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**Midwives' Awareness, Attitudes, and Perceived Barriers Toward
Reproductive Health of Women with Disabilities
in the Northern Region of the West Bank**

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**Midwives' Awareness, Attitudes, and Perceived Barriers Toward
Reproductive Health of Women with Disabilities
in the Northern Region of the West Bank**

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Midwives' Awareness, Attitudes, and Perceived Barriers Toward
Reproductive Health of Women with Disabilities
in the Northern Region of the West Bank

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Dedication

I would like to extend my deepest appreciation to Dr. Maha Nahal for her exceptional guidance and invaluable feedback throughout my thesis work. Her expert advice was instrumental in shaping my research and bringing it to completion.

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With immense gratitude to you all.

Declaration

I certify that this thesis which is submitted for the degree of master is the result of my own research, except where otherwise acknowledged, and that this study (or any part of the same) has not been submitted for a higher degree to any other university or institution.

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Abstract

Introduction: Women with disabilities are among the most underserved groups when it comes to accessing sexual and reproductive health services, facing numerous barriers—physical, financial, attitudinal, and communication-related. Midwives play a crucial role in addressing and understanding the specific needs of these women. Therefore, midwives need to have adequate knowledge and cultivate a proper, supportive attitude to ensure inclusive and effective care.

Aim: Assessing the midwife’s knowledge, attitudes, and perceived barriers toward reproductive health care services for women with disabilities in the northern region of the West Bank/Palestine.

Methodology: The study implemented a cross-sectional, quantitative design on a convenient sample of 158 midwives who were currently working at the targeted governmental and private hospitals in the Northern West Bank—Palestine. They were asked to fill in a self-administered questionnaire that was analyzed using SPSS software, with full commitment to anonymity and confidentiality as essential ethical considerations.

Results: Midwives had a median age of 29 years old and experience of 6 years, and mostly had bachelor’s degrees (n = 91 , 57.6%), were married (n = 99 , 62.7%), working in the private sector (n = 126 , 79.7%), and did not receive a specific training for reproductive health care for women with disabilities (n = 141 , 89.2%). Around half of the midwives had a high level of knowledge (n = 78 , 49.4%), while (n = 103 , 65.2%) had a moderate attitude, and (n = 76 , 48.1%) perceived a high level of barriers, with physical barriers being the most common category. Higher educational level was significantly associated with higher knowledge and perceived barriers, with higher attitudes among younger and single midwives, and a better attitude and higher perceived barriers among midwives who received related training (p-value < 0.05). Higher perceived barriers were significantly correlated with higher knowledge and lower

attitudes (p-value = 0.001).

Conclusion: The study reviewed an important topic in the field of sexual and reproductive health care for a highly vulnerable category of patients, and showed that midwives in Palestine tend to have a high level of knowledge and an acceptable level of attitude and perceived barriers. Level of knowledge and training play a significant role in having a better attitude and perceiving more barriers. It is recommended to train more midwives and implement qualitative research in this field for both women with disabilities and midwives in Palestine.

Keywords: Awareness, knowledge, Attitudes, Perceived barriers, Women with disabilities, sexual health, reproductive health, maternal health.

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List of Abbreviations

Abbreviation	Full term
WHO	World Health Organization
PCBS	Palestinian Central Bureau of Statistics
PMOH	Palestinian Ministry of Health
MS	MicroSoft (Corporation)
SPSS	Statistical Package for Social Sciences
IQR	Interquartile Range
F	Frequency
SA	Strongly agree
A	Agree
N	Neutral
D	Disagree
SD	Strongly disagree
HCPs	Healthcare providers
YO	Years old
P	p-value
R	Correlation coefficient

Chapter One:

Introduction

1.1 Background

Disability is defined as having a persistent limitation in the physical, sensory, mental, or intellectual capabilities that hinder the affected individuals from full or equal participation in society (Márton et al., 2013). Physical disabilities might occur as a result of chronic health conditions like multiple sclerosis, epilepsy, cerebral palsy, and others. On the other hand, sensory disabilities including hearing loss and loss of vision as well as mental or intellectual disabilities might be related to a cluster of conditions that are characterized by low intelligence and limitations in adaptive behaviors (Rydzewska et al., 2019; Salvador-Carulla et al., 2011).

The number of people with disabilities is growing worldwide due to many factors as armed conflicts, wars, natural disasters, aging, substance use, changes in diet, and chronic diseases (Emerson, 2021; Lewis et al., 2022). It was reported by the World Health Organization (WHO) that people with disabilities constitute about 15% of the general population and that 80% of them are living in low- and middle-income nations (Krahn, 2021). Also, studies have shown that 10.1% of the children globally have moderate-to-severe disabilities, with higher prevalence rates in the Sub-Saharan Africa and South Asia (Olusanya et al., 2022), with an increase of 9.5% in the prevalence of developmental disabilities in children aged 3 – 17 years old in the United States between 2009 and 2017 (Zablotsky et al., 2019). Women in the reproductive age have a 15% prevalence rate of disabilities, which was reported by them to limit their preconception care (Deierlein et al., 2022), in addition to 41% of the women with disabilities showing concerns of reproductive healthcare services disparities (Farr et al., 2023). According to the Palestinian Central Bureau of Statistics (PCBS), 92,710 Palestinians (including 41,017 women) had disabilities in 2017 (PCBS, 2017). This represented (2.1%) of all Palestinians living in the West Bank and Gaza Strip, and the majority of them (47,109) were affected by mobility impairments.

People with disabilities are often marginalized and socially excluded, they also face considerable challenges to access healthcare services (Kazembe et al., 2022). Women with disabilities are even more marginalized, and they face serious psychosocial challenges (Hridaya Raj Devkota et al., 2017; Kazembe et al., 2022). They are struggling with unmet healthcare needs in all stages of their lives, particularly during the reproductive stage (Devkota et al., 2018; Kazembe et al., 2022). They face difficulties in reaching reproductive healthcare services and get insufficient information about their reproductive health (Aresu & Mac-Seing, 2019; Chrastina & Večeřová, 2020; Peta & Ned, 2019). Women with disabilities often endure the consequences of hazardous sexual practices, unwanted pregnancies, and suffering sexual dysfunctions (Chappell, 2019; Peta & Ned, 2019; Streur et al., 2019). Moreover, they were shown to suffer poor health outcomes and higher maternal morbidity and mortality due to limited access to reproductive and obstetric services compared to women without disabilities (Ganle et al., 2020).

The lack of healthcare services that women with disabilities could access has been highlighted in previous qualitative studies (Devkota et al., 2018; Ganle et al., 2020; Kazembe et al., 2022). Studies have reported that women with disabilities often experience limited access to healthcare facilities, and get inadequate information about sexuality, maternal, and reproductive health (Blair et al., 2022; H. R. Devkota, A. Clarke, et al., 2017; Devkota et al., 2019; Devkota et al., 2018; Satchidanand et al., 2012).

To date, limited attention has been given by the Palestinian Ministry of Health (PMOH) to women with disabilities in the reproductive stage. Studies about the awareness of Palestinian health care providers, particularly the midwives' awareness and attitudes toward the essential needs of Palestinian women with disabilities in the reproductive stage are still lacking. Moreover, the barriers to reaching the reproductive health care services that are faced by women with disabilities in Palestine are still not well understood. Therefore, this study aims to explore the midwives' awareness, attitudes, and perspectives toward the barriers that hinder women with disabilities from reaching reproductive healthcare services. Barriers might include physical, communication, environmental, and cultural barriers. Further barriers might be related to the lack of information among midwives related to the reproductive health care needs of Palestinian women with disabilities. Probably, understanding the barriers as well as exploring the knowledge and attitudes of the Palestinian midwives toward women with disabilities in the reproductive stage might be considered as the first step in improving the provision of healthcare services to this vulnerable group of women.

1.2 Problem statement

Previous global studies have shown that women with disabilities were less likely to receive maternal and reproductive healthcare services compared to their counterparts without disabilities (M. Tara Casebolt, 2020; Fletcher et al., 2023; Gudlavalleti et al., 2014; Haque et al., 2023; Murthy et al., 2014). They often have less access to information of sexuality and reproductive health, screening services, preventive services, and other maternal and reproductive healthcare services (M. Tara Casebolt, 2020; Devkota et al., 2018; Elkhateeb & Peter, 2019). Women with disabilities in Palestine might face multiple barriers to accessing safe, acceptable, and respectful

reproductive healthcare services. Therefore, ensuring their access to acceptable maternal and reproductive care is becoming a crucial public health issue.

Moreover, women with disabilities might lack awareness about their special needs and they often encounter discriminatory practices, insensitivities, and negative attitudes from society and healthcare providers (Blair et al., 2022; M. Tara Casebolt, 2020; H. R. Devkota, A. Clarke, et al., 2017; Devkota et al., 2019; Elkhateeb & Peter, 2019; Schildberger et al., 2017). They often receive inadequate pre- and post-natal care, mostly delivered by cesarean sections, and have underweight babies (Schildberger et al., 2017).

Midwives are central providers regarding the reproductive health of women, including pregnancy, and childbirth, as well as antenatal and post-natal healthcare services (Antonio, 2023; Heri et al., 2023; Mathibe-Neke, 2020). Therefore, it is imperative to study the midwives' awareness, level of knowledge, and attitudes toward the provided maternal care for women with disabilities in Palestine. Further to explore their perspectives about the barriers that women with disabilities experience in receiving reproductive health services in Palestine. The results of this study are expected to influence the stakeholder's knowledge about the important needs of women with disabilities in Palestine and to ensure the provision and safe access to maternal healthcare services for these women.

1.3 Gap of knowledge

Currently, little is known about the awareness of Palestinian Midwives' regarding the healthcare needs of women with disabilities and the attitudes and associated barriers to reaching reproductive health services for these women. No studies were found in Palestine about women with disabilities in the reproductive stage, most of the studies about women with disabilities concerned for the women rights and equity of care in general. Moreover, little is known about the adequacy of maternal services provided to women with disabilities in Palestine. Therefore, there is a need to identify the midwives' awareness of the health care needs of these women during pregnancy, childbirth, antenatal and post-natal periods, and to identify the barriers to reproductive health of women with disabilities.

1.4 Justification and significance of the study

In Palestine, limited attention was paid to the reproductive health of women with disabilities. This can be seen by the paucity of studies that were conducted in this domain. On the other hand, the reproductive health of women is being considered as a vital issue in the public health policy for the general population. This might indicate that the reproductive health of women with disabilities was neglected.

Midwives are key providers of reproductive healthcare services during pregnancy, childbirth, antenatal and post-natal periods. Therefore, assessing the awareness of the midwives, their attitudes and perceived barriers toward reproductive healthcare services in Palestine is crucial. The focus of this study on midwives caring for women with disabilities in hospitals is based on the assumption that these women may have more complex health needs and might require longer hospital stays. This extended time allows midwives to provide more comprehensive care.

Additionally, the hospital setting offers more time to assess and address the needs of the mother, which can span several days, unlike the limited interaction time in primary healthcare settings. The choice of tools to evaluate midwives' knowledge, attitudes, and perceived barriers was also deemed more appropriate for the hospital environment.

The gaps of awareness toward the barriers that might be identified in this study are expected to promote the health of women with disabilities in the reproductive stage by informing policies, recommendations, and interventions to bridge these gaps and improve accessibility and adequacy of reproductive healthcare services provided to women with disabilities in Palestine.

1.5 Aim of the study

Assessing the midwife's knowledge, attitudes, and perceived barriers toward reproductive health care services for women with disabilities in the northern region of the West Bank/Palestine. In the long run, this might help in informing policies, recommendations, or interventions to improve awareness of midwives, eliminate barriers, and improve reproductive healthcare services provided to women with disabilities in Palestine.

1.6 Specific objectives of the study

1. To Assess the midwives' knowledge about the reproductive health care needs of women with disabilities in the northern region of the West Bank.
2. To evaluate the midwives' attitudes toward the reproductive health care needs of women with disabilities in the northern region of the West Bank.
3. To identify the barriers that women with disabilities face while accessing and receiving reproductive healthcare services in the northern regions of the West Bank of Palestine from the perspectives of the midwives.
4. To examine the relationship between independent variables (age, academic degree, place of practice, type of hospital/facility, number of years in practice) and other factors such as (the number of women cared for, number of women with disability cared for, receiving a course on caring for women with disability, and receiving training on caring for women with disability) and the midwives' knowledge of the reproductive health care needs of the women with disabilities in the northern region of the West Bank.
5. To examine the relationship between independent variables (age, academic degree, place of practice, type of hospital/facility, number of years in practice), and other factors such as (the number of women cared for, number of women with disability cared for, receiving a course on caring for women with disability, and receiving training on caring for women with disability) and the midwives' attitudes toward the reproductive health care needs of the women with disabilities in the northern region of the West Bank.
6. To assess the relationship between independent variables (age, academic degree, place of practice, type of hospital/facility, number of years in practice) , and other factors such as (number of women cared for, number of women with disability cared for, receiving a course on caring for women with disability, and receiving training on caring for women with disability) and the identified barriers that

women with disabilities face while accessing and receiving the reproductive healthcare services in the northern regions of the West Bank of Palestine.

1.7 Questions of the study

1. What is the level of midwives' knowledge about the reproductive health care needs of women with disabilities in the northern region of the West Bank?
2. What are the midwives' attitudes toward the reproductive health care needs of women with disabilities in the northern region of the West Bank?
3. What are the barriers that women with disabilities face while accessing and receiving reproductive healthcare services in the northern regions of the West Bank of Palestine from the perspectives of midwives?
4. Are there any relationships between independent variables (age, academic degree, place of practice, type of hospital/facility, number of years in practice) and other factors such as (the number of women cared for, number of women with disability cared for, receiving a course on caring for women with disability, and receiving training on caring for women with disability) and the midwives' knowledge of the reproductive health care needs of the women with disabilities in the northern region of the West Bank.
5. Are there any relationships between independent variables (age, academic degree, place of practice, type of hospital/facility, number of years in practice) and other factors such as (the number of women cared for, number of women with disability cared for, receiving a course on caring for women with disability, and receiving training on caring for women with disability) and the midwives' attitudes toward the reproductive health care needs of the women with disabilities in the northern region of the West Bank.
6. Are there any relationships between independent variables (age, academic degree, place of practice, type of hospital/facility, number of years in practice) and other factors such as (the number of women cared for, number of women with disability cared for, receiving a course on caring for women with disability, and receiving training on caring for women with disability) and the identified barriers that women with disabilities face while accessing and receiving reproductive healthcare services in the northern regions of the West Bank of Palestine.

1.8 Novelty

This would be the first study that would explore the awareness of midwives, their attitudes, and perceived barriers toward reproductive healthcare services in the northern areas of the West Bank of Palestine. The findings of this study might help inform policies, recommendations, or interventions to improve awareness of midwives, eliminate barriers, and improve reproductive healthcare services provided to women with disabilities in Palestine.

1.9 Study boundaries

Time boundary: this study was conducted between February and June of 2024.

Place boundary: this study was conducted at 13 governmental and private hospitals that represent the northern part of West Bank–Palestine, including Jenin, Tulkarem, Qalqilyah, Nablus, and Tubas.

Population boundary: this study targeted all midwives who were currently working at the mentioned hospitals, which reached 227 midwives.

Sampling boundaries: The calculated sample based on the total number of midwives in the targeted hospitals was 143, while the researcher intended to reach all of the midwives, and the total number of participating midwives was 158.

Subject topic boundary: The main focus of the current study was on the area of awareness, attitude, and perceived barriers of the recruited midwives toward reproductive health among women who have disabilities.

Methodological and practical boundaries: The study implemented a cross-sectional, quantitative design, with no specific intervention or follow-up. Self-administered questionnaires were disseminated to the targeted midwives using paper forms, and the researcher returned to the midwives to pick the fill in the questionnaires that were kept in a safe envelope till the start of data analysis.

1.10 Definition of terms

Reproductive health: The type of health that constitutes of physical, mental, and social well-being of women during the reproductive age, as well as the complex correlation between determinants of health, both in direct and indirect ways, and between the woman and the surrounding environment, including the awareness of such correlation (Nagar, 2020).

Women with disability: women with disability are defined as women who have any restrictions to their ability to perform normal human being activities or daily life activities (Mcculloch et al., 2020). The World Health Organization (WHO) has defined disability in terms of physical activity impairment or “abnormality of psychological, physical or anatomic structure or function”. However, handicap is another term that is used to describe women who have abnormalities in functionality in cultural and social roles.

Midwives: These are the competent healthcare professionals who practice midwifery, after gaining an official license from a recognized healthcare teaching facility and committing to the scope of midwifery practice. Therefore, the definition of midwives should include midwifery education, registration, and acceptance standards (Li et al., 2018).

Awareness: it can be understood as the information and data that have been learned and assumed within a cognitive system, forming part of an individual’s intellectual legacy, and can include

structured and organized information, experimental familiarity, and a comprehensive understanding of a subject, both in theory and practice (Bolisani & Bratianu, 2018).

Knowledge: enables individuals to interpret, rationalize, and formulate concepts, actions, and motives, and is considered when information is recognized as relevant by a user and, upon sufficient incorporation, modifies the individual's cognitive framework, promoting growth for both the person and the broader community, which is the process in that information becomes a crucial structure that facilitates the creation of knowledge, serving as a bridge in its development (Hetherington, 2022).

Attitudes: A specific definition of attitude can be applied to midwives as the psychological construct representing the evaluative and affective disposition of midwives towards providing reproductive health services to women with disabilities. This involves a range of beliefs, feelings, and predispositions to respond in a certain manner to related scenarios and information, and includes the readiness to engage positively with this patient population, informed by personal experience, education, societal norms, and professional ethics (Wolf et al., 2020).

Perceived barriers: When applied to reproductive health in the current thesis, it covers the cognitive and practical obstacles identified by midwives that delay or challenge their ability to provide effective reproductive health services to women with disabilities. These barriers may include but are not limited to, limited access to specialized training, inadequate resources, organizational constraints, cultural and societal prejudices, as well as personal beliefs or lack of knowledge about disability-specific needs in reproductive health (Duong, 2023).

Chapter Two

Literature Review

2.1 Background

People with physical, sensory, or intellectual disabilities represent a considerable percentage of the population. It is noteworthy to mention that the number of people with disabilities is growing worldwide due to wars, armed conflicts, natural disasters, aging, substance use, changes in diet, and chronic diseases, the number of people with disabilities is growing worldwide (Lee et al., 2020). Today, the majority of people with disabilities live in low- and middle-income nations. People with disabilities, notably women, face considerable challenges and barriers to accessing healthcare services in many healthcare systems around the world (Hridaya Raj Devkota et al., 2017; Kazembe et al., 2022). Moreover, women with disabilities have considerable unmet healthcare needs (Devkota et al., 2018; Kazembe et al., 2022). Women with disabilities often receive substandard reproductive healthcare services (Aresu & Mac-Seing, 2019; Chrastina & Večeřová, 2020; Peta & Ned, 2019).

2.2 Reproductive health

Reproductive health is an essential aspect of women's overall health and well-being, regardless of their physical abilities. However, women with disabilities often face unique challenges and barriers in accessing reproductive health care. They face significant disparities in accessing reproductive healthcare services compared to women without disabilities. women with

disabilities were less likely to receive preventive reproductive health services, such as Pap smears and mammograms. They reported higher rates of unintended pregnancies and were less likely to use contraceptive methods compared to women without disabilities (M Tara Casebolt, 2020).

One significant barrier to accessing reproductive health care for women with disabilities is the lack of accessible facilities and equipment. It was reported that women with disabilities face significant difficulties in accessing appropriate gynecological examinations due to a lack of accessible examination tables and equipment (Fletcher et al., 2023; Haque et al., 2023). Similarly, other studies found that women with physical disabilities reported difficulty accessing mammograms and cervical screening services due to inaccessible equipment (Arana-Chicas et al., 2019; Pearson et al., 2020; Traci et al., 2020).

Moreover, healthcare providers may not be adequately trained to work with women with disabilities, leading to a lack of appropriate information and education about reproductive health. A study published in the *Disability and Health Journal* found that healthcare providers may lack knowledge and skills in providing reproductive healthcare services to women with disabilities (Höglund et al., 2013). This can result in a lack of appropriate information about contraception and family planning, leading to unintended pregnancies and other reproductive health issues.

2.3 Disability in the Palestinian context

In the literature, there are many studies on the Palestinian people with disabilities, which explore their struggle with the difficult life situation and with medical therapy and rehabilitation (Alonso et al., 2022; Biggeri & Ciani, 2019; Brønnum-Hansen et al., 2015; Elkhateeb & Peter, 2019; Harsha et al., 2019; Salti & Ghattas, 2016). The growing literature suggests that women with disabilities in the reproductive stage might face much more difficulties compared to men with disabilities.

Although the rights to marriage, family, and reproduction were embodied in the Convention of the Rights of People with Disabilities, a recent study reported that some Palestinian women with disabilities were prohibited from marrying by their families (Elkhateeb & Peter, 2019). These women related the censure of marriage to the negative sociocultural attitudes towards the marriage of women with disabilities.

The paucity of literature on reproductive health in particular and health issues of Palestinian women with disabilities, in general, indicates that more studies are needed to enrich knowledge about the barriers that hinder accessibility and provision of adequate healthcare services to this fragile and vulnerable category of women.

2.4 The role of midwives in providing services to women with disabilities

Midwives play a critical role in providing healthcare services to women, including those with disabilities. Women with disabilities often face significant barriers to accessing quality healthcare, including reproductive and maternal health services. In this essay, we will explore the role of midwives in providing services to women with disabilities and the importance of

addressing their unique healthcare needs. According to some studies, midwives can play a crucial role in addressing the healthcare needs of women with disabilities (Homeyard et al., 2016). Studies reported that midwives can provide appropriate care and support for women with disabilities during pregnancy and childbirth, including addressing physical, emotional, and social needs. Midwives can also help to identify and address any barriers to care that may exist, such as inaccessible facilities or equipment.

One important aspect of midwifery care for women with disabilities is the provision of appropriate education and information about reproductive and maternal health. A study found that midwives can provide essential information and support for women with disabilities related to contraception, prenatal care, and childbirth preparation (Beake et al., 2013). Additionally, midwives can help to facilitate communication between healthcare providers and women with disabilities to ensure that their healthcare needs are adequately addressed. Another critical aspect of midwifery care for women with disabilities is the provision of accessible facilities and equipment. Studies that midwives can play a critical role in advocating for accessible healthcare facilities and equipment for women with disabilities (M. Tara Casebolt, 2020; Fletcher et al., 2023; Haque et al., 2023). Additionally, midwives can work with women with disabilities to identify any specific accommodations that may be necessary to ensure that their healthcare needs are appropriately addressed.

Furthermore, midwives can play a critical role in addressing the unique challenges faced by women with disabilities related to sexuality and intimacy. Midwives can provide essential education and support for women with disabilities related to sexual health and intimate relationships (Höglund et al., 2013). Additionally, midwives can help to address any barriers to care that may exist, such as the lack of accessible sexual healthcare services. Midwives play a critical role in providing healthcare services to women with disabilities (Höglund et al., 2013). The provision of appropriate education and information, accessible facilities and equipment, and support related to sexuality and intimacy are all essential components of midwifery care for women with disabilities. It is crucial to continue to address the unique healthcare needs of women with disabilities to ensure that they receive the same quality of care as women without disabilities.

2.5 Accessibility of women with disabilities to and experiences with reproductive and maternal healthcare services

Women with disabilities have long faced significant barriers to accessing productive health services, leading to poorer reproductive health outcomes and increased health disparities compared to non-disabled women. The World Health Organization defines reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (Kühn & Rieger, 2017). Thus, the right to reproductive health services is a fundamental human right, and it is essential to ensure that women with disabilities are able to access these services on an equal basis with non-disabled women.

Unfortunately, the reality is that many women with disabilities still face significant barriers to accessing reproductive health services (Nguyen, 2020). These barriers can include a lack of accessible facilities, transportation, and equipment, as well as negative attitudes and discrimination from healthcare providers. These barriers can lead to delayed or inadequate care, which can result in serious health consequences for women with disabilities. One study found that women with disabilities were less likely to receive reproductive health services, including Pap smears and mammograms, than non-disabled women (Iezzoni, 2011). Another study found that women with disabilities were less likely to receive prenatal care, leading to increased rates of preterm birth and low birth weight (Nishat et al., 2022).

In addition to these physical barriers, women with disabilities also face significant social and cultural barriers to accessing reproductive health services. Negative attitudes and stereotypes about disability can lead to healthcare providers making assumptions about the sexual activity of women with disabilities and their ability to use contraception, which can lead to the denial of reproductive health services (Nguyen, 2020).

There have been some positive steps towards improving the reproductive health of women with disabilities. In 2010, the United Nations adopted the Convention on the Rights of Persons with Disabilities, which recognizes the right of people with disabilities to the highest attainable standard of health, including reproductive health (Chibaya et al., 2022; Sousa, 2019; Szmukler, 2019). In addition, some countries have implemented policies and programs aimed at improving access to reproductive health services for women with disabilities. However, much work still needs to be done to ensure that women with disabilities can access reproductive health services on an equal basis with non-disabled women. This includes increasing awareness among healthcare providers about the needs of women with disabilities, improving accessibility of healthcare facilities and equipment, and challenging negative attitudes and stereotypes about disability (Fletcher et al., 2023; Haque et al., 2023).

Many studies that were conducted in poor and developing nations reported suboptimal accessibility of women with disabilities to reproductive and maternal healthcare services (M. Tara Casebolt, 2020; H. R. Devkota, A. Clarke, et al., 2017; Devkota et al., 2018). These studies have shown that women with disabilities were more likely to face challenges in accessing and receiving reproductive and maternal healthcare services compared to their counterparts without disabilities (Devkota et al., 2018). In Nepal, a mixed method was used among 354 women of whom 79 had disabilities to compare accessibility to reproductive and maternal healthcare services. Women with disabilities were more likely to report unavailability of beds during delivery, abusive behaviors, negative attitudes, insensitivity of the healthcare provider, lack of adequate knowledge about the nature of the disability, and lack of experience in providing the service to women with disabilities, and unwelcoming environments in the healthcare facilities (Devkota et al., 2018).

In their recent systematic review, Kazembe et al., (2022) reported that women with disabilities faced considerable challenges during pregnancy and childbirth (Kazembe et al., 2022). In another review, Casebolt (2020) systematically reviewed major databases of the literature

reporting on the accessibility of women with disabilities to reproductive healthcare services in low- and middle-income nations (M. Tara Casebolt, 2020). The studies included in the review reported that the major barriers limiting access of women with disabilities to reproductive healthcare services were: lack of trained healthcare providers, negative attitudes of the society and healthcare providers, abusive behaviors, inadequate knowledge of the healthcare providers, inadequate communication, inaccessible facilities, lack of transport, higher costs of healthcare services, and inappropriate referrals.

Another systematic review was conducted to identify barriers for women with disabilities to access reproductive and sexual healthcare services in sub-Saharan Africa (Ganle et al., 2020). The review identified that women with disabilities face many barriers to accessing reproductive and sexual healthcare services in 12 sub-Saharan African nations. These barriers were related to inaccessible facilities and infrastructure, stigma, and discrimination. The authors categorized the barriers into different levels that included: national, healthcare system, individual, community, and economic barriers.

A study was conducted in southern India to determine the health needs of people with disabilities and to assess accessibility to healthcare services (Gudlavalleti et al., 2014). The study included 839 people with disabilities and 1,153 people without disabilities. The study showed that people with disabilities were more likely to need healthcare services compared to people without disabilities. Similarly, people with disabilities were more likely to have been hospitalized, have diabetes mellitus, and have depression compared to people without disabilities. The study also showed that people with disabilities were more likely to face barriers to accessing healthcare services compared to people without disabilities. The main barriers identified in the study were a lack of knowledge about the availability of healthcare services, costs of the healthcare services, and transportation.

2.6 Knowledge and attitudes of healthcare providers toward reproductive health issues of women with disabilities

A study was conducted in Nepal to examine the attitudes of healthcare providers regarding disabilities and to explore the experiences of women with disability while using maternity and reproductive healthcare services (Hridaya Raj Devkota et al., 2017). The study included 396 healthcare providers and 18 in-depth interviews with women with disability. The study identified negative attitudes among healthcare providers towards disability. The study showed that auxiliary nurse midwives had more positive attitudes towards disability compared to other healthcare providers as indicated by higher scores. The study also showed that younger healthcare providers and those working in urban facilities had more positive attitudes towards disability. In the qualitative interviews, women with disability believed that healthcare providers had poor knowledge, negative attitudes, and inadequate skills, and were less than optimally prepared to provide care for women with disability.

In Vietnam, a study assessed knowledge of reproductive health and sexuality among people with disabilities (Nguyen et al., 2018). The study reported that people with disabilities receive no formal education about sex and reproductive health. The participants reported that they obtained information from their experiences and through informal sources.

Another study in Ethiopia assessed knowledge of sex and reproductive health among young people with disabilities (Kassa et al., 2016). The study reported that about (35%) of young people with disabilities were unaware of sex and reproductive health services. The young people with disabilities stated that television and radio were their main sources of information about sex and reproductive health. The majority of the young people with disabilities stated that they had never discussed sex and reproductive health with their parents. Again, the majority of the young people with disabilities reported poor knowledge about the ways to prevent sexually transmitted diseases.

2.7 Barriers to reproductive health of women with disabilities

Women with disabilities face numerous barriers to accessing reproductive health services, including physical, attitudinal, and systemic barriers (M. Tara Casebolt, 2020; Fletcher et al., 2023; Haque et al., 2023). One of the most significant barriers to reproductive health for women with disabilities is attitudinal. Women with disabilities often experience stigmatization and discrimination, which can make it difficult for them to access quality reproductive health services (Shiwakoti et al., 2021). Many healthcare providers may have negative attitudes towards individuals with disabilities, and this can lead to inappropriate or inadequate care. Women with disabilities reported encountering negative attitudes and discrimination when seeking reproductive healthcare services (Lee et al., 2015; Shandra et al., 2014).

Another significant barrier to reproductive health for women with disabilities is physical accessibility (Burke et al., 2017). Many healthcare facilities are not designed to accommodate individuals with disabilities, which can make it challenging for them to access reproductive health services. For example, gynecological examination tables may be too high or lack appropriate support, making it difficult for women with mobility impairments to access necessary exams. Additionally, many healthcare facilities lack adequate parking, ramps, and elevators, making it difficult for women with disabilities to enter and exit the building. Systemic barriers also play a significant role in limiting access to reproductive health services for women with disabilities. For example, insurance coverage for necessary reproductive health services may be limited or non-existent for individuals with disabilities (Shiwakoti et al., 2021). This can make it challenging for women with disabilities to afford necessary reproductive health services, leading to delays in care and increased risk for negative health outcomes.

Additionally, communication barriers can also impact access to reproductive health services for women with disabilities (M. Tara Casebolt, 2020; Lee et al., 2015). Many healthcare providers may not have adequate training or experience working with individuals with disabilities, leading to communication difficulties. This can make it challenging for women with disabilities to discuss their health concerns, access necessary information, and receive appropriate care. Women with disabilities face numerous barriers when it comes to accessing reproductive health services (Lee et al., 2015). Attitudinal, physical, and systemic barriers can limit access to care, leading to negative health outcomes and decreased quality of life. It is crucial to address these barriers and work towards providing equitable access to reproductive health services for all women, regardless of ability status (Lee et al., 2015).

Chapter Three

Conceptual Framework

3.1 Conceptual framework

The framework of this study includes factors related to the demographic data of the midwives, as well as their awareness of the reproductive health care needs of women with disabilities in the northern area of West Bank Palestine. Awareness of the midwives includes studying their knowledge and attitudes toward reproductive health care needs. Further, perceived barriers to reproductive health care needs will be evaluated by assessing the midwife's knowledge about these barriers.

Kalpakjian et al., (2020) developed an initial conceptual framework for reproductive health in women with disabilities, and it was used to develop the conceptual framework for this study. It includes the major concepts of reproductive health issues as caring for women during menstruation sexuality issues, pregnancy, labor, childbirth, and the use of contraception. Factors that might impact reproductive health issues in this conceptual framework include knowledge attitudes, and communication of reproductive health issues. It also includes reproductive health care environment, self-advocacy, and self-identity (Kalpakjian et al., 2020). This chapter presents the conceptual and operational definitions of the major concepts in this study, presented as dependent and independent variables by giving a detailed explanation of how to measure the study variables.

3.2 Operational definition of the study variables

Independent variables

In this study, the independent variables were the socio-demographic characteristics of the midwives which include (age, gender, academic degree, number of years in practice, place of practice, and type of hospital/facility). In addition, Midwives were asked about the number of women cared for, the number of women with disability cared for, if receiving a course on caring for women with disability, and if receiving training on caring for women with disability. These variables were collected from the midwives through a self-administered questionnaire after getting their agreement to participate and after signing the informed consent.

Dependent variables

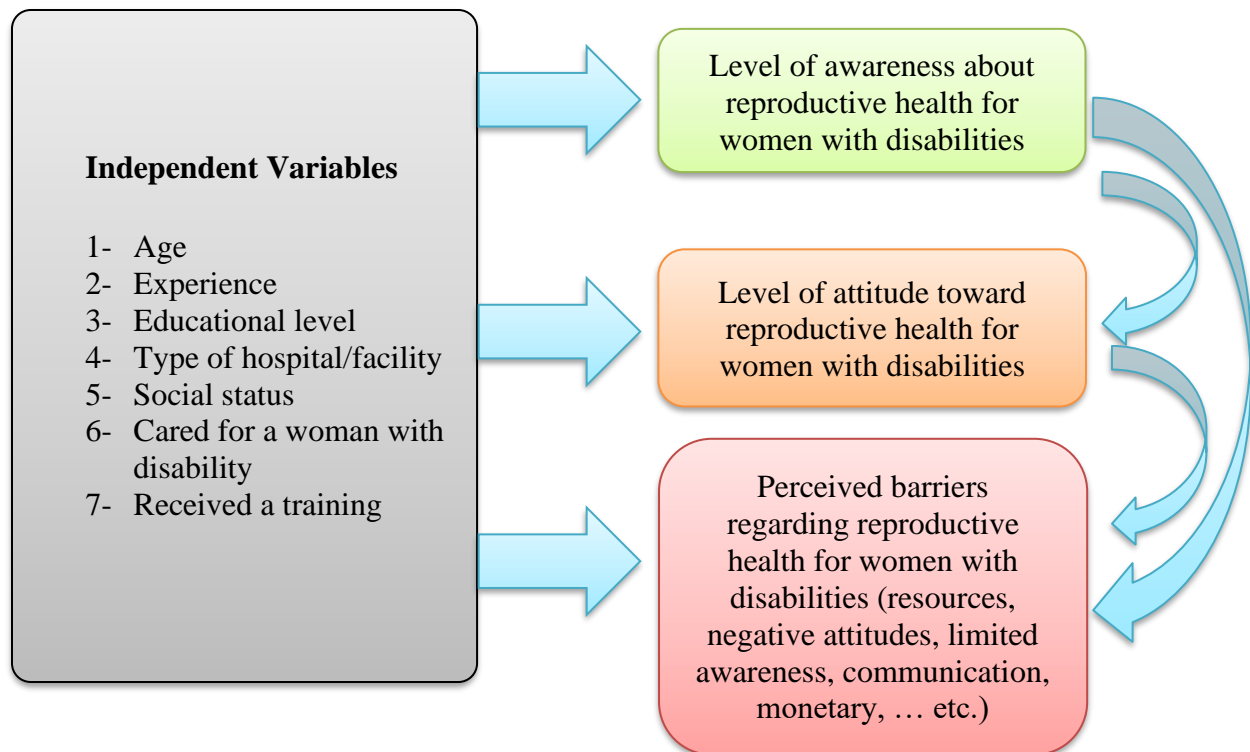
The dependent variables in this study were the Midwives' Awareness of Providing reproductive health care to women with disabilities. It includes measuring the midwives' knowledge, attitudes, and perceived barriers to reproductive healthcare services for women with disabilities.

The level of the midwives' knowledge of reproductive healthcare services for women with disabilities was assessed by using a self-administered questionnaire including the overall issues about the health care needs of women with disabilities in the reproductive stage. It used close-ended questions with a five-point Likert scale scored from 1 to 5. Strongly Agree (1) Agree (2) Neutral (3) Disagree (4) Strongly Disagree (5). The correct and incorrect answers were identified by the researchers through revising the literature for the content of each question. Accordingly, the level of knowledge was defined by the number of correct answers out of the total number of knowledge questions, which generated a continuous variable.

The attitude level of the midwives was assessed by answering close-ended Likert-scale statements of agreement towards caring for women with disabilities, like the preparedness, relationship with these women, and opinions about educational opportunities and health training. The scale includes five points scored from 1 to 5. Strongly Agree (1) Agree (2) Neutral (3) Disagree (4) Strongly Disagree (5).

The scale of perceived barriers includes 7 domains and 24 items about the obstacles and limitations that women with disabilities might face through their reproductive period. According to the previous studies (M. Tara Casebolt, 2020; Gartrell et al., 2017; Lee et al., 2015) the perceived barriers scale was classified as (physical barriers of 3 items), (stereotyping, 4 items), (limitation in knowledge and awareness, 4 items), (communication barriers, 3 items), (financial obstacles 3 items), and (5 items of factors related to the health policies and (2 items were classified as others. The scale includes five points scored from 1 to 5. Strongly Agree (1) Agree (2) Neutral (3) Disagree (4) Strongly Disagree (5).

Figure 3.1: Conceptual framework of the knowledge, attitude and perceived barriers among Palestinian midwives toward reproductive health to women with disabilities.



Chapter Four

Methodology

4.1 Study Design

This descriptive quantitative study was conducted in a cross-sectional design. This design is simple, time- and cost-effective, it allows the researcher to understand the level of awareness among the midwives toward reproductive health care of women with disabilities. It assesses the midwives' knowledge, attitude, and perceived barriers of midwives about reproductive health among women with disabilities. Therefore, the design allowed for the investigation of the study variables and the relationships between them in a quantitative way.

4.2 Target Population

The target population of this study consisted of all midwives working in different hospitals in the northern regions of the West Bank of Palestine. The study covered 5 governmental hospitals and 8 Private hospitals. The names of these hospitals, their location, whether government or private, and the number of midwives in each hospital are presented in table (4.1).

Table (4.1): Distribution of targeted hospitals in the current study and the related city and number of working midwives.

Hospitals and types			No of the midwives
Hospitals in Jenin			
1	Khalil Suliman Hospital	Government	30
2	Alrazi Hospital	Private	10
3	Ibn Sina Hospital	Private	14
4	Al-Amal Hospital (Red Crescent)	Private	4
Hospitals in Nablus			
1	Rafidia Surgical Hospital	Governmental	33
2	Arab Specialized Hospital	Private	22
3	Nablus Specialized Hospital	Private	11
4	Arab Evangel Hospital (Injili)	Private	14
5	Arab United Society (Ettihad)	Private	24
Hospitals in Tubas			
1	Turkish Tubas Hospital	Governmental	17
Hospitals in Tulkarem			
1	Thabet Thabet Hospital	Governmental	20
2	Al-Israa' Hospital	Private	15
Hospitals in Qalqilyah			
1	Darwish Nazzal Hospital	Governmental	13

4.3 Sample Size and Recruitment of the Participants

The sample size was calculated based on the total number of midwives working in labor wards in different hospitals in the West Bank of Palestine. The total number of midwives was taken from the recent reports of statistics from the PCBS and the PMOH which were about 1,363 midwives working in different hospitals in Palestine (Ministry of Health, 2023).

The sample size was calculated at a (95%) confidence interval based on Daniel's formula that is embedded in the Raosoft sample size calculator, with a margin of error of (5%). The population size was 227 midwives, and the calculated sample size was 143 midwives. The researcher added (10%) to the calculated sample size to overcome attrition. The researcher also attempted to recruit all midwives who were currently working in the targeted hospitals to decrease bias and increase representation. However, a convenient sample of 158 midwives participated in the study and were able to fulfill the distributed questionnaire.

4.4 Study Settings

The study was conducted in different hospitals that are administered by the Palestinian Ministry of Health (governmental), and the private sector in the cities of Tulkarm, Nablus, Qalqilya, Tubas and Jenin.

4.5 Inclusion Criteria

Midwives were included when they met the following inclusion criteria:

- Working in labor and postnatal wards in government and private hospitals
- Willing to participate in this study

4.6 Exclusion Criteria

The exclusion criteria in this current study included:

- Midwifery students
- Midwives who work in outpatient ward, emergency and operation rooms.

4.7 Study Period

The study's data collection phase was conducted in the period between February 1st and June 30th 2024, which was a suitable period for collecting proper sample size.

4.8 Instrument of the Study

This study used a self-administered questionnaire that was designed by the researcher based on the review of previous literature. The content of the knowledge items included in the questionnaire was primarily based on the findings of a previous systematic review of the maternity care experiences of women with physical disabilities (Heideveld-Gerritsen et al.,

2021). It was also taken from a cross-sectional study by Höglund et al. (2013), which revealed a significant gap in education and training.

The midwives' attitude toward caring for women with disabilities was selected primarily based on the study of Höglund et al. (2013), which reflected a concern about the attitude of midwives toward women with disabilities, especially intellectual disabilities, in terms of their ability to have childbirth. The researcher also used the knowledge explored in the previous studies that focused on the attitude aspect for the formation of the questionnaire (H. R. Devkota, E. Murray, et al., 2017; Taouk et al., 2018). The perceived barriers to reproductive care for women with disabilities were written after reading several qualitative and quantitative studies concerned with the perceived barriers (M. Tara Casebolt, 2020; Sharma et al., 2015).

The final version of the study instrument is composed of four parts:

The first part is concerned with assessing the sociodemographic characteristics of the midwives as age, academic degree, place of practice, type of hospital/facility, and number of years in practice. In addition, midwives were asked about whether they have cared for women with disabilities, the type of disabilities they took care of, and whether received a course on caring for women with a disability.

The second part of the questionnaire focused on assessing the midwives' knowledge about the reproductive health care of women with disabilities, which consisted of 10 questions with three possible answers: "Yes", "No" and "I don't know", where all the provided questions were considered true and the correct answer was "Yes", except for one sentence with a correct answer of "No", while all answers of "I don't know" were considered incorrect. The calculation of knowledge level was done by summing up the number of correct answers for each midwife and giving a total out of 10, and then classified into three categories: Poor "a score from 0 to 5 out of 10", Moderate "a score between 6 and 7 out of 10" and High "a score between 8 and 10 out of 10", which was based on the common classification of knowledge scores in previous literature (H. R. Devkota, E. Murray, et al., 2017).

The third part of the questionnaire is about assessing the midwives' attitude toward caring for women with disabilities. It consisted of 10 statements that were rated on a 5-point Likert scale: "Strongly agree", "Agree", "Neutral", "Disagree", and "Strongly disagree". Out of the provided 10 statements, 4 of them had negative direction, where their codes have been reversed to keep the higher score indicating a better attitude level, which was calculated by summing up the codes of statements from 1 "Strongly disagree" to 5 "Strongly agree", with higher scores indicating better attitude levels. The attitude score was then categorized into three categories: Poor "a score of less than (60%)", Moderate "a score between (60%) and less than (80%)" and High "a score equal to or more than (80%)".

The fourth part of the questionnaire is about the perceived barriers to reproductive care for women with disabilities, which consisted of statements that were classified into 6 domains: physical (3 statements), negative attitudes and stereotypes (4 statements), communication (3 statements), financial (2 statements), legal and policy gaps (3 statements) and others (2 statements). The statements were also rated on a 5-point Likert scale: “Strongly agree”, “Agree”, “Neutral”, “Disagree”, and “Strongly disagree”. The score of perceived barriers was calculated by summing up the codes of each statement from 1 “Strongly disagree” to 5 “Strongly agree” and convert the score to 100%, with higher scores indicating higher perceived barriers, which were classified into three categories: Low “a score of less than (60%)”, Moderate “a score between (60%) and less than (80%)” and High “a score equals to or more than (80%)”.

4.9 Validity of the Instrument

To obtain the face and content validity of the instrument, the final version of the structured questionnaire was reviewed by an obstetrician and two experienced midwives working in antenatal care and at a labor ward in a private hospital. Their comments were invaluable, and the questionnaire was modified accordingly. The questionnaire was also reviewed by two expert midwives and two doctors in midwifery and maternal child health nursing working in the field of midwifery education. Their comments and modifications were taken seriously, and the questionnaire was modified accordingly and returned to them to confirm the final version of the questionnaire. Finally, they accepted this tool as appropriate for measuring the midwives’ awareness, attitudes, and perceived barriers to reproductive health care of women with disabilities in Palestine. The questionnaire was then translated into Arabic by a professional translator to make it clear and understandable for the midwives. The final version of the questionnaire was distributed in Arabic to all the participating midwives.

4.10 Reliability of the Instrument

The reliability of the questionnaire was established following a pilot study that was conducted among about (10%) of the sample size. The participants in the pilot study were given copies of the questionnaire and asked to respond to each item. The internal consistency of the items in the questionnaire was tested using Cronbach’s alpha, with a cut point of > 0.70 to be considered acceptable. The results of Cronbach’s alpha were 0.762 for knowledge, 0.772 for attitude, and 0.906 for perceived barriers scales, which indicated an acceptable reliability level for knowledge and attitude scales, and a high-reliability level for the perceived barriers scale, and reflecting a satisfactory level of inter-connectedness between the statements, as well as the ability to use the provided scales in future studies.

The participants of the pilot study were then given a copy of the questionnaire and asked to respond to the questionnaire for a second time. Answers in both rounds were correlated to ensure test-retest reliability. The Pearson’s correlation coefficient of > 0.80 was considered acceptable. The results of the Pearson correlation test indicated a high level of correlation, where the results were 0.869 for knowledge, 0.832 for attitude, and 0.884 for perceived barriers scales, indicating high levels of test-retest reliability.

4.11 Collection of the Data

The targeted hospitals were contacted first via official manners to clarify the aims of the study and the process needed to collect the data from midwives, and after the explanation of the study's methodology, the hospitals were asked to facilitate the data collection process by asking for official letters, which was different from a hospital to another, where a facilitation letter was granted from the Palestinian Ministry of Health (MoH) to start data collection in the governmental hospitals, while each private hospital was separately asked to provide a facilitation letter depending on the specific process for each of them.

After granting the facilitation letter, the researcher started data collection by heading to each of the targeted hospitals and met midwives who were available during duty, and trying to reach the hospitals during the handover process between morning and evening shifts, so that more midwives are available. Each midwife was asked to participate in the study, after ensuring the eligibility of inclusion criteria, and when agreed, the researcher explained the aim of the study and the content of the questionnaire, with a commitment to anonymity and confidentiality principles. The researcher waited for midwives to finish the questionnaire filling so that any inquiry related to answering the questions can be answered. The questionnaires were then kept in closed and secured envelopes, so that only the researcher and supervisor have access to them, until the start of data collection.

4.12 Data Analysis

The collected data was entered into MS Excel Spreadsheets and then transferred into IBM's Statistical Package for Social Sciences (SPSS). Descriptive statistics were generated as appropriate, including medians and interquartile ranges (IQR), as the data were checked for normality and showed non-normal distribution, as well as frequencies and percentages that were tabulated for categorical demographic data and the statements of each scale. Depending on the normality of the distribution of the data, appropriate statistical tests were used, including Mann-Whitney U and Kruskal Wallis tests to investigate the differences in mean ranks of scale scores across the categories of the demographic factors, and bivariate correlation using Spearman Correlation test to investigate the significance and direction correlation between scale demographic factor (age) and the scales, and between the scales themselves. A cut point of 0.05 was considered for the p-value to indicate significant differences in mean ranks and correlations.

4.13 Ethical Considerations

It was obtained from the ethical scientific research committee of Al-Quds University. Permission to conduct the study was taken from the PMOH and the administrators of the private hospitals. Midwives were informed that their participation was voluntary, and they could withdraw from the study at any time they wanted to, which was stated using informed consent before they would be able to respond to the questionnaire. Strict measures were taken to ensure the anonymity and confidentiality of the participants and the data collected.

Chapter Five

Results

This chapter reviews the descriptive and analytical results of the current study about the midwives' awareness, attitudes, and perceived barriers related to reproductive health care for women with disabilities. The descriptive results include frequencies and percentages of midwives' responses to demographic data and statements of awareness, attitudes, and perceived barriers scales, as well as the description of awareness and perceived barriers scores. The analytical results show the investigation of the relationships between midwives' demographic factors (as independent variables) and their awareness, attitude, and perceived barriers scores (as dependent variables), and the correlations between them.

Part 1: Demographic data of midwives

The Age of the participating midwives ranges from 21 to 59 years old, with around one-third of them between 26 and 30 years old. The median age of the midwives in the current study (N = 158) was 29 years old, and the interquartile (IQR) was (8.25 years). In terms of experience, the median experience they had was 6 years (IQR = 8 years). The general experience of the participating midwives ranged from 1 to 36 years, with around half of them (n = 75, 47.5%) having an experience between 1 and 5 years. More than half of the midwives (n = 91, 57.6%) hold a bachelor's degree, and were mostly recruited from the private sector (n = 126, 79.7%), while more than half of the midwives who participated in the current study (n = 99, 62.7%) were married.

Table 5.1.: Distribution of midwives' socio-demographic characteristics (N = 158)

Variables	Values	Frequency	Percentage
Age	21 - 25 years old	39	24.7%
	26 - 30 years old	53	33.5%
	31 - 35 years old	37	23.4%
	36 - 40 years old	12	7.6%
	> 40 years old	17	10.8%
	Median (IQR), min – max	29 (8.25), 21 – 59	
Experience	1 - 5 years	75	47.5%
	6 - 10 years	38	24.1%
	11 - 15 years	28	17.7%
	> 15 years	17	10.8%
	Median (IQR), min – max	6 (8), 1 – 36	
Educational level	Diploma degree	43	27.2%
	Bachelor's degree	91	57.6%
	Higher educations	24	15.2%
Type of hospital/facility	Governmental sector	32	20.3%
	Private sector	126	79.7%
Social status	Single	46	29.1%
	Married	99	62.7%
	Widowed/Divorced	13	8.2%

Among the midwives who reported previously providing care for a woman with a disability (n=78, 49.4%), more than half of them reported caring for a woman with physical disabilities (n=46, 59.0%), and (n=21, 26.9%) experienced caring for women with intellectual disability. On the other hand, the majority of the midwives (n=141, 89.2%) reported not receiving specific training on caring for women with disabilities.

Table 5.2: Distribution of midwives' variables of treating and training on women with disabilities (N = 158)

Previously provided care for a woman with disability	Yes	78	49.4%
	No	80	50.6%
Type of disability among women who received care	Physical disability	46	59.0%
	Intellectual disability	21	26.9%
	Other disability	11	14.1%
Received training for caring of women with disabilities	Yes	17	10.8%
	No	141	89.2%

IQR = Interquartile range

Part 2: Midwives' awareness of reproductive health of women with disabilities

Midwives were asked to answer a set of questions to measure their level of knowledge regarding reproductive care for women with disabilities. More than half of the midwives (n=84, 53.2%) agreed about the item which indicated that women with disabilities experience negative reactions towards the idea of becoming parents. Higher percentages were found for midwives who approved the stressful, risky, and harmful pregnancy and childbirth among women with disabilities (n=121, 76.6%), as well as the sexual and reproductive needs among them similar to women without disabilities (n=124, 78.5%).

More than half of the midwives (n=96, 60.8%) said "Yes" about women with disabilities in terms of being not sure about their abilities to give adequate care for an infant and be a good mother, while similar percentages were found for midwives who agreed and disagreed on the idea related to such women having no custody of their children (n=64, 40.5% each). More than half of the midwives (n=101, 63.9%) agreed on the item related to the difficulty of getting the required reproductive care among women with disabilities due to difficulties in access and use of resources.

More than three-fourths of the midwives approved the item which said that women with disabilities often deliver by CS, although they can deliver vaginally (n=125, 79.1%). The need for midwives to be trained in the sexual and reproductive health of women with disabilities of different types was positively answered by a higher percentage of (n=139, 88.0%), and (n=113 71.5%) agreed that midwives are generally qualified to provide teaching and counseling about safe pregnancy, labor and postnatal care for women with disabilities.

Table 5.3: Distribution of midwives' responses to statements of awareness of reproductive health of women with disabilities

Statement*	Yes		No		I don't know	
	F	%	F	%	F	%
1. ... often experience negative reactions ...	84	53.2%	36	22.8%	38	24.1%
2. ... often experience stress, risk and ...	121	76.6%	25	15.8%	12	7.6%
3. ... have sexual and reproductive ...	124	78.5%	12	7.6%	22	13.9%
4. ... are often not sure about their abilities ...	96	60.8%	44	27.8%	18	11.4%
5. ... often do not have custody	64	40.5%	64	40.5%	30	19.0%
6. ... often did not get the required reproductive care ...	101	63.9%	38	24.1%	19	12.0%
7. ... often are good mothers ...	133	84.2%	14	8.9%	11	7.0%
8. ... often delivered by cesarean section ...	125	79.1%	24	15.2%	9	5.7%
9. Midwives need to be trained ...	139	88.0%	14	8.9%	5	3.2%
10. Midwives are qualified to ...	113	71.5%	32	20.3%	13	8.2%

*F = Frequency, *= All sentences were considered correct except for No. 5, the response "I don't know, was considered a wrong answer.*

The level of knowledge was calculated by summing up the number of correct answers across the 10 questions. The median number of correct answers was 7 out of 10 (IQR = 3), ranging from 0 to 10 correct answers for each midwife, which is considered to have an overall moderate level of knowledge among the participating midwives regarding providing reproductive care for women with disabilities.

When categorized, it was found that nearly half of the midwives (n=78, 49.4%) had a high level of knowledge, answering 8 or more correct answers, with around one-third of them (n=51, 32.3%) having a moderate level of knowledge, answering 6 or 7 correct answers.

Table 5.4: Distribution of midwives’ knowledge levels regarding reproductive health of women with disabilities

Knowledge level	Cut points	Frequency	Percentage
Poor knowledge	0 – 5 correct answers	29	18.4%
Moderate knowledge	6 – 7 correct answers	51	32.3%
High knowledge	8 – 10 correct answers	78	49.4%
Median (IQR), min – max		7 (3), 0 – 10	

IQR = Interquartile range

Part 3: Midwives’ attitudes towards reproductive health of women with disabilities

Midwives were also asked to identify their agreement levels on statements related to their attitude toward providing reproductive care for women with disabilities. While more than one-third of the midwives (n=59, 37.3%) agree that they are not well prepared to satisfy the reproductive health care needs of women with disabilities, a higher percentage (n=96, 60.8%) agreed on their ability to communicate well with such women to increase their competency and confidence. In parallel, (n=63, 39.9%) of the midwives disagreed, and (n=43, 27.2%) strongly disagreed that they can’t listen to the views and questions of women with disabilities. The percentage of midwives who believe that these women are often incapable of getting pregnant or giving birth was low (n=57, 36.1% disagree). More than half of the midwives (n=84, 53.2%) agreed and (n=44, 27.8%) strongly agreed that they do not hold prejudiced or discriminant attitudes towards women with disabilities when seeking sexual and reproductive health services. A similar agreement level was found (n=82, 51.9% agree and n=52, 32.9% strongly agree) towards their belief that such women should be informed about sexual and reproductive health at a young age. The majority of the midwives agree (n=68, 43.0%) and strongly agree (n=71, 44.9%) that such women need family support in their sexual and reproductive health issues.

In addition, the majority of the midwives agree (n=66, 41.8%) or strongly agree (n=72, 45.6%) that these women should be informed about family planning methods to avoid unwanted and illegal pregnancies. Most of the midwives (n=77, 48.7%) agree and (n=67, 42.4%) strongly agree that teaching women with disabilities about their sexual and reproductive health rights is essential. Lastly, (n=72, 45.6%) of the midwives agreed that such women would reduce the frequency of visiting reproductive health care services to avoid associated stigma.

Table 5.5: Distribution of midwives' attitude towards reproductive health of women with disabilities

Statement	SA		A		N		D		SD	
	F	%	F	%	F	%	F	%	F	%
1. I am not well prepared ...	20	12.7%	59	37.3%	46	29.1%	30	19.0%	3	1.9%
2. I can communicate well ...	31	19.6%	96	60.8%	25	15.8%	6	3.8%	0	0.0%
3. I can't listen to the views ...	15	9.5%	22	13.9%	15	9.5%	63	39.9%	43	27.2%
4. I believe that ...are often incapable ...	21	13.3%	26	16.5%	26	16.5%	57	36.1%	28	17.7%
5. I do not hold any prejudiced attitudes ...	44	27.8%	84	53.2%	15	9.5%	13	8.2%	2	1.3%
6. I believe that ... should be informed ...	52	32.9%	82	51.9%	18	11.4%	2	1.3%	4	2.5%
7. I believe that ... are in high need ...	71	44.9%	68	43.0%	14	8.9%	1	0.6%	4	2.5%
8. I believe that ... should be informed ...	72	45.6%	66	41.8%	10	6.3%	6	3.8%	4	2.5%
9. I believe that it is essential to teach	67	42.4%	77	48.7%	10	6.3%	0	0.0%	4	2.5%
10. I think that ... will reduce their visits ...	25	15.8%	72	45.6%	31	19.6%	23	14.6%	7	4.4%

SA = Strongly agree, A = Agree, N = Neutral, D = Disagree, SD = Strongly disagree, F =

Frequency

The attitude score was calculated by summing up the agreement levels of positive statements and disagreement levels on negative statements and then converting the score to out of (100%), with higher scores indicating better attitudes towards reproductive health care delivery for women with disabilities. The median attitude score was 74% (IQR = 12.5%), which indicates an overall moderate attitude level among the participating midwives and ranges between (48%) and (96%), with around two-thirds of the midwives (n=103, 65.2%) having a moderate attitude level, compared to (n=46, 29.1%) with a high positive attitude category.

Table 5.6: Distribution of midwives’ attitude levels regarding reproductive health of women with disabilities

Attitude level	Cut points	Frequency	Percentage
Poor attitude	Attitude score < 60%	9	5.7%
Moderate attitude	Attitude score = 60 - <80%	103	65.2%
Positive attitude	Attitude score ≥ 80%	46	29.1%
Median (IQR), min – max		74 (12.5), 48 – 96	

IQR = Interquartile range

Part 4: Midwives’ perceived barriers to the reproductive health of women with disabilities

Midwives in this study were asked to rate their agreement on specific statements to rate the perceived barriers they face when delivering reproductive healthcare for women with disabilities, which were divided into various domains.

In the domain related to physical barriers, the majority of the midwives agree (n=96, 60.8%) and strongly agree (n=44, 27.8%) on barriers related to the lack of appropriate reproductive health care facilities and services for such women. Approximately (n=95, 60.1% of the midwives agree and n=43, 27.2% strongly agree) on the lack of required medical equipment and devices that help obtain integrated reproductive care.

The study results revealed that (n=94, 59.5%) of the midwives agreed and (n=46, 29.1%) strongly agreed on the barriers related to the lack of equipped transportation that makes accessibility to reproductive health care services hard among women with disabilities.

Concerning negative attitudes and stereotypes, (n=89, 56.3%) of the midwives agreed and (n=40, 25.3%) strongly agreed on barriers related to women with disabilities being afraid of exposure to stigma and stereotypes about their disabilities by the HCPs. The majority of the midwives (n=96, 60.8%) agreed on the barrier related to feeling embarrassed when examined by HCPs. Further, (n=89, 56.3%) of the midwives agree that women with disabilities may feel stigmatized and discriminated against when compared to non-disabled women when reproductive health care is delivered. The lack of midwives' knowledge about the sexual and reproductive health care needs of women with disabilities might be related to inadequate training was reported by (n=88, 55.7%) of the midwives who agreed on this point.

In terms of the domain of communication barriers, nearly half of the midwives (n=77, 48.7%) agree on the communication difficulties that women with disabilities face when receiving reproductive health care, and more than half of them (n=81, 51.3%) agree that they also face difficulties in understanding the given reproductive health advice and instructions. Results of this study also revealed that (n=88, 55.7%) agreed on the physical and emotional disturbances that women with disabilities face due to poor communication with HCPs.

Financial barriers also showed a high agreement level among the midwives (n=66, 41.8% agree and n=45, 28.5% strongly agree) on barriers related to high reproductive healthcare costs related to the specific needs of women with disabilities. The lack of health insurance among women with disabilities to get required reproductive health care services also showed agreement to an acceptable level among the midwives (n=67, 42.4% agree and n=38, 24.1% strongly agree).

There was also high agreement levels on statements related to the legal and policy gaps, where (n=82, 51.9%) of the midwives agreed and (n=40, 25.3%) strongly agreed to the unavailability of unique sexual and reproductive healthcare needs for women with disabilities. Moreover, (n=87, 55.1%) agree and (n=33, 20.9%) strongly agree that related programs lack responsiveness and flexibility to meet those women's needs, and (n=89, 56.3%) agree and (n=33, 20.9%) strongly agree on the confusion that women with disabilities face when dealing with diagnostic and therapeutic measures, as well as waiting and referral procedures.

Lastly, other barriers included the fear of pain and discomfort among women with disabilities when investigated by HCPs, which was agreed on by (n=85, 53.8%), in addition to the lack of family and social support for those women, resulting in their isolation and difficulties in understanding their needs and rights, which was agreed on by (n=74, 46.8%) of the midwives.

Table 5.7. A: Distribution of midwives' responses to statements of perceived barriers towards reproductive health of women with disabilities

Physical barriers	SA		A		N		D		SD	
	F	%	F	%	F	%	F	%	F	%
1. Lack of ... facilities	44	27.8%	96	60.8%	16	10.1%	2	1.3%	0	0.0%
2. Lack of medical equipment	43	27.2%	95	60.1%	15	9.5%	5	3.2%	0	0.0%
3. Lack of equipped transportation	46	29.1%	94	59.5%	13	8.2%	3	1.9%	2	1.3%
Negative Attitudes and Stereotypes										
4. ... afraid of stigma ...	40	25.3%	89	56.3%	20	12.7%	9	5.7%	0	0.0%
5. afraid of embarrassment ...	24	15.2%	96	60.8%	26	16.5%	12	7.6%	0	0.0%
6. ... stigmatized and discriminated ...	31	19.6%	89	56.3%	22	13.9%	14	8.9%	2	1.3%
7. lack knowledge and awareness ...	37	23.4%	88	55.7%	21	13.3%	8	5.1%	4	2.5%
Communication Barriers										
8. ... face difficulties in communicating ...	25	15.8%	77	48.7%	26	16.5%	30	19.0%	0	0.0%
9. ... face difficulties in understanding ...	37	23.4%	81	51.3%	17	10.8%	18	11.4%	5	3.2%

Table 5.7. B: Distribution of midwives' responses to statements of perceived barriers towards reproductive health of women with disabilities										
10. ... face physical and emotional disturbances ...	26	16.5%	88	55.7%	31	19.6%	11	7.0%	2	1.3%
Financial Barriers										
11. Higher reproductive healthcare costs ...	45	28.5%	66	41.8%	28	17.7%	15	9.5%	4	2.5%
12. Lack of insurance ...	38	24.1%	67	42.4%	23	14.6%	20	12.7%	10	6.3%
Legal and Policy Gaps										
13. Healthcare policies ... are not available	40	25.3%	82	51.9%	26	16.5%	8	5.1%	2	1.3%
14. ... healthcare are lacking the flexibility	33	20.9%	87	55.1%	22	13.9%	14	8.9%	2	1.3%
15. Diagnostic measures ... are confusing ...	33	20.9%	89	56.3%	28	17.7%	8	5.1%	0	0.0%
Others										
16. Fear of pain or discomfort ...	41	25.9%	85	53.8%	24	15.2%	8	5.1%	0	0.0%
17. The lack of family and social support ...	61	38.6%	74	46.8%	19	12.0%	4	2.5%	0	0.0%

SA = Strongly agree, A = Agree, N = Neutral, D = Disagree, SD = Strongly disagree, F =

Frequency

Similarly, the perceived barriers level was calculated by summing up the scores of all statements and converting them to a score out of (100%), with higher scores indicating higher perceived barriers among the sampled midwives in accordance to delivering reproductive health care for women with disabilities. The overall score had a median of (78.82%, IQR = 13.24%), which indicates an overall moderate barrier perceived by the midwives, which ranged from (36.47%) to (100%). Almost all of the midwives perceived either moderate (n=78, 49.4%) or high (n=76, 48.1%) levels of perceived barriers towards delivering reproductive health care services to women with disabilities.

Table 5.8: Distribution of midwives’ perceived barrier levels regarding reproductive health of women with disabilities

Perceived barrier level	Cut points	Frequency	Percentage
Low barrier level	Barrier score < 60%	4	2.5%
Moderate barrier level	Barrier score = 60 - <80%	78	49.4%
High barrier level	Barrier score ≥ 80%	76	48.1%
Median (IQR), min – max		78.82 (13.24), 36.47 – 100.0	

IQR = Interquartile range

Part 5: Analytical results

The relationships between midwives' demographic factors and their scores of awareness, attitudes, and perceived barriers towards delivering reproductive health care to women with disabilities were tested using non-parametric analytical tests, as the distribution of data was not normal. The study used the Mann-Whitney U test and Kruskal-Wallis tests to investigate the differences in mean ranks of scores across dichotomous and non-dichotomous demographic factors, respectively. The Spearman Correlation test was used to investigate the strength and direction of the correlations between scale demographic factors and scales' scores, as well as between scales' scores themselves, with a cut point of 0.05 for the p-value to consider it significant.

Results of this study showed that the awareness of reproductive health care for women with disabilities was not significantly related to midwives' age (p-value = 0.705) or experience (p-value = 0.296). however, it was significantly related to their educational level (p-value = 0.010), where higher mean ranks of awareness levels were found among midwives with higher education degrees (mean rank = 89.08) compared to holders of bachelor's (82.63) and diploma (67.53) degrees. On the other hand, the rest of the demographic factors did not significantly relate to the differences in awareness of the reproductive health of women with disabilities.

Table 5.9.A: Relationship between midwives' demographic factors and their awareness of reproductive care of women with disabilities

Factors	Values	Awareness		
		Mean rank	Test value	<i>P</i>
Age	21 - 25 YO	79.18	2.168	0.705
	26 - 30 YO	79.18		
	31 - 35 YO	75.00		
	36 - 40 YO	96.79		
	> 40 YO	78.82		
	Correlation	-0.011	0.887	

Table 5.9.B: Relationship between midwives' demographic factors and their awareness of reproductive care of women with disabilities

Experience	1 - 5 years	78.37	3.699	0.296
	6 - 10 years	75.26		
	11 - 15 years	93.43		
	> 15 years	71.03		
	Correlation	0.006	0.936	
Educational level	Diploma	67.53	4.605	0.010
	Bachelor	82.63		
	Higher edu.	89.08		
Type of hospital/facility	Governmental	88.88	1716.0	0.185
	Private	77.12		
Social status	Single	69.64	3.253	0.197
	Married	84.07		
	Other	79.62		
Cared for a disabled woman	Yes	75.88	2838.0	0.317
	No	83.03		
Received training	Yes	79.21	1193.5	0.977
	No	79.54		

The highest rank of Positive attitudes was found among midwives with younger age groups between 21 and 25 years old (mean rank = 101.15, and it showed a significant difference with (p-value = 0.014). However, midwives aged between 31 and 35 years old showed a lower rank of the positive attitudes (mean rank = 77.62), while Midwives older than 40 years old were ranked as (mean rank = 73.24) in the positive attitudes scores. Results also showed that midwives of ages between 26 and 30 years old (mean rank = 69.23) and between 36 and 40 years old (mean rank = 69.17). Therefore, significantly higher scores were found among midwives age between 31 and 35 years old (mean rank = 77.62) and older than 40 years old (mean rank = 73.24), compared with midwives of ages between 26 and 30 years old (mean rank = 69.23) and between 36 and 40 years old (mean rank = 69.17), with an overall significantly moderate negative correlation between midwives age and attitude levels, indicating moderately lower attitude levels among older midwives ($r = -0.203$, $p\text{-value} = 0.010$)

The highest attitude levels were significantly found to be related to midwives' educational level, in which the lower education showed high positive attitude levels. The bachelor's degrees (mean rank = 88.83), compared to midwives with diploma degrees (mean rank = 79.20), which is higher than midwives with higher educations (mean rank = 70.67, $p\text{-value} < 0.001$). However, the attitude levels of the participating midwives were not significantly related to their experience level ($p\text{-value} = 0.592$).

This study also found that more positive attitudes were significantly related to marital status. It was found that single midwives had higher positive attitudes (mean rank = 97.60) than married midwives (mean rank = 74.53, $p\text{-value} = 0.002$). Those midwives who received reproductive health training for women with disabilities had higher attitude scores (mean rank = 82.91) compared to those who did not (mean rank = 51.24, $p\text{-value} = 0.007$).

Table 5.10.A: Relationship between midwives' demographic factors and their attitude toward reproductive care of women with disabilities

Factors	Values	Attitude		
		Mean rank	Test value	<i>p</i>
Age	21 - 25 YO	101.15	12.503	0.014
	26 - 30 YO	69.23		
	31 - 35 YO	77.62		
	36 - 40 YO	69.17		
	> 40 YO	73.24		
	Correlation	-0.203	0.010	

Table 5.10.B: Relationship between midwives' demographic factors and their attitude toward reproductive care of women with disabilities

Experience	1 - 5 years	82.92	1.907	0.592
	6 - 10 years	70.70		
	11 - 15 years	81.02		
	> 15 years	81.59		
	Correlation	-0.094	0.239	
Educational level	Diploma	79.20	17.842	<0.001
	Bachelor	88.83		
	Higher edu.	70.67		
Type of hospital/facility	Governmental	80.13	1996.0	0.931
	Private	79.34		
Social status	Single	97.60	12.729	0.002
	Married	74.53		
	Other	53.31		
Cared for a disabled woman	Yes	79.19	3096.0	0.933
	No	79.80		
Received training	Yes	82.91	718.0	0.007
	No	51.24		

Barriers to delivering reproductive health care for women with disabilities were not significantly perceived differently among midwives across their age (p-value = 0.058) or experience levels (p-value = 0.253). On the other hand, higher perceived barriers were found among midwives with higher educations (mean rank = 131.71) compared to those who have bachelor's (mean rank = 74.48) and diploma degrees (mean rank = 60.99, p-value < 0.001), and among midwives who received related training (mean rank = 100.56) compared to who did not (mean rank = 76.96, p-value = 0.044).

Table 5.11.A: Relationship between midwives' demographic factors and their perceived barriers of reproductive care of women with disabilities

Factors	Values	Barrier		
		Mean rank	Test value	<i>p</i>
Age	21 - 25 YO	64.58	9.112	0.058
	26 - 30 YO	91.69		
	31 - 35 YO	77.46		
	36 - 40 YO	90.50		
	> 40 YO	72.41		
	Correlation	0.099	0.217	
Experience	1 - 5 years	74.73	4.080	0.253
	6 - 10 years	87.41		
	11 - 15 years	88.45		
	> 15 years	68.15		
	Correlation	0.070	0.383	
Educational level	Diploma	60.99	39.498	<0.001
	Bachelor	74.48		
	Higher Edu.	131.71		
Type of hospital/facility	Governmental	86.70	1785.5	0.318
	Private	77.67		
Social status	Single	71.35	3.524	0.172
	Married	80.96		

Table 5.11.B: Relationship between midwives' demographic factors and their perceived barriers of reproductive care of women with disabilities

Cared for a disabled woman	Yes	75.93	2841.5	0.332
	No	82.98		
Received training	Yes	100.56	840.5	0.044
	No	76.96		

Finally, the correlations between the scales' scores were tested and showed that the attitude of midwives towards reproductive health care of women with disabilities was not significantly related to their level of awareness, although mildly related in a positive way ($r = 0.112$, p -value = 0.163). There was a significant positive correlation between the awareness levels of the midwives and the perceived barriers to delivering reproductive health care for women with disabilities ($r = 0.252$, p -value = 0.001). However, there was a negative correlation between the midwives' attitudes and the perceived barriers ($r = -0.259$, p -value = 0.001).

Table 5.12: Correlations between awareness, attitude, and perceived barriers toward productive health for women with disabilities

Factor	Attitude		Barrier	
	R	p-value	R	p-value
Awareness	0.112	0.163	0.252	0.001
Attitude			-0.259	0.001

$r =$ Correlation Coefficient (Spearman Correlation test)

Conclusion

The median age of the midwives who participated in the current study ($N = 158$) was 29 years old, with a median experience of 6 years, and more than half of them ($n=91$, 57.6%) hold a bachelor's degree. They were mostly working at private sector healthcare facilities ($n=126$, 79.9%), and married ($n=99$, 62.7%), with nearly half of them ($n=78$, 49.4%) previously cared for women with disabilities, mostly physical types of disabilities ($n=46$, 59.0%). Most of the

midwives (n=141, 89.2%) did not receive related training.

The overall awareness level among midwives was moderate (median = 7 out of 10, IQR = 3), with nearly half of them (n=78, 49.4%) having high awareness levels, which was significantly higher with higher educational levels. The overall attitude of midwives was moderate (median = 74%, IQR = 12.5%), with (n=103, 65.2%) of them having moderate attitude levels, and was significantly higher among younger midwives, bachelor's degree holders, single midwives, and those who received related training.

The overall barriers towards reproductive health care for women with disabilities were perceived as moderate (median = 78.82%, IQR = 13.24), which was significantly perceived higher among midwives with higher educational levels and who received related training. Lastly, awareness and attitude levels were not significantly correlated, while the awareness levels were significantly correlated with perceiving more barriers ($r = 0.252$, $p\text{-value} = 0.001$), and the attitudes were negatively correlated with perceiving barriers ($r = -0.259$, $p\text{-value} = 0.001$).

Chapter Six

Discussion

6.1 Introduction

The following chapter is concerned with discussing the results of the current study, as the researcher compared the findings with what has been reviewed earlier in the literature review and provided critique comments from the researcher's point of view. Also, the current chapter provides a comprehensive conclusion of the study, followed by recommendations that are based on what has been discussed, and limitations that were addressed when conducting the study.

6.2 Discussion of Demographic Findings of the Current Study

The current study focused on a critical issue that faces women with disabilities, considering them one of the most underserved populations, especially in terms of healthcare services, therefore, the focus of the current study is a part serving both human rights and public health. This increases in importance when considering the unique socio-political and challenging situation of Palestine, related to complex healthcare infrastructure and socio-cultural dynamics. Also, the situation of Palestinian midwives should not be ignored in this area of research, where they work under significant pressure and constrained healthcare system (Hassan-Bitar & Narrainen, 2011), although their role is considered remarkable in addressing the needs of women with disabilities (Mortensen et al., 2019).

The methodological aspects of the current study, have several noticeable advantages in terms of sampling, where the study successfully recruited midwives from various age groups, ranging from 21 to 59 years old, reflecting a variety of experience levels. Also, the distribution of midwives according to their educational level reflects the actual distribution, where more than half of them hold a bachelor's degree (n=91, 57.6%).

The current study found that nearly half of the midwives (n=80, 50.6%) did not experience taking care of women with disabilities, which may indicate less than desired experience level, and can be related to a lack of exposure caused by less sufficient opportunities to develop necessary skills (Nguyen, 2020). The training deficiencies, as (n=141, 89.2%) of the participating midwives in this study did not receive specific training for the care of women with disabilities were similar to the findings of Smeltzer et al. (2018). This also explored the barriers that hinder women with disabilities from seeking health care, such as stigmatization, lack of accessible facilities, and inadequate referral system in addition to the low number of women with disabilities to be cared for by the targeted midwives in this study.

6.3 Discussion of the Awareness, Attitude and Perceived Barriers Findings of the Current Study

The median scores of awareness and attitude of midwives towards reproductive health care for women with disabilities show that the overall levels are satisfying, with a median awareness score of 7 and a median attitude score of (74%). On the other hand, awareness levels showed more percentage of the high category (n=78, 49.4%) than of the attitude levels (n=46, 29.1%), which means that despite having a sufficient level of awareness, it doesn't necessarily indicate a proper attitude level, and that attitude of midwives can be directly or indirectly affected by other factors rather than awareness, which also appears in the absent of a significant correlation between awareness and attitude scores ($r = 0.112$, $p\text{-value} = 0.163$).

Perceived barriers in this study showed a moderate median score of (78.82%), with almost all of the midwives perceiving moderate (n=78, 49.4%) or high (n=76, 48.1%) levels of barriers toward delivering reproductive health care for women with disabilities. The perceived barriers level seems to be the more obvious factor to be affected by the awareness and attitude of midwives, where a significantly positive correlation was found between having higher awareness and more perceived barriers ($r = 0.252$, $p\text{-value} = 0.001$), and between lower awareness and more perceived barriers ($r = - 0.259$, $p\text{-value} = 0.001$).

The positive correlation between midwives' awareness and perceived barriers in this study can be explained by the higher recognition of midwives to the barriers that exist in providing appropriate care, resulting in having more awareness of the systemic and logistical issues, like lack of accessible facilities, inadequate training, and insufficient support system, which may be unnoticed among midwives with less awareness. It was also emphasized in the study of Smeltzer et al. (2018), that the midwives' attitudes toward the reproductive care of women with disabilities are often related to their awareness of the needs of women with disabilities at the reproductive stage, which helped them to realize the barriers that hinder effective care.

Moreover, the negative correlation between midwives' attitudes and their perceived barriers in this study can be related to the positive impact of higher attitudes on the sense of commitment and willingness of midwives to face the challenges of caring for women with disabilities. Midwives in Palestine might try to help women with disabilities overcome the barriers, as they often seem to be proactive in meeting the needs of the women at the reproductive stage. A previous study suggested that enhancing midwives' attitudes in this area of care makes them more likely to engage effectively in providing the necessary care (Nguyen, 2020).

The sociodemographic characteristics that were found to significantly associated with the midwife's awareness, attitude and perceived barriers was their level of education. The higher educational levels resulting in higher awareness scores, and they perceived barriers more than those with lower educational levels. This was inconsistent with the attitude's correlation, as the highest attitude score was correlated with the lower educational level of the midwives as bachelor's degree. These findings support the idea that higher educational level results in more exposure of midwives to broader curriculum that covers both theoretical knowledge and practical skills, which allows them to better understand complexities in providing reproductive health care. The previous study of Höglund et al. (2013) reported that midwives faced difficulties to acquire suitable knowledge and skills about women with disabilities in the reproductive stage. There was relatively high agreement on this as a barrier by the midwives who participated in the current study in which (n=88, 55.7% agree and n=37, 23.4% strongly agree). Also, this supports the idea that higher educational level tends to positively increase the midwives' awareness of the systemic aspects of health care delivery, resulting in more exposure and perception of the challenges they face.

Previous studies stated that a major barrier that is faced by the women with disabilities when receiving reproductive health care services is the difficulties of gynecological examination, facilities and equipment accessibility (Fletcher et al., 2023; Haque et al., 2023). This is parallel with the findings of the current study related to the high agreement among midwives on perceiving barriers related to lack of appropriate reproductive health care facilities and services (n=96, 60.8% agree) and medical equipment (n=95, 60.1% agree). Such barriers and others that were found in the current study are also consistent with the findings of the previous systematic reviews of M. Tara Casebolt (2020) and Ganle et al. (2020), especially in aspects of physical, attitude and stereotyping barriers. It is important to address the specific physical barriers in the healthcare facilities that face women with disabilities when receiving reproductive health care, which were stated in previous literature, like inappropriate examination tables, inadequate parking and elevators (Burke et al., 2017).

Further, the current study found that (n=57, 56.3%) of the midwives agree on the barrier related to women with disabilities being afraid of being exposed to stereotyping and stigmatization, and with relatively more disagreement that women with disabilities are incapable of being pregnant and giving birth (n=57, 36.1% disagree and n=28, 17.7% strongly disagree). These findings were consistent with the study of Elkhateeb and Peter (2019), who focused on the prohibition of women with disabilities by their families to marry, which is added to being afraid of the negative sociocultural attitudes towards these marriages. Such findings are important to be emphasized to address the sociocultural barriers that contribute to the stigmatization and stereotyping of women with disabilities. There is a need for collaborative efforts with community leaders and families to shift cultural perceptions about women with disabilities and reduce the negative attitudes towards the marriage and reproductive rights of these women. This can be done by prioritizing community education, cultural sensitivity training for healthcare providers, and active engagement with families.

The high agreement of midwives related to specific physical barriers to provide appropriate reproductive health care for women with disabilities related to lack of facilities and equipment is consistent with the previous studies of Castell and Stenfert Kroese (2016) and Haque et al. (2023), where they showed that midwives with agreement on such point play an important role in advocating for the accessibility of equipment and facilities for women with disabilities.

Moreover, the midwives' role extends to educating women with disabilities about sexual health and intimate relationships, which was stated in the previous study of Höglund et al. (2013). These findings are also consistent with specific findings of the current study related to high agreement of midwives on their need to educate women with disabilities about their sexual and reproductive health at a young age (n=82, 51.9% agree and n=52, 32.9% strongly agree), family planning methods (n=66, 41.8% agree and, n= 72, 45.6% strongly agree) and their rights toward sexual and reproductive health (n=77, 48.7% agree and n=67, 42.4% strongly agree). Based on such discussion, it is recommended for policymakers and union members to empower and support the reproductive health of women with disabilities. It is necessary to develop comprehensive educational programs that target both midwives and women with disabilities, and therefore both high quality of care and support are served. Women with disabilities are in need for educational improvement in terms of their sexual and reproductive healthcare, which is agreed by the findings of previous literature that showed deprived knowledge levels among them (Kassa et al., 2016; Nguyen et al., 2018).

More than three fourths of the midwives in the current study (n=124, 78.5%) stated that women with disabilities are in need for sexual and reproductive health care as women without disabilities, which goes parallel with the findings of the Indian study of Gudlavalleti et al. (2014). The previous studies stated that barriers related to lack of knowledge about the availability of healthcare services, are their costs and transportation issues, which were commonly perceived as barriers among women with disabilities (Shiwakoti et al., 2021). The findings of the current study also agreed with these perceived barriers, where (n=66, 41.8%) of the midwives agree and (n=45, 28.5%) strongly agree on the high costs of reproductive healthcare services related to disability-focused needs, with (n=67, 42.4%) agree and (n=38, 24.1%) strongly agree that the lack of insurance and referrals is another financial barrier, which is also consistent with the findings of previous literature. Addressing the financial barriers and trying to overcome them is a highly recommended action to be considered by policymakers, which can be added to the charity and non-governmental efforts in this area of support.

6.4 Comparison Between Awareness, Attitude and Perceived Barriers of Reproductive Health Care for Women with Disabilities in the Current and Previous Studies

In the study of H. R. Devkota, E. Murray, et al. (2017) in Nepal, the results showed that the attitude of healthcare providers who participated in their study was significantly better among auxiliary (aid) nurses, which indicates a better attitude level in converse with the educational level. This was partially found in the current study, where the attitude level of midwives towards reproductive health care for women with disabilities significantly differed according to educational level (p-value < 0.001), but the highest attitude score was among midwives with bachelor's degree, and secondly among midwives with diploma degree and the lowest when having higher education's degree. The inconsistency in such comparison can be related to specific factors related to higher work pressure and responsibilities for midwives with higher educational levels. Also, the previous study showed that younger healthcare providers tended to have better attitude levels, which is also partially consistent with the findings of the current study, where attitude levels significantly differed across age groups, with the highest attitude score among 21 – 25 and 31 – 35 years old groups (p-value = 0.014), with generally a significant converse correlation between age and attitude score (r = - 0.203, p-value = 0.010). Both comparisons may add to each other, where midwives with lower educational level are younger in age, and did not face more complex responsibilities in reproductive health care. While the current study did not implement the qualitative approach, the previous study found in their qualitative part that women with disabilities find healthcare providers to have poor knowledge,

negative attitudes and inadequate skills, which were addressed and had high agreement levels when the midwives in the current study answered about statements related to perceived barriers. The similarities in findings are present while both studies were conducted in different places, have different sample size and design, and the previous study recruited a variety of healthcare providers compared to only midwives in the current study.

One of the points that needs the most attention in terms of the barriers that face women with disabilities when seeking reproductive health care services is the negative attitude of the healthcare providers (Gartrell et al., 2017; Lee et al., 2015; Shandra et al., 2014). Such findings highlight the negative impact of negative attitude and stigmatization of the community in general, and specialized healthcare providers in specific, on the satisfaction and outcomes of reproductive healthcare for women with disabilities. Also, the current study found some consistent results, where the agreement level was high among midwives in terms of the barriers related to fear of stigmatization (n=89, 56.3% agree), embarrassment (n=96, 60.8% agree), and midwives having inadequate training (n=88, 55.7% agree). Moreover, the current study found that negative attitudes significantly correlate with higher perceived barriers of reproductive health care for women with disabilities ($r = - 0.259$, $p\text{-value} = 0.001$). Therefore, it is recommended to increase the awareness and improve the attitude of midwives towards this type of care, by addressing the uniqueness of care of women with disabilities.

6.5 Conclusion

This study aims to assess the midwife's knowledge, attitudes, and perceived barriers toward reproductive health care services for women with disabilities in the northern region of the West Bank/Palestine. The study implemented a cross-sectional, quantitative design, and recruited a convenient sample of 158 midwives from different private and governmental hospitals in West Bank, Palestine. The researcher distributed a questionnaire with close-ended questions that was developed based on previous literature, and was analyzed using SPSS software, with full commitment to ethical considerations of anonymity and confidentiality.

Main results showed a median midwives' age of 29 years old (IQR = 8.25), and experience of years (IQR = 8), (n=91, 57.6%) holding bachelor's degree, (n=80, 50.6%) not provided a care for women with disabilities and (n=141, 89.2%) not receiving a specialized training for it. The median knowledge score was 7 out of 10, with (n=78, 49.4%) having a high level of knowledge, a median attitude score of (74%), with (n=103, 65.2%) having a moderate attitude level, and a median score of (78.82%) for perceived barriers, with physical barriers, like lack of facilities, medical equipment and equipped transportation, found to be the highest agreed domain of barriers.

Midwives in this study reported that women with disabilities face several barriers when receiving reproductive healthcare services, which include attitudes of healthcare providers and the overall community, communication, stereotyping, financials and others. Educational level significantly affected all outcomes, while attitude was significantly related to midwives' age, social status and training. The perceived barriers were significantly related to receiving training and were significantly correlated with higher awareness of the midwives about reproductive health care for women with disabilities. Perceived barriers were also correlated with lower attitude scores. These findings were generally consistent with the findings of previous literature, with slight variations related to the unique situation of the Palestinian context.

6.6 Recommendations

Based on the discussion of the current study findings, the researcher recommends the following:

6.6.1 Recommendations for midwives

1. Midwives should receive regular and specialized training programs that focus on the unique needs of women with disabilities in the reproductive stage. These trainings should cover the reproductive health care needs of these women, the required care and to address and reduce stigmatization and stereotyping as an important issue.
2. Midwives also need to advocate for the improvements of the facilities that provide
3. reproductive health care for women with disabilities, as well as playing a critical role in the education of these women about their sexual and reproductive health.

6.6.2 Recommendations for Healthcare Facilities

1. Healthcare facilities should prioritize the installment of appropriate equipment to overcome several physical barriers that are addressed by both midwives and women with disabilities, which will provide a safe care environment.
2. Provide cultural sensitivity training and awareness campaigns to support the positive attitude of midwives towards these women.
3. Implement actions that strengthen the referral and insurance systems for women with disabilities to overcome their financial barriers of appropriate care.

6.6.3 Recommendations for policymakers

1. Implement policies and protocols that mandate the inclusion of accessible reproductive health care services in the facilities, as well as the healthcare providers to receive the appropriate training in this area.
2. Enhance the funding and structural support that provide reproductive health care for women with disabilities, including in the facilities and equipment.
3. Implement community educational programs to change the sociocultural attitudes towards these women, and focus on areas of decreasing stigmatization and promoting reproductive healthcare rights.

6.6.4 Recommendations for future research

1. Conduct longitudinal or pre-post studies that aim to test the impact of educational programs on the awareness and attitude levels of midwives towards reproductive health care for women with disabilities.
2. Implement qualitative research design to explore the individual experience of women with disabilities in accessing, and midwives in providing, health care services in Palestine.
3. Implement study in other governorates in Palestine and include Nurses and midwives in the primary health care centers as well as in hospitals.

6.7 Limitations

The study was limited by the following points:

1. Although the sample size is adequate for a quantitative approach, the study was limited by low number of midwives in each hospital of the targeted areas, which can be improved in future research by recruiting larger number of midwives from the rest of West Bank – Palestine.
2. Sometimes, there was a decreased level of participation among the midwives, which is mostly related to their work pressure, and this can be overcome by trying to use softer methods of data collection, like online form and reminders.
3. The use of cross-sectional design was limited by time constraints related to academic pressure, in which a longitudinal or pretest-posttest design could have provided more in-depth findings.

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Annexes

Figures

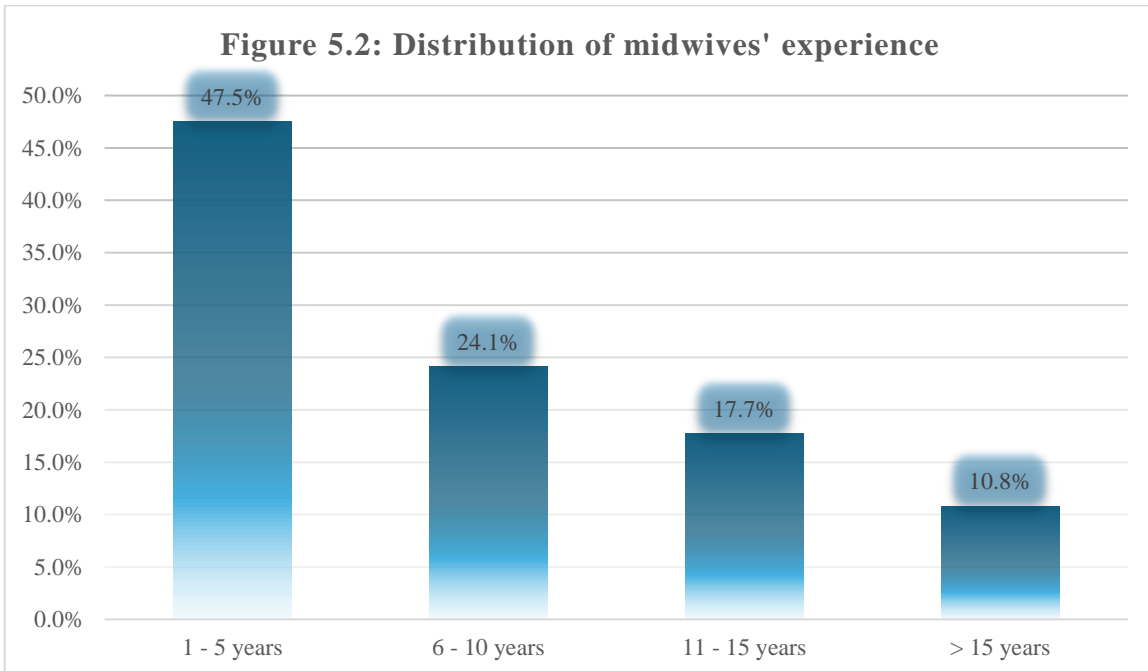
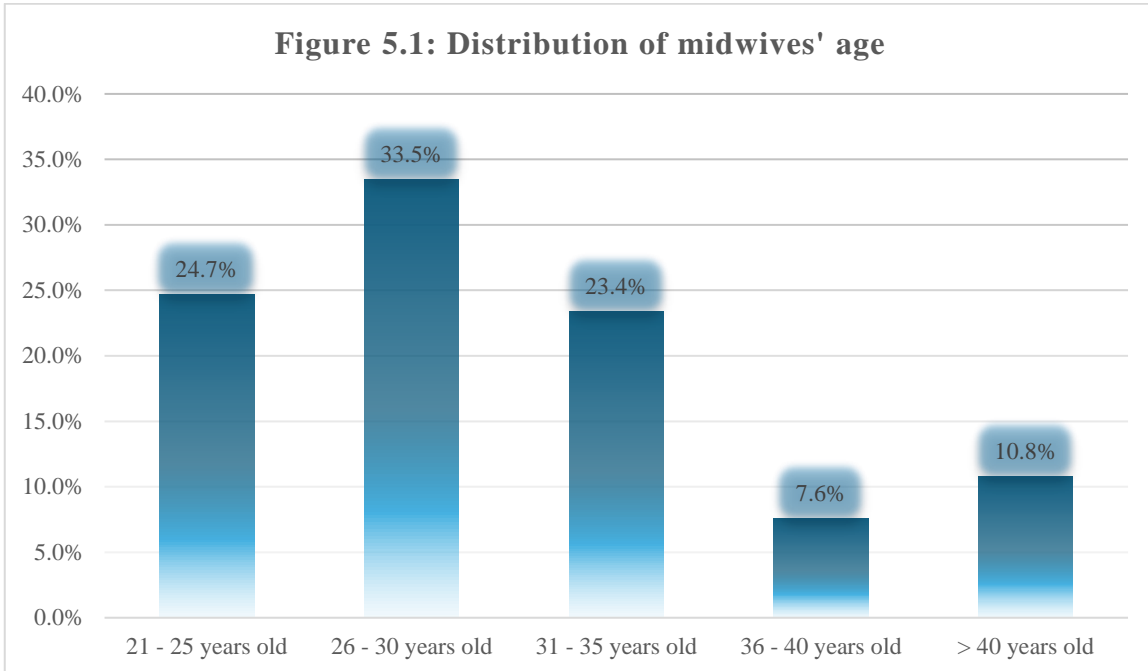


Figure 5.3: Distribution of midwives' educational level

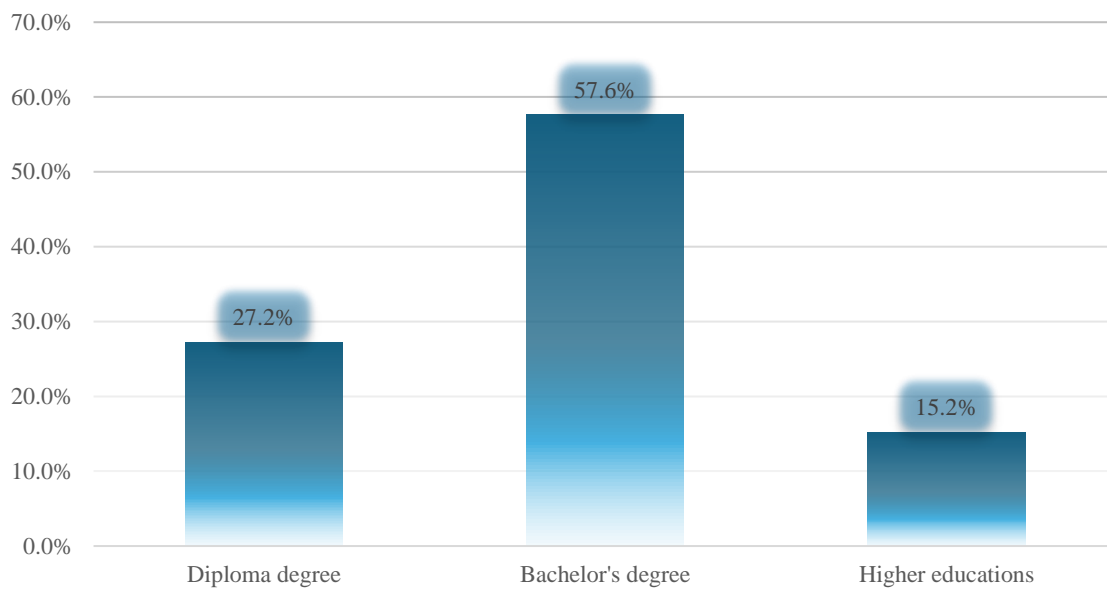


Figure 5.4: Distribution of midwives' workplace type

■ Governmental sector ■ Private sector

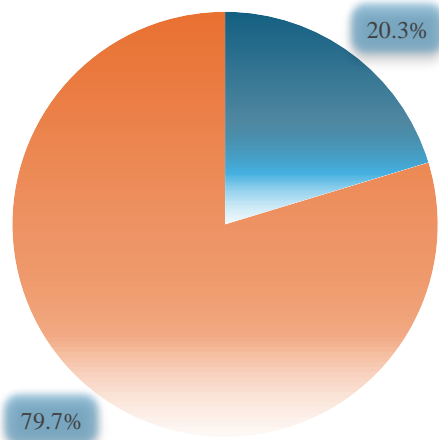


Figure 5.5: Distribution of midwives' social status

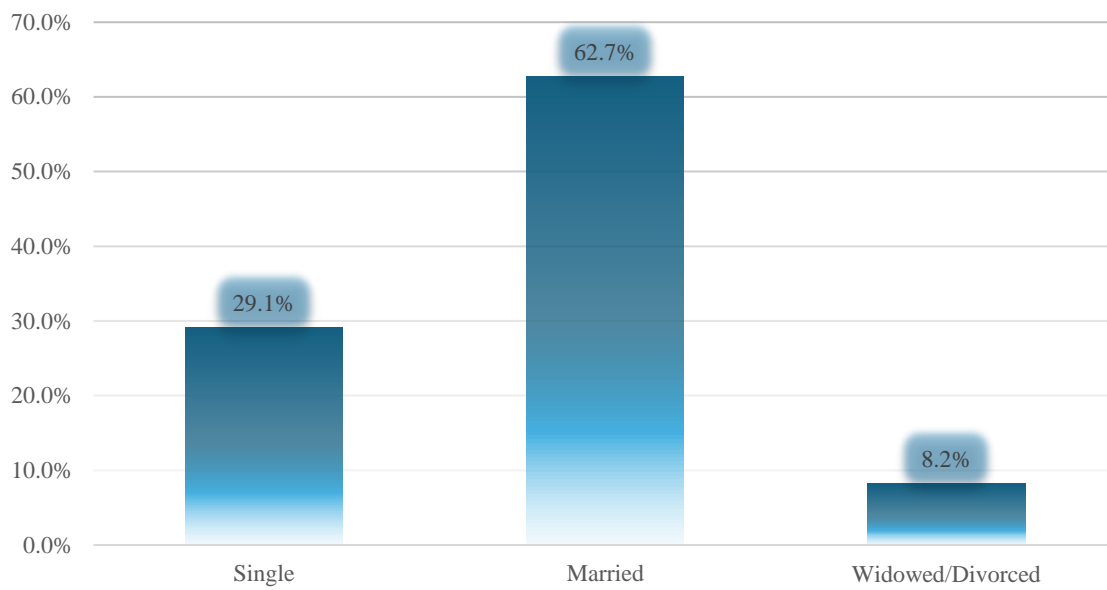


Figure 5.6: Distribution of midwives who provided care for women with disabilities

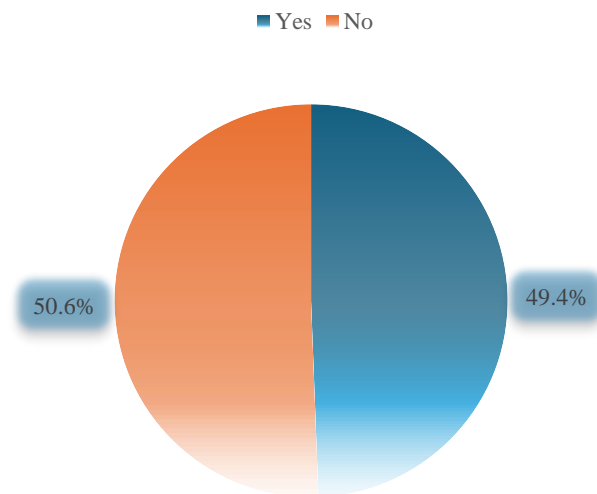


Figure 5.7: Distribution of type of disabilities among women whom midwives took care of

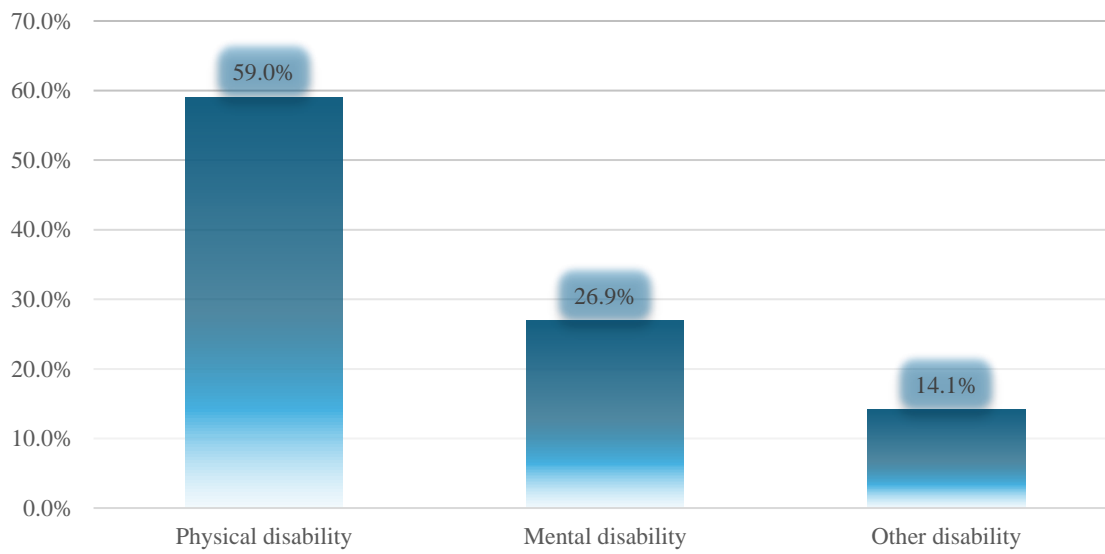


Figure 5.8: Distribution of midwives who received training on caring for women with disabilities

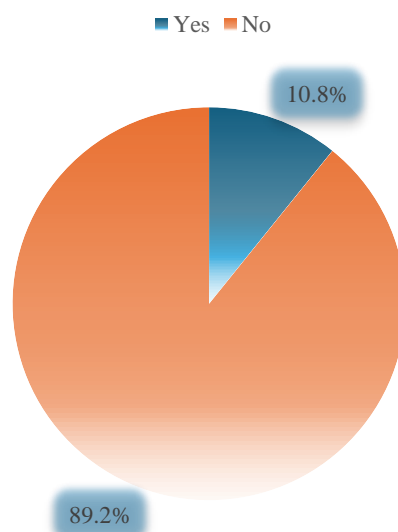


Figure 5.9: Distribution of midwives' knowledge levels about reproductive health of women with disabilities

■ Poor knowledge ■ Moderate knowledge ■ High knowledge

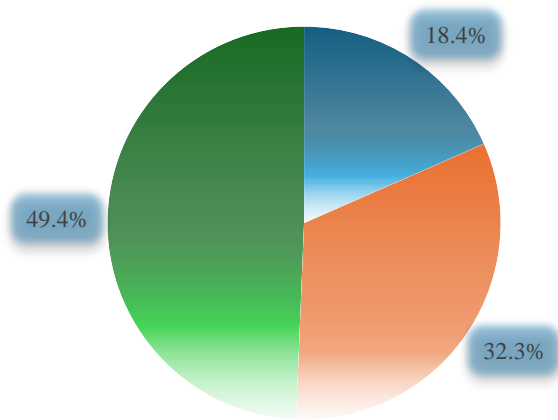


Figure 5.10: Distribution of midwives' attitude levels towards reproductive health of women with disabilities

■ Poor attitude ■ Moderate attitude ■ Positive attitude

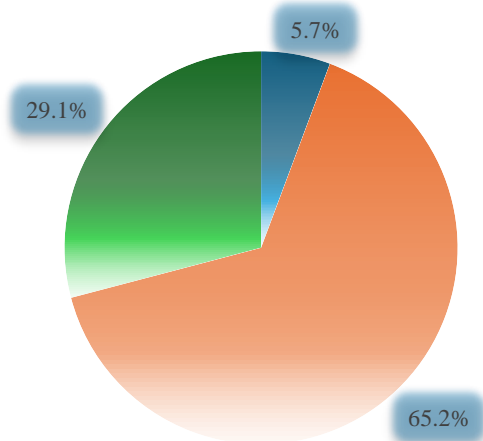
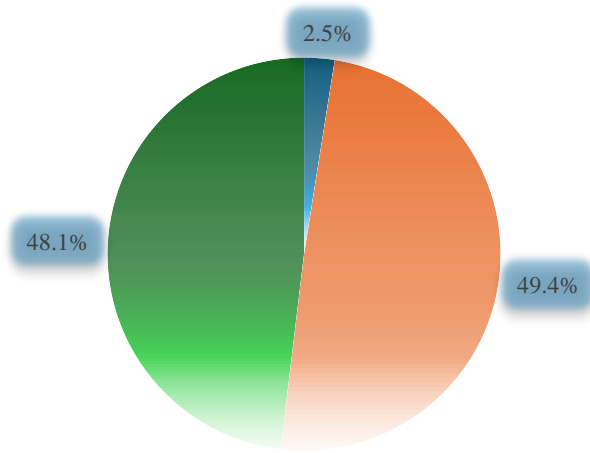


Figure 5.11: Distribution of midwives' perceived barriers towards reproductive health of women with disabilities

■ Low barrier level ■ Moderate barrier level ■ High barrier level



Ethical Approval from University



Research Ethics Subcommittee of Faculty of Health Professions Letter of approval

April 29, 2023
Ref. No.: RESC/2023-31

Dear Applicants, (Dr. Maha Nahhal, Ms. Alaa Qaadani)

Program: MSc Nursing Department

The Research Ethics subcommittee of the Faculty of Health Professions has recently reviewed your proposal entitled (**Midwives' awareness of caring for women with disabilities and perceived barriers during antenatal and childbirth in the northern region of the West Bank**) submitted by (Dr. Maha Nahhal). Your proposal is deemed to meet the requirements of research ethics at Al-Quds University, but further assessment is required by the Central Research Ethics Committee of Al-Quds University. We wish you all best for the conduct of the project.

Hussein ALMasri, PhD
Associate Professor of Medical Imaging
Research Ethics Subcommittee Chair
Faculty of Health Professions

Hussein ALMasri

CC: File
CC: Committee members

Permission for Hospitals

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3- مستشفى ثابت ثابت الحكومي - مديرية صحة طولكرم

4- مستشفى خليل سلمان الحكومي - مديرية صحة جنين

5- مستشفى الحكومي التركي الحكومي - مديرية صحة طوباس

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حضرة الاستاذة غادة حسن المحترمة

نائب مدير مستشفى الامل / جنين

الموضوع : تسهيل مهمة بحث

تحية وبعد ..

يرجى تسهيل مهمة الطالبة : آلاء واصف جميل قعدان رقمها الجامعي "22112729" - برنامج ماجستير صحة امومة وطفولة / جامعة القدس ، في عمل بحث بعنوان :

"دراسة حول وعي القابلات نحو الصحة الإيجابية للنساء ذوات الإعاقة والعوائق التي تواجه تلك النساء في شمال الضفة الغربية - فلسطين"

Midwives' awareness of caring for women with disabilities and perceived barriers during antenatal and childbirth in the northern region of the West Bank

بإشراف الدكتورة: مها نحال.

يرجى السماح للطالبة آلاء واصف جميل قعدان بالحصول على المعلومات اللازمة لبحثها من خلال توزيع الاستبيان المرفق على القابلات اللاتي يعملن في مشفاكم (بعد أخذ موافقتهن على المشاركة). سيتم توزيع الاستبيان في الفترة الواقعة 2024/2/15 حتى 2024/5/15

وتفضلوا بقبول الاحترام والتقدير...

منسق برنامج الماجستير / دائرة التمريض

Dr. Kefach Zabin

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Questionnaire of the Study

Midwives' awareness and perceived barriers toward reproductive health of women with disabilities in the northern region of the West Bank

Informed Consent

Dear Participant:

I am a master's student at Al-Quds University, kindly invite you to participate in this research study. The study is carried out as part of fulfilling the requirements for a master's degree in Maternal child health. **This study aims to assess the midwives 'awareness and perceived barriers toward reproductive health care services for women with disabilities in the northern region of the West Bank.** Your participation is voluntary, your cooperation is highly appreciated. You have the right to withdraw at any time during the data collection process without limitation. Filling out the questionnaire will not take more than 15 minutes of your time, and assuring that your answers will be kept anonymous and confidential and will be used for research purposes only. If you have any further inquiries about the questionnaire, please contact Mrs. Alaa' Qa'dan .

Researcher: Ala' Qa'dan . Phone number: 00972 598925475

Supervised By: Dr. Maha Nahal

Part I: Demographic Data

lease put a tick mark (√) next to your choice on the following items:

1-1 Ageyears

1-2 Experienceyears

1-3 Education Level Diploma Bachelors Postgraduate

1-4 Type of hospital/facility: Governmental Private

1-5 Social Status Married Single Widow/ Divorced

1-6 Have you ever provided care to women with disability? Yes No

• if you answered yes for Q6, state the type of disability?

physical disability Intellectual disability Others

1-7 Have you had training in caring for women with any type of disability?

Yes No

Part II: Assessing the knowledge of the Midwives toward reproductive health of women with disabilities.

Please put a tick mark (√) taking into consideration that 1 means Yes, 2 means No, 3 means Don't know:

Statement: Midwives knowledge of reproductive health among women with disabilities	Yes	No	I don't know
1. Women with disabilities often experience negative reactions to the idea of becoming parents.			
2. women with disabilities often experience stress, risk and harmful Pregnancy and childbirth			
3. Women with disabilities have sexual and reproductive needs as women without disabilities			
4. Women with disabilities are often not sure about their abilities to give adequate care for an infant and be a good mother..			

5. Women with disabilities often do not have custody of their children.			
6. women with disabilities often did not get the required reproductive care due to the difficulties they faced in their access and use of the resources.			
7. Women with disabilities often are good mothers if given specialized care			
8. Women with disabilities often delivered by cesarean section but they can give birth vaginally			
9. Midwives need to be trained in the sexual and reproductive health of women with disabilities of different types			
10. Midwives are qualified to provide teaching and counseling for women with disabilities to ensure safe pregnancy, labor, and post-natal period			

Part III: Midwives' attitudes toward the reproductive health of women with disabilities.

Please put a tick mark (✓) taking into consideration that 1 means Strongly agree, 2 means agree, 3 means Neutral, 4 means Disagree, and 5 Means strongly Disagree:

	Midwives' attitudes	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	I am not well prepared to satisfy the reproductive health care needs of women with a physical disability					
2	I can communicate well with women with disabilities to increase their competency and confidence in					

	themselves and their reproductive health abilities					
3	I can't listen to the views and questions of women with disabilities, it is a waste of time					
4	I believe that women with disability are often incapable of getting pregnant or giving birth to a child.					
5	I do not hold any prejudiced attitudes or discrimination about women with a disability who seek sexual and reproductive health services					
6	I believe that women with disabilities should be informed about their sexual and reproductive health needs at young age					
7	I believe that women with disabilities are in high need of family support in sexual and reproductive health issues					
8	I believe that Women with disabilities should be informed about family planning methods to avoid unwanted and illegal pregnancies					
9	I believe that it is essential to teach Women with disabilities about their rights toward sexual and reproductive health.					
10	I think that women with disabilities will reduce their visits to reproductive health services to avoid social stigma					

Part V: Perceived barriers to the reproductive healthcare for women with disabilities?

	Statement: Perceived barriers to reproductive health care for women with disabilities	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
❖	Physical barriers:					
1	lack of appropriate reproductive health care facilities and services for women with disabilities..					
2	Lack of required medical equipment and devices that help women with disabilities obtain integrated reproductive care..					
3	Lack of equipped transportation that makes the reproductive health services inaccessible for women with disabilities					
❖	Negative Attitudes and Stereotypes:					
1	women with a disability might be afraid of being exposed to stigma and stereotypes about their disability by healthcare providers.					
2	women with a disability might be afraid of embarrassment as being examined by the healthcare providers					
3	Women with disabilities may feel stigmatized and discriminated against by non-disabled women in reproductive health care facilities					

1	Midwives lack knowledge and awareness about the sexual and reproductive healthcare needs of women with disabilities through not receive adequate training					
2	Midwives lack knowledge and awareness about the rights of women with disabilities in sexual and reproductive health					
❖	Communication Barriers:					
1	Women with disabilities face difficulties in communicating with healthcare providers in the health care facility					
2	Women with disabilities face difficulties in understanding the given advice and instructions regarding their reproductive health					
3	Women with disabilities face physical and emotional disturbances due to Poor communication with healthcare providers					
❖	Financial Barriers:					
1	Lack of insurance for getting the required reproductive health care services for women with disabilities					
2	low income and poor economic status of the women with disability					

❖	Legal and Policy Gaps:					
1	Healthcare policies towards the unique sexual and reproductive health care needs of women with disabilities are not available					
2	sexual and reproductive healthcare programs are lacking the flexibility and responsiveness to meet the special needs of women with disability.					
3	Diagnostic and therapeutic measures for reproductive health and waiting, and referral procedures are confusing for women with disabilities					
❖	Others:					
1	Fear of pain or discomfort when being investigated in the reproductive health care centers					
2	The lack of family and social support for women with disabilities may contribute to their isolation and difficulties in understanding their needs and rights of reproductive health					

الاستبيان باللغة العربية

وعي القابلات والعوائق المحسوسة نحو الصحة الإيجابية للنساء ذوات الإعاقة في شمال الضفة الغربية – فلسطين

نموذج الموافقة

عزيزتي المشاركة

تقوم هذه الدراسة على جمع البيانات من أجل تقييم مدى وعي القابلات حول رعاية الصحة الإيجابية المقدمة للنساء ذوات الإعاقة ومعرفتهن بالعوائق التي قد تواجه النساء ذوات الإعاقة وتحد من تلقيهن لخدمات الصحة الإيجابية في شمال الضفة الغربية من فلسطين. تجرى هذه الدراسة كمتطلب أكاديمي من أجل الحصول على درجة الماجستير في صحة الام والطفل من جامعة القدس أبو ديس. نتائج واستنتاجات هذه الدراسة ستساعد في زيادة وعي القابلات حول أهمية الرعاية المقدمة للنساء ذوات الإعاقة. مشاركتكم في الإجابة على هذا الاستبيان طوعية وتخدم البحث العلمي، وتعاونكم له كل التقدير والاحترام. ولن تستغرق الإجابة على هذا الاستبيان أكثر من (15) دقيقة. سيتم توفير السرية الكاملة لإجاباتكم كما يمكنكم الانسحاب من الدراسة في أي وقت او حين لا ترغبون بالاستمرارية للمشاركة. أشركم جزيل الشكر على مشاركتكم ويرجى الاتصال مع الباحثة على الهاتف المرفق في حال احتياجكم لأي استفسار.

اسم الباحثة: اء قعدان التلغون 0598925475

اسم المشرفة: د. مهى نبال

الجزء الأول : المعلومات السكانية أو الشخصية

ضعي إشارة (√) في المكان المناسب لإجابتك:

1-1 العمر :سنوات

2-1 الخبرة:سنوات

3-1 الدرجة العلمية : دبلوم بكالوريوس دراسات عليا

4-1 مكان العمل : حكومي خاص

5-1 الحالة الاجتماعية عزباء متزوجة أرملة / مطلقة

6-1 هل سبق وقدمت العناية والرعاية للنساء ذوات الاعاقة ؟ نعم لا

• إذا كان جوابك نعم للسؤال السادس فأى نوع من الإعاقة ؟

أعاقة جسدية أعاقة فكرية أخرى

7-1 هل تلقيت أي تدريب للعناية بالنساء ذوات الاعاقة ؟ نعم لا

الجزء الثاني: تقييم معرفة القابلات نحو الصحة الإيجابية لدى النساء ذوات الإعاقة
الرجاء وضع إشارة (√) آخذين بعين الاعتبار أن (1) يعني نعم , (2) لا , (3) لا أعلم

	لا أعلم	لا	نعم	لدى القابلات معرفة بالصحة الإيجابية لدى النساء ذوات الاعاقة
1				النساء ذوات الاعاقة يواجهن ردة فعل سلبية تجاه فكرة أن يصبحن والداً
2				تعاني النساء ذوات الاعاقة من التوتر والمخاطرة والحمل والولادة المؤذية
3				لدى النساء ذوات الاعاقة رغبات وحاجات جنسية وإيجابية كما النساء صحيحات الجسم
4				النساء ذوات الإعاقة غالباً ما يكن غير واثقات من قدرتهن على توفير العناية الكافية للرضيع وأن يكن أمهات جيدات

5	النساء ذوات الإعاقة غالباً ليس لهن حق الوصاية على أطفالهن		
6	غالباً لا تتمتع النساء ذوات الإعاقة بالعناية الإيجابية المطلوبة بسبب الصعوبات التي تواجههم للوصول لتلك المصادر والاستفادة منها		
7	الأمهات ذوات الإعاقة هن غالباً أمهات جيدات إذا تلقين الرعاية التخصصية		
8	النساء ذوات الإعاقة غالباً ما يلدن أو ينجبن بالعمليات القيصرية ولكن من الممكن أن ينجبن بطريقة الولادة الطبيعية		
9	على القابلات أن يكنّ على دراية وتدريب عالٍ في التعامل مع النساء ذوات الإعاقة بمختلف أنواعها فيما يتعلق بالصحة الجنسية والإنجابية		
10	لدى القابلات القدرة لتعليم وإرشاد النساء ذوات الإعاقة لضمان الحمل الآمن والولادة الآمنة وما بعد الولادة		

الجزء الثالث : اتجاهات/ميول القابلات نحو الصحة الإنجابية للنساء ذوات الإعاقة

الرجاء وضع إشارة (√) أخذين بعين الاعتبار أن (1) يعني أوافق بشدة , (2) أوافق , (3) محايد , (4) لا أوافق , (5) لا أوافق بشدة

اتجاهات القابلات / القابلة	أوافق بشدة	أوافق	محايد	لا أوافق	لا أوافق بشدة
1 أنا غير متهيئة جيداً لتلبية حاجات الرعاية الصحية الإنجابية للنساء ذوات الإعاقة					
2 أستطيع التواصل بشكل جيد مع النساء ذوات الإعاقة لكي تزيد قدرتهن وثقتهن بأنفسهن وإمكانياتهن الصحية الإنجابية					
3 لا أستطيع الإصغاء إلى رأي وأسئلة النساء ذوات الإعاقة لأن ذلك مضيعة للوقت					

					4	أعتقد أن النساء ذوات الإعاقة غير قادرات على أن يحملن أو يلدن طفلاً
					5	ليس عندي أي تحامل أو إحفاف أو تمييز ضد المرأة ذات الإعاقة التي تسعى للحصول على خدمات الصحة الجنسية الإنجابية
					6	أعتقد أنه يجب تعليم النساء ذوات الإعاقة حاجات الصحة الإنجابية لديهن منذ الصغر
					7	أعتقد أن النساء ذوات الإعاقة بحاجة ماسة إلى الدعم العائلي فيما يخص القضايا الجنسية والصحة الإنجابية
					8	أعتقد أن النساء ذوات الإعاقة يجب أن يتعلمن ويعرفن وسائل التخطيط الإنجابي لكي يتجنبن أي حمل غير مرغوب به
					9	أعتقد أنه من الضروري أن يتعلم النساء ذوات الإعاقة حقوقهن نحو الصحة الجنسية والإنجابية
					10	أظن أن النساء ذوات الإعاقة سوف يقلن من زيارتهن للمراكز الصحية الإنجابية من أجل تجنب الوصمة الاجتماعية

الجزء الرابع: العوائق للرعاية الصحية الإنجابية لدى النساء ذوات الإعاقة

لا أوافق بشدة	لا أوافق	محايد	أوافق	أوافق بشدة	بيان: العوائق الملموسة أمام رعاية الصحة الإنجابية للنساء ذوات الإعاقة
					❖ محدودية الموارد والمصادر المساعدة
					1 هناك نقص في خدمات الصحة الإنجابية المقدمة للنساء ذوات الإعاقة
					2 هناك نقص في الأدوات والأجهزة الطبية التي تحتاجها النساء ذوات الإعاقة ليحصلن على العناية الإنجابية المتكاملة
					3 هناك نقص في وسائل المواصلات المجهزة مما يجعل الحصول على خدمات الصحة الإنجابية غير متاح لهؤلاء النساء ذوات الإعاقة
					❖ النمطية والاتجاهات السلبية:
					1 تخشى النساء ذوات الإعاقة من وصمة النقص والنموذج

					النمطي / النمطية من قبل مزودي خدمة الرعاية الصحية
					2 تخشى النساء ذوات الاعاقة من الشعور بالإحراج عند فحصهن من قبل مزودي خدمة الرعاية الصحية الإنجابية
					3 تخشى النساء ذوات الإعاقة الجسدية من شعورهن بالنقص الجسدي والتمييز ضدهن من غير العاجزات جسدياً فيما يخص خدمات الرعاية الإنجابية
					❖ محدودية المعرفة والوعي:
					1 تنقص القابلة المعرفة والوعي حول الحاجات الجنسية والإنجابية عند النساء ذوات الاعاقة من خلال عدم الحصول على التدريب الكافي
					❖ عوائق التواصل :
					1 تواجه هذه الفئة من النساء ذوات الاعاقة صعوبة في التواصل مع القابلة
					2 تواجه النساء ذوات الاعاقة صعوبات في فهم التعليمات والنصائح فيما يتعلق بالصحة الإنجابية
					3 تعاني النساء ذوات الاعاقة اضطرابات جسدية وعاطفية بسبب ضعف التواصل مع القابلة
					❖ المعوقات المالية :
					1 الرعاية الصحية الإنجابية تزداد تكاليفها كلما كانت مرتبطة بحاجات ذوات الاعاقة
					2 عدم وجود تأمين صحي يغطي ذوات الاعاقة من النساء
					❖ عوامل لها علاقة بالسياسات الصحية المتبعة
					1 سياسات الرعاية الصحية للحاجات الجنسية والإنجابية الفريدة للنساء ذوات الاعاقة غير متوفرة
					2 برامج الرعاية الجنسية والإنجابية تفتقد للمرونة والاستجابة لحاجات النساء ذوات الاعاقة
					3 معايير التشخيص والعلاج للصحة الإنجابية والانتظار وإجراءات الإحالة تتسبب في الإرباك للنساء ذوات الاعاقة
					❖ عوامل أخرى :

					1 تشعر النساء ذوات الاعاقة من الخوف من الألم عند الفحص في مراكز الرعاية الإنجابية
					2 عدم وجود الدعم العائلي والاجتماعي للنساء ذوات الاعاقة يساهم في مزيد من الصعوبات والعزلة لديهن في فهم حاجاتهن وحقوقهن في الرعاية الإنجابية

الملخص

عنوان الدراسة: وعي القابلات ومواقفهن والعوائق المدركة تجاه الصحة الإيجابية للنساء ذوات الإعاقة

في المنطقة الشمالية من الضفة الغربية

الباحثة: آلاء فعدان

المشرفة: د. مها نحال

المقدمة: تعد النساء ذوات الإعاقة من بين الفئات الأكثر حرماناً من الخدمات عندما يتعلق الأمر بالوصول إلى خدمات الصحة الجنسية والإنجابية، حيث يواجهن العديد من الحواجز - الجسدية والمالية والسلوكية والمتعلقة بالتواصل. تلعب القابلات دوراً حاسماً في معالجة وفهم الاحتياجات المحددة لهؤلاء النساء. لذلك، من الضروري أن تتمتع القابلات بالمعرفة الكافية وتنمية موقف داعم مناسب لضمان الرعاية الشاملة والفعالة.

الهدف: تهدف هذه الدراسة إلى استكشاف وعي القابلات الفلسطينيات ومواقفهن والعوائق المدركة لديهن تجاه رعاية الصحة الجنسية والإنجابية للنساء ذوات الإعاقة، كما تسعى للتحقق من العلاقة بين هذه المتغيرات والعوامل الديموغرافية الأكثر شيوعاً التي تؤثر فيها.

المنهجية: تم تنفيذ هذه الدراسة باستخدام تصميم مقطعي كمي على عينة ميسرة مكونة من 158 قابلة كن يعملن في المستشفيات الحكومية والخاصة المستهدفة في شمال الضفة الغربية - فلسطين. طُلب منهن ملء استبيان ذاتي التعبئة تم تحليله، مع الالتزام الكامل بسرية البيانات وعدم الإفصاح عنها كاعتبارات أخلاقية أساسية SPSS باستخدام برنامج النتائج: بلغ العمر الوسطي للقابلات 29 عامًا وخبرة 6 سنوات، وكانت الأغلبية منهن تحمل شهادة البكالوريوس، (حجم العينة = 91، 57.6%)، متزوجات (حجم العينة = 99، 62.7%)، يعملن في القطاع الخاص (حجم العينة = 126، 79.7%) ولم يتلقين تدريباً خاصاً برعاية الصحة الإيجابية للنساء ذوات الإعاقة (حجم العينة = 141، 89.2%). حوالي نصف القابلات كان لديهن مستوى عالٍ من المعرفة (حجم العينة = 78، 49.4%)، بينما كانت (حجم العينة = 103، 65.2%) منهن لديهن موقف معتدل، و (حجم العينة = 76، 48.1%) أدركن وجود مستوى عالٍ من العوائق، حيث إن العوائق المادية كانت الأكثر شيوعاً. لوحظ وجود ارتباط ذي دلالة إحصائية بين مستوى التعليم الأعلى والمزيد من المعرفة والعوائق المدركة، مع مواقف أفضل بين القابلات الأصغر سناً والعازبات، مع موقف أفضل ومستوى أعلى من العوائق المدركة بين القابلات اللواتي كما لوحظ وجود ارتباط ذي دلالة إحصائية بين العوائق المدركة العالية ومستوى ($p < 0.05$) تلقين تدريباً ذا صلة (قيمة

($p = 0.001$) المعرفة العالي والموقف المنخفض (قيمة

الخلاصة: تناولت الدراسة موضوعًا هامًا في مجال رعاية الصحة الجنسية والإنجابية لفئة مهمشة من المرضى، وأظهرت أن

القابلات في فلسطين يمتلكن مستوى عاليًا من المعرفة ومستوى مقبولًا من المواقف والعوائق المدركة. يلعب مستوى المعرفة

والتدريب دورًا هامًا في تحسين المواقف وإدراك المزيد من العوائق. يوصى بتدريب المزيد من القابلات وتنفيذ أبحاث نوعية

في هذا المجال لكلا الفئتين: النساء ذوات الإعاقة والقابلات في فلسطين

الكلمات المفتاحية: الوعي، المعرفة، المواقف، العوائق المدركة، النساء ذوات الإعاقة، الصحة الجنسية، الصحة الإنجابية،

الصحة الأمومية