BIZCOMMUNITY

The role of bias in how women are treated during childbirth: a Kenyan case study

By Patience Afulani

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Global maternal mortality is unacceptably high. Around 810 women die every day from preventable causes related to pregnancy and childbirth.

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A number of factors drive maternal mortality. In developing countries it is often due to women not having access to basic health-care during pregnancy and when they give birth.

Another contributory factor is the way in which women are treated when they seek care.

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Studies in poor countries have highlighted disparities in respectful and responsive care during childbirth based on women's socioeconomic status and other characteristics. Yet few studies have explored factors that may underlie these disparities.

My colleagues and I conducted a study into the biases – implicit and explicit – in the perceptions of providers based on the socioeconomic status of women seeking care during childbirth. We conducted the study with maternity care providers in western Kenya to understand how their personal biases might influence the way they treat their patients.

We found a complex and contradictory web of perceptions among maternity care providers. Some of the considerations shared by the providers included the educational level of women, their economic status and their appearance. These perceptions affected the kind of maternity care given.

We also found evidence of both explicit and implicit bias among maternity care providers towards women giving birth.

How biases show up in patient care

The providers told us about a variety of ways bias affected the care patients receive.

Some of the providers said the treatment they meted out to women was sometimes based on their appearance. When women appeared well-dressed and clean, they were treated better than those who were dirty and unkempt. One provider told us:

> *“Mostly you will find yourself not treating them equally. You will see the clean one to be special than the other one..”*

Providers said their attitudes were also affected by assumptions they made about who was knowledgeable about their health and who was likely to cooperate. Providers perceived more educated women as having a better understanding of information about their care. This, in their view, made them easier to deal with. Uneducated women from the village were assumed to lack understanding. One provider put it this way:

> *“If you explain and they do not do what you explained, then you become angry because the mother and baby can die.”*

Another said.

> *“So when you explain and they don’t cooperate, it will force you to apply some pressure to cooperate because if you become too soft, the result will be poor.”*

Another factor was a person’s level of education. More educated women were thought to know what was right and were treated with caution.

Some providers also said that they gave better care to people who they assumed had higher expectations and could fend for themselves. Women of higher social and economic status were perceived as having higher expectations about the care they received. They were therefore more likely to demand higher-quality care.

Women who knew someone who could hold the provider accountable were said to be more likely to get good care. A provider shared:

> *“Maybe she is related to an MP or somebody who works at the county… and will always feel that she is right and whatever she said is what is important.”*

Another factor at play was whether a woman could pay for care. Those that could were given more timely care. Providers

acknowledged giving more timely care to women who were able to bring – or pay – for supplies such as gloves and cotton wool. Those able to pay for needed tests and medications also received more timely care.

Providing better care didn't necessarily mean a provider preferred that patient.

Providers' preferences for women who could understand their instructions sometimes conflicted with their preference for women to be cooperative. High status women were more likely to understand, but also more likely to challenge providers.

Providers valued obedience and preferred cooperation over knowledge.

We also heard concerning ideas that conflicted with treating patients with dignity. Nearly half of the providers said that they assumed that women had already given their consent to examination and treatment by the mere fact that they had come to the facility. They therefore felt no need to ask for approval for procedures from the women.

About a third agreed that women were likely to be uncooperative when it is time to push and would need to be physically restrained.

How to fix this problem

Providers' biases can contribute to maternity care being poor. This is true for both low and high socioeconomic status women.

Working directly with providers to recognise both implicit and explicit biases could help reduce disparities.

Structural changes are also needed to prevent those biases from influencing care. One step would be to empower women so that they were able to articulate what they needed, and to make demands. Another would be to train providers and companions to serve as advocates for patients.

Making lasting change will require a shift in thinking about what makes a good patient-provider encounter. We need to help providers embrace a model where all women are encouraged to be active participants in their care. These changes are essential to ensuring that women get the quality, dignified maternity care they deserve, and that can save lives.

ABOUT THE AUTHOR

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