysis was done on descriptive data where themes were coded using a framework analysis approach and transcribed. This method is applicable to this research since it has specified questions, a limited timeline, and a sample that is predesigned. (Srivastava & Thompson, 2009). Interviews were transliterated and interpreted into English, analysed in themes with some

representative quotes from interviews presented to illustrate responses. Quantitative data was analysed through SPSS version 22 software, involving multivariate variables derived from the Likert scale coded from the questionnaire. Chi-square tests were done to test hypothesised variables associated with the desire for a child and/or more, birth spacing, and sex preference in women with disability in relation to their social and cultural environment. Research objectives were independently analysed as indicated below.

RESULTS AND DISCUSSIONS

The response rates were 83% which was attributed to good rapport with the respondents. According to Baruch and Haltom (2008), the minimal mean threshold of response rate for surveys of behavioural science research is 52.7%; therefore, the response rate for this study (83%) was considered to be satisfactory.

Sociocultural Factors Influencing Fertility Attainment

In this study, stigma, community perceptions, attitudes, cultural beliefs, and community support

were discussed thematically using the following subheadings.

Community Attitudes on WLWD Getting Married

This study also determined the community’s perception of WLWD getting married. The results show community approval of the WWD being married. With respect to community perception of WLWD getting married, 64.0% of the respondents were against marriage, while 20.0% were mostly supporting WLWD getting married. It was established that 16.0% were not sure whether WLWD should get married or not. Most respondents, who disapproved, cited the inability for them to work, the burden and the stigma. However, a few respondents who approved of the question of getting married attributed this to the religion that all individuals are the same before the eyes of God and, therefore should get married and have children according to the Bible (Genesis 1:22), the way other people do.

How Women Living with Disability Get Married

To gain insight into the study objectives, respondents were asked how they got married (*Table 1*).

Table 1: How WLWD get married

How WLWD are married	Frequency	Percent	Cumulative %
Others	8	8.0	8.0
Forced	32	32.0	40.0
Arranged	42	42.0	82.0
Self-choice	18	18.0	100.0
Total	100	100.0	

On the question of how they got married, the outcome showed that 42% of participants agreed that marriage was arranged, 32% were forced, 18% made self-choices, and 8% were for other reasons, as shown in *Table 1* above. Through interviews, it was revealed that respondents who had some form of education made self-choices since it gave them an advantage over the rest as they could make independent decisions (WHO, 2018). Those

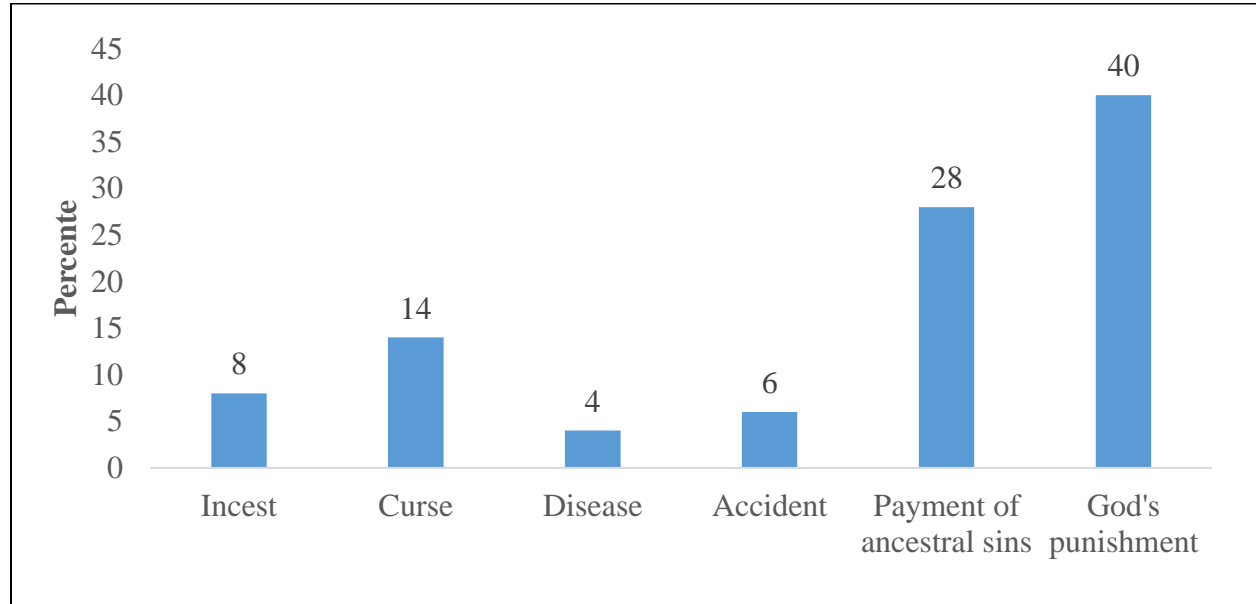
respondents who were forced to get married attributed this to their families seeing them as a burden; hence it is a way of offloading them to others. Marriage is an important proximate determinant in the fertility of WLWD.

Community Attitudes on Causes of Disability

Distinct causes of disability among WLWD were identified in the study area: incest, curses, diseases,

accidents, payment of ancestral sins, and God’s punishment. The distributions for the perceptions about causes are shown in *Figure 1* below.

Figure 1: Community perception of the cause of disability



The results indicated that the largest proportion of the respondents was 40% and supposed that disability was an outcome of God’s punishment. With respect to other causes of disability by the community perception, 28% of the respondents perceived it as being payment of ancestral sins, 14% were a curse, 8% was incest, 4% is disease, and 6% was caused by accident. Most of the WLWD interviewed respondents were Christians and this perhaps explains why a large number attributed the cause of disability to God’s punishment. During the FGD, religion featured with 34% identified as Catholics, 61% identified as other Christians and 5% identified as others. About 52% of participants agreed that cultural attitudes influence childbearing

motivations, while 32% were not sure, with 16% who disagreed that culture matters in the lives of WWD. With so much community attachment to faith, stigma has been solidified against persons with disability as WWD have no chance to prove their innocence of the causes of disability (Grut & Ingstad, 2005).

From the interviews, it was further revealed in *Table 2* that 68% of WLWD agreed that local cultural practices deny WLWD from getting intimate and children, 18% were not fully aware, while 14% disagreed that cultural practices deny WLWD children.

Table 2: Do Cultural practices deny WLWD children

	Frequency	Percent	Cumulative Percent
Yes	68	68.0	68.0
Not sure	18	18.0	86.0
No	14	14.0	100.0
Total	100	100.0	

Cultural Barriers to Fertility Attainment

This study presumed that fertility attainment among WLWD was affected by culture. To gain insight

into this study, an investigation was done on the cultural barriers that limit WLWD from getting a child or the number of children desired.

Table 3: Cultural barriers hindering WLWD

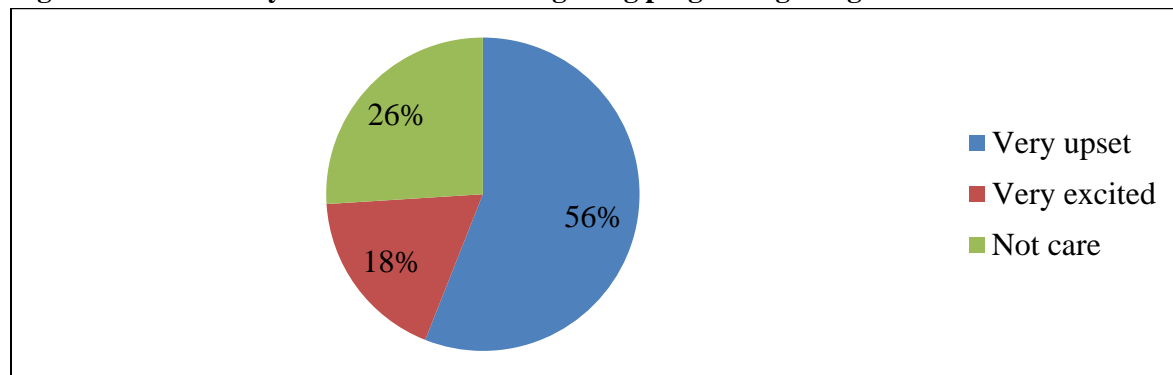
	Frequency	Percent	Cumulative %
Prejudice	4	4.0	4.0
Low expectation	6	6.0	10.0
Fear	8	8.0	18.0
Shame	6	6.0	24.0
Discrimination	24	24.0	48.0
Stigma	31	31.0	79.0
Violence	6	6.0	85.0
Exclusion	12	12.0	97.0
Others	3	3.0	100.0
Total	100	100.0	

According to *Table 3* above in this study, most participants identified cultural barriers hindering WLWD to be 31% stigma, 24% discrimination, 12% exclusion, 8% fear, 6% low expectation, shame, and violence. It was clear prejudice was the lowest with 4%, as shown in *Table 3*. Through FGD interviews, it was revealed that most of the respondents cited beliefs and stigmatisation as the major barrier against fertility preferences. Respondents revealed that this affected them and the above results appeared the same in research by Karen *et al.* (2022).

Community Attitudes on WLWD Getting Pregnant/ Getting A Child

This part of the study presents community attitudes on WLWD getting pregnant. Therefore, this research examined these attitudes among participants. This is demonstrated in *Figure 2* below. It was revealed in the survey that about 56% of the community was very upset with WLWD getting pregnant, 26% did not care, and 18% of the community was very excited. It was clear from the figure that the most likely community is not happy with WLWD getting pregnant. This is because they feared this could extend this type of disability trait to the next generation (Ahumuza *et al.*, 2014).

Figure 2: Community attitudes on WLWD getting pregnant/ getting a child

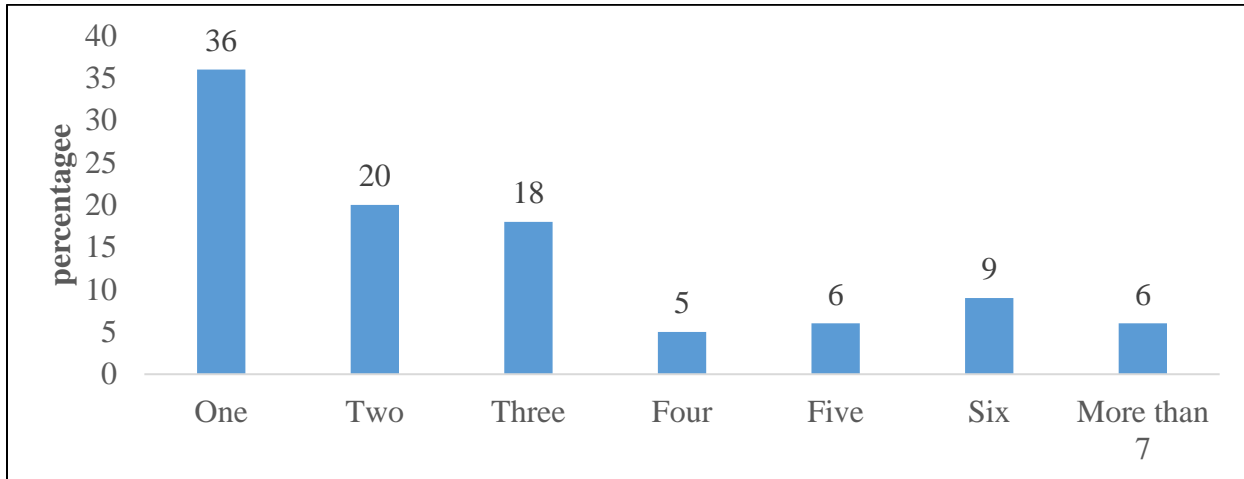


Number of Children

Figure 3 shows the number of children that WLWD have in the study area. From this survey, it was noted that 36.0% of the WLWD had one child, and 20% had three children, as shown in Figure 3. Only 5.0% had four children, indicating that most likely WLWD had one to four and a few had more than 4 children in a family. For having more than two children, gender preference, age, and husband accessibility plays an important role (May & Murray, 2003). Through interviews, it was also revealed that WWD, who had a few children

attributed it to the effect of lack of partners and societal disapproval. These findings were found to be in line with those of the WHO report (2014), which suggested that lack of exposure and accessibility to risks of pregnancy reduced their WLWD preference to have more children. From FGD interviews with respondents, it was also revealed that the desire for more children decreased with an increase in the age of WLWD. This was attributed to the fact that as age advances, most WLWD appear to be more contented or abandon this desire (Quieros et al., 2015).

Figure 3: How many children do you have

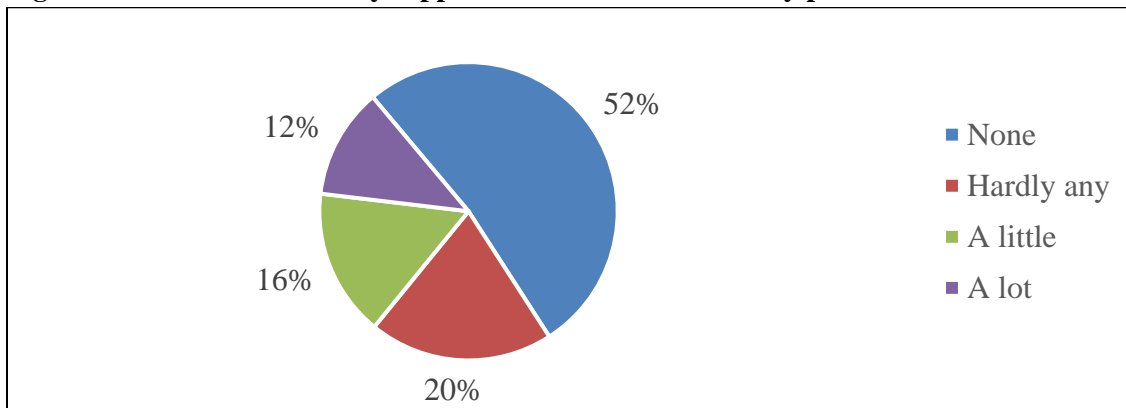


Community Support for Women Living with Disability

In a bid to understand the community support for WLWD in Bungoma County, it was imperative that

the perception of the community on fertility attainment among WWD was studied. This was determined, as shown in Figure 4.

Figure 4: Does the community support WLWD achieve fertility preference



It was revealed in this study that 52% of the respondents did not receive support towards achieving fertility outcomes, 20% hardly got support, and 16% got support. From the interviews, it was clear that the community did not offer support to WLWD with fertility preferences. They felt that most of these women were not financially stable (Women Groups in Kenya, 2017). One key informant narrated that,

“The community perceives WWD as ‘mzigo’ meaning burdensome, one can use all means to take care of bad omen, carry spirits.

Community Influence in Accessing a Partner

Participants were also asked to establish whether community influenced access to the husband. This was core since access to a husband pre-determines the attainment of fertility outcomes of a woman, as shown below.

Table 4: Community influence access to husband/partner

Access to husband	Frequency	Percent	Cumulative %
Agree	58	58.0	58.0
Disagree	16	16.0	74.0
Do not know	26	26.0	100.0
Total	100	100.0	

From the above results, it was revealed that participants 58.0% agreed that the community influenced WLWD from accessing partners, while 26.0% were not aware, as shown in *Table 4* above. It was also evident that 16.0 % disagreed that it was easy for them to access a husband without being influenced by the community.

Number of Children Preferred by WLWD

The number of children preferred by WLWD also influenced their fertility achievement. It was

observed in this study that 36% of WLWD preferred about four children, 23.0% preferred five children, and 2.0% preferred one child. It is shown in *Table 5* above that WLWD mostly preferred to have many children. In a study by Miller (1995), it's reported that the society regarded WWD seeking to get children as selfish and wanting to bequeath children with disability blood hence cementing the attitude that they should have no child.

Table 5: Preferred number of children

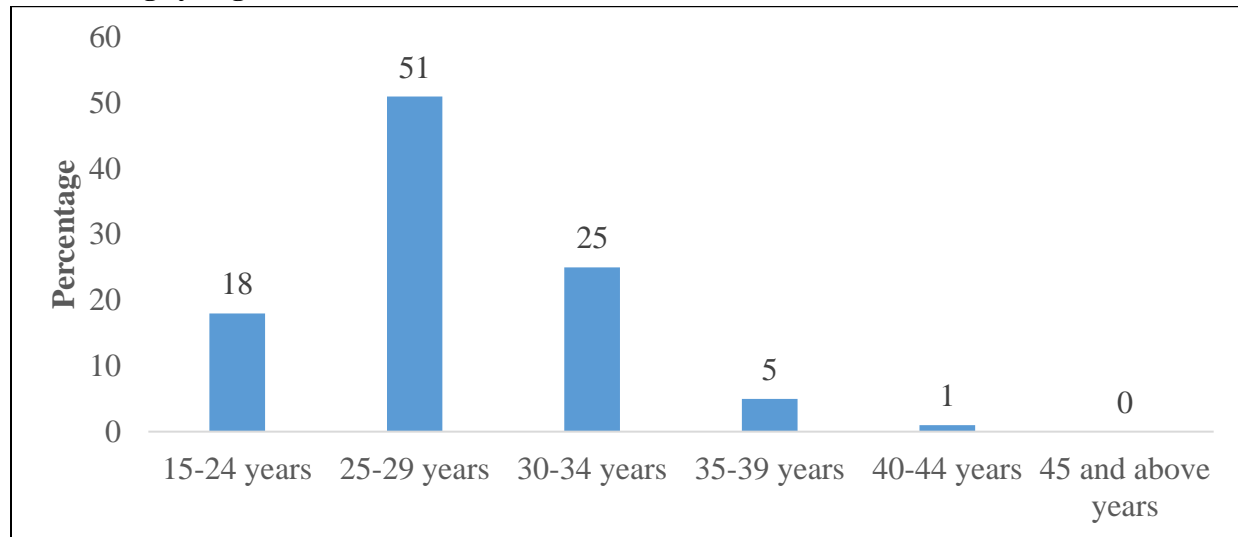
Number of children	Frequency	Percent	Cumulative %
One	2	2.0	2.0
Two	6	6.0	8.0
Three	18	18.0	26.0
Four	36	36.0	62.0
Five	23	23.0	85.0
Six	9	9.0	94.0
Seven or more	6	6.0	100.0
Total	100	100.0	

Preferred Age of Getting the First Child

Respondents were asked to state the age they got their first child, as shown in *Figure 5*. It was revealed that 51% of WLWD got their first child towards the end of age 25-29years, 25% got their first child at age 30-34years, 18% got at age 15-24years, 5% got at age 35-39years, 1% got their first child at age 40-44years while no WLWD got a child

at 45years and above. From the interviews, it was evident that many WLWD preferred to immediately get their children after completing school. The modal age for getting the first child in this study was as high as 25-29 years. This is usually the age range at which most of the WLWD complete school (OECD, 2010) and could access partners or desire to be married (Wells *et al.*, 2003).

Table 6: Age you got the first child



Number of Years for Birth Spacing

The study also identified the preferred and achieved birth spacing intervals as indicated in *Table 6* below.

Table 7: Birth spacing achieved

	Frequency	Percent	Cumulative %
5 years	24	24.0	24.0
4 years	30	30.0	54.0
3 years	20	20.0	74.0
2 years	17	17.0	91.0
Less than 2 years	9	9.0	100.0
Total	100	100.0	

The waiting time ideal for women was forecast by the number of children women with a disability had (Tumin, 2016). Based on the number of living children, married women preferred to have a longer birth interlude. The research found that 24% of

participants achieved spacing between 5 years, 30% preferred spacing between 4 years, 20% achieved spacing between 3 years, 17% achieved spacing between 2 years, and only 9% achieved birth spacing of less than 2 years. Those who preferred

spacing of less than 3 years were a majority of those who had no child or had few children. This makes sense since WLWD lacking children are more willing to conceive one when contrasted to a woman having numerous (Ganle *et al.*, 2020). From focus group discussions, it was revealed that the number of living children influenced preferred birth spacing. Those with few children preferred short birth spacing, while those with more children preferred prolonged spacing (Shandra, 2011).

Influence of Educational Level on Fertility Preferences

The key objective of this research was to explore the impact of social-cultural factors on fertility attainment among WLWD of childbearing age in Bungoma County. Specifically, the research examined the connection between levels of education among WLWD and their fertility attainment. To test the specific research objectives, Chi-Square was used at a 0.05% importance level.

Table 8: Influence of Educational Level on Fertility Preferences

		Educational level					Total
		None	Pre-primary	Primary	Secondary	Post-secondary	
Does the community support WLWD achieve fertility preference	Count	14	36	2	0	0	52
	None	26.9%	69.2%	3.8%	0.0%	0.0%	100.0%
	Educational level	100.0%	100.0%	7.7%	0.0%	0.0%	52.0%
	Count	0	0	20	0	0	20
	Hardly any	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%
	Educational level	0.0%	0.0%	76.9%	0.0%	0.0%	20.0%
	Count	0	0	4	12	0	16
	A little	0.0%	0.0%	25.0%	75.0%	0.0%	100.0%
	Educational level	0.0%	0.0%	15.4%	80.0%	0.0%	16.0%
	Count	0	0	0	3	9	12
	A lot	0.0%	0.0%	0.0%	25.0%	75.0%	100.0%
	Educational level	0.0%	0.0%	0.0%	20.0%	100.0%	12.0%
Total	Count	14	36	26	15	9	100
Total		14.0%	36.0%	26.0%	15.0%	9.0%	100.0%
Educational level		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The table above is a response to a question if the community valued level of education as a condition to support fertility achievement among WLWD. From the results, 26.9 per cent and 69.2 per cent of WLWD with no education agreed that education was key to supporting their fertility preferences, but there was none. About 100 per cent of WLWD who had primary education agreed with the influence of

education and rated no community support, while 25 per cent attested little support. Among the WLWD with secondary and post-secondary education, about 100 per cent and 75 per cent, respectively, regarded education highly in influencing desired fertility. Community support increased accessibility among the WWD across all fertility care services.

Table 9: Chi-Square tests for educational level and fertility attainment

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	217.219 ^a	12	.000
Likelihood Ratio	191.174	12	.000
Linear-by-Linear Association	84.610	1	.000
N of Valid Cases	100		

From the chi-square table above, it's clear that we do reject the null hypothesis ($\chi^2_{(12)} = 217.219$, $p = 0.000 < 0.05$). Therefore, we conclude that there is a relationship between levels of education among WLWD and their fertility preferences in Bungoma County.

CONCLUSION

The findings from the study concluded that there was an increasing prevalence of disability in poverty-stricken areas like Bungoma County. Furthermore, it was observed that low education levels, poor healthcare accessibility and the invisible hand of cultural bias had critically affected the social status of WWD. Popular perceptions held that WWDs were asexual and lacked desire for children; however, this study laid bare the facts that WWDs still held onto their childbearing preferences.

This study also identified the gaps in the provision of quality education for PWDs, inadequate SRH system and lack of public sensitisation to eradicate cultural biases against PWDs. Lastly, the study advocated for the government and other stakeholders to do further research, develop, and facilitate the redesigning of a new Pronatalist Social cultural-based SRH policy for PWDs. This policy shall help lay the practice framework in line with Article 25 of the United Nations (2008), CRPD, where PWD are regarded to have equal rights for family and marriage.

Recommendations

This study recommended the following measures to be taken by governments, NGOs and other stakeholders: Establish special and integrated

fertility centres for WLWD to offer quality family planning services and maternal care, design targeted public or community awareness and sensitisation programs to be run in the community through mass media to help change negative attitudes against WLWD and government needs to push through legislation targeting cultural and religious practices which are discriminatory against persons with disabilities.

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