RESPECTFUL MATERNITY CARE (RMC) AMONG HEALTH WORKERS IN MALAWI: A QUANTITATIVE ANALYSIS OF SELF-REPORTED EXPERIENCE AND PRACTICE

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KEY FINDINGS

- **Provider-reported RMC offers insights into quality of care from the perspectives of health workers; differs between self and others**
- **Inverse associations between RMC, years of experience, and time spent in training may reflect system-level support issues**
- **Greater clinical knowledge and confidence associated with higher RMC**
- **Reports of physical and verbal abuse were infrequent, but opportunities exist to improve communication and autonomy**

BACKGROUND

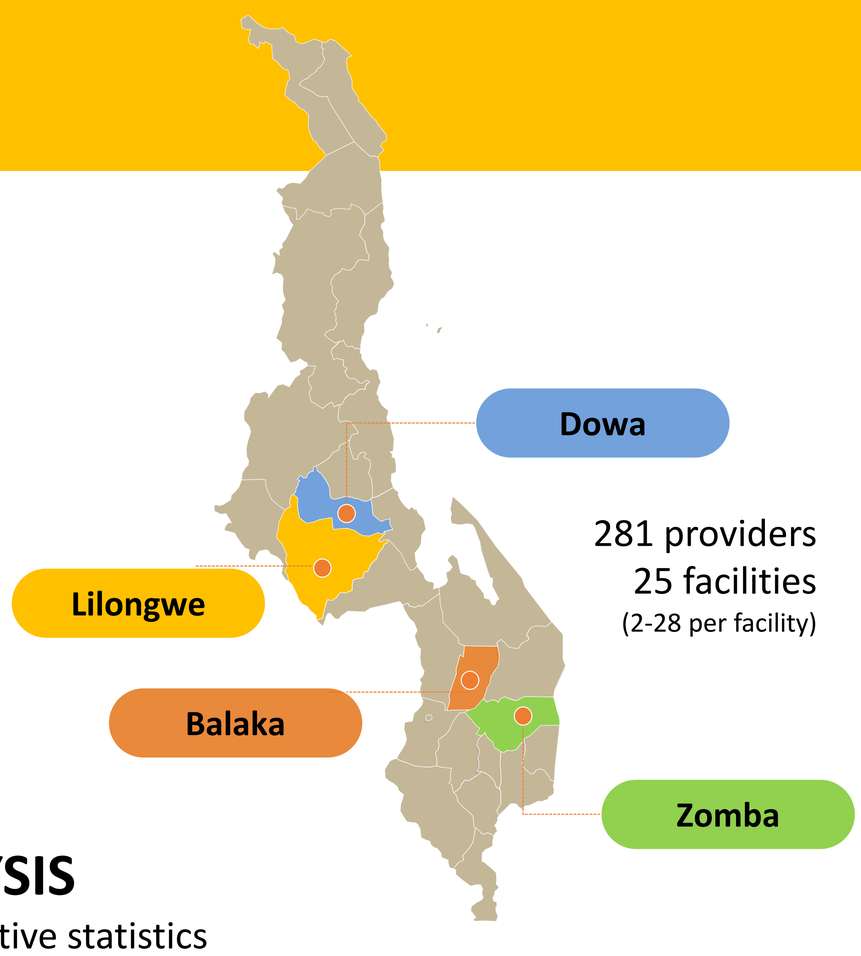
- Respectful maternity care (RMC) as a basic human right and critical to quality of care
- Disrespect and abuse is complex, yet most studies rely only on women's perspectives
- Health workers often lack the tools, training, and support provide respectful care
- Health workers are critical to improve quality of care and develop interventions

OBJECTIVES

- Describe providers' perceptions of RMC provision in Malawi
- Identify provider, facility, or system factors that may predict RMC
- Identify opportunities to improve quality and experience of care

METHODS

- Multi-site cross-sectional survey of health workers in Malawi
- Data collected in March 2020 (pre-COVID-19 shutdown in-country)
- RMC measured using 15-item person-centered maternity care (PCMC) scale, measured as continuous variable
- Predictors included provider-, facility-, and system-level factors



281 providers
25 facilities
(2-28 per facility)

DATA ANALYSIS

- Generate descriptive statistics
- Create and evaluate bivariable and multivariable linear regression models, adjusted for clustering

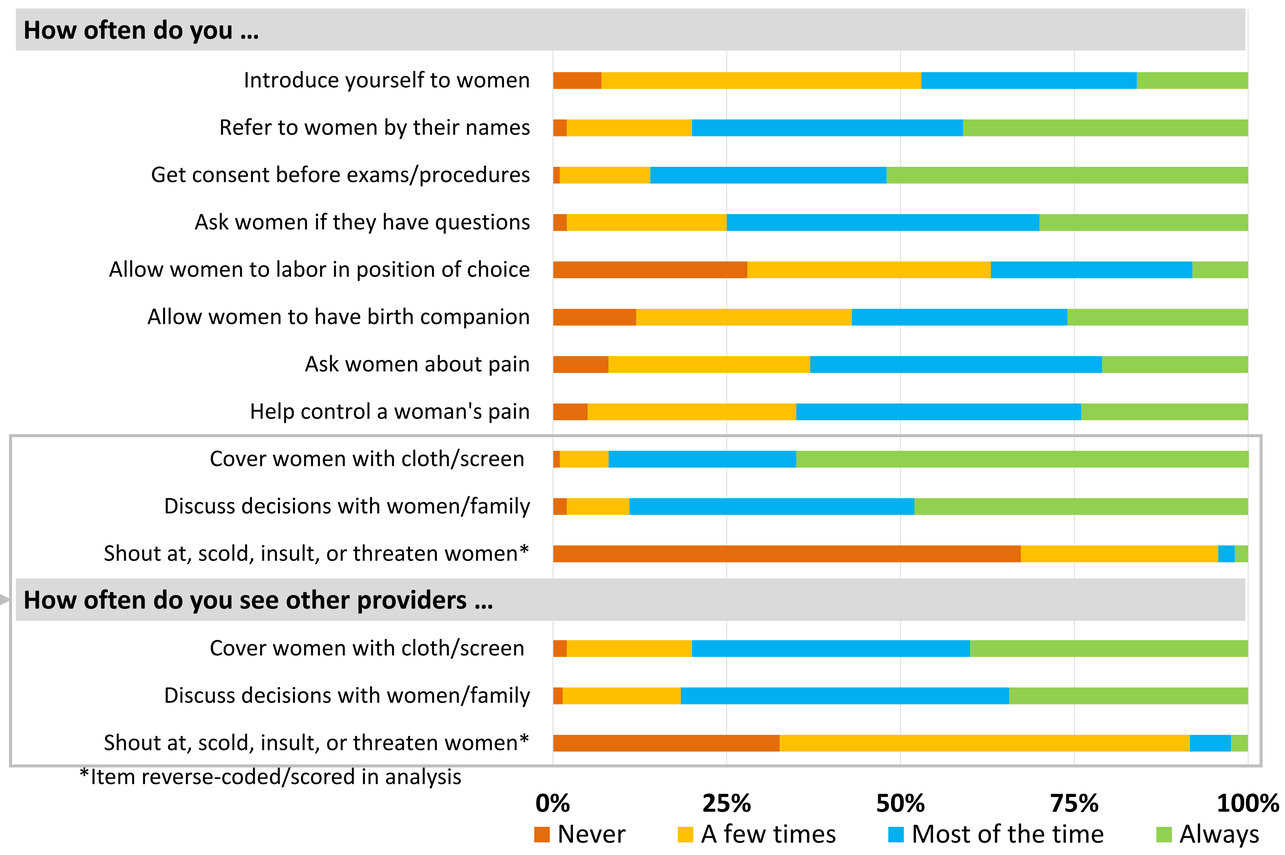
RESULTS

Table 1: Baseline characteristics and predictors of PCMC

		Association with PCMC[d]
Provider age in years, mean (sd)	31.1 (7.1)	No
Female	68% (191/281)	No
Cadre Physician/Clinician Registered nurse/midwife Nurse/midwife technician	 12% (34/281) 58% (162/281) 30% (85/281)	No
Years of experience, mean (sd)	5.9 (6.6)	↑ experience, ↓ PCMC
Worked unscheduled time in past month	59% (165/281)	No
Training days per year, mean (sd)	6.3 (23.4)	↑ days, ↓ PCMC
PPH care self-efficacy score[a], mean (sd)	31.4 (7.3)	↑ score, ↑ PCMC
PPH knowledge score[b], mean (sd)	8.1 (1.9)	↑ score, ↑ PCMC
Relationship with manager[c]	34.2 (11.9)	↑ relationship, ↑ PCMC
Public sector facility	52% (146/281)	No

[a] PPH=postpartum hemorrhage; composite score based on of 15-item self-assessment of ability to identify and manage PPH (range 1-45).
[b] Based on number of correct answers to 13 clinical questions about diagnosing and treating PPH.
[c] Based on composite score measuring level of support from and relationship with manager.
[d] $p<0.05$ in adjusted linear random effects model, accounting for clustering at facility level.

Figure 1: Provider PCMC scale – select item scores



- Age, gender, and cadre not associated with self-reported PCMC
- Years of experience, time in training associated with lower PCMC
- Increases in PPH self-efficacy, PPH knowledge, and manager support associated with higher PCMC scores
- Facility sector and district (not shown) not associated with PCMC

- Mean total PCMC score was 73.7 (rescaled to 100; range: 36-100)
- Respectful and inclusive communication with women not practiced consistently
- Few providers reported frequent physical (not shown) or verbal abuse of women
- Providers generally reported higher scores for themselves vs others

RECOMMENDATIONS

- **Further assess facility- and system-level support issues that providers face and their effect on experience of care**
- **Educate providers on RMC, help them improve interpersonal interactions–including communication and engaging women in care**
- **Interventions integrating clinical skills, RMC principles, and supervisor support may improve experiences for women and providers**

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