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Women Who Break the Rules:

Social Exclusion and Inequities in Pregnancy and Childbirth Experiences in Zambia

Abstract

Health inequities are a growing concern in low- and middle-income countries, but reducing them requires a better understanding of underlying mechanisms. This study is based on 42 semi-structured interviews conducted in June 2018 with women who gave birth in the previous year, across rural and urban clinic sites in Mansa district, Zambia. Findings show that health facility rules regulating women's behaviour during pregnancy and childbirth create inequities in women's maternity experiences. The rules and their application can be understood as a form of social exclusion, discriminating against women with fewer financial and social resources. This study extends existing frameworks of social exclusion by demonstrating that the rules do not only originate in, but also reinforce, the structural processes that underpin inequitable social institutions. Legitimising the rules supports a moral order where women with fewer resources are constructed as "bad women", while efforts to follow the rules widen existing power differentials between socially excluded women and others. This study's findings have implications for the literature on reversed accountability and the unintended consequences of global and national safe motherhood targets, and for our understanding of disrespectful maternity care.

Keywords

Health inequities; Social exclusion; Maternal health; Access to care; Norms; Zambia; Power; Disrespectful care

1. Introduction

The maternal health literature's excessive focus on individual-level barriers to maternal healthcare access may have fuelled individual-level approaches to addressing maternal health inequities (Gabrysch and Campbell, 2009; Moyer and Mustafa, 2013). Targeted behaviour change interventions, abolishing user fees, or conditional cash transfers have been rolled out to increase access to care among those shown to have least access: the uneducated, the poor, those who do not save, or older women (Målqvist et al., 2013). Other studies have taken a more systemic perspective, investigating whether some health facilities may simply be too far or too low quality for certain populations to access them (Gabrysch et al., 2011). This line of enquiry has yielded its own set of interventions, such as building more facilities, distributing transport vouchers or bicycle ambulances, or introducing performance-based financing. Yet despite the growing prioritisation of health equity, intra-country inequities in access to maternal healthcare services in Low- and Middle-Income Countries (LMICs) remain larger and are reducing at slower rates than inequities in other primary healthcare areas (Boerma et al., 2018). Given this comparative lack of progress, we need to better understand the underlying mechanisms producing inequities in order to inform policy (Friedman and Gostin, 2017; Krieger, 2001; Wainwright and Forbes, 2000). Understanding mechanisms may depend on including power processes in our analyses, a rare occurrence in the LMIC health policy and disrespectful maternity care literatures (Bradley et al., 2016; Sriram et al., 2018).

Also lacking is a broader understanding of maternal health inequities that includes the absence of "unfair and avoidable" differences in "mental and social well-being" (Ramírez, 2016; Whitehead, 1991, p. 219; World Health Organisation, 1946, p. 1). If we take this definition of *health* equity seriously, we cannot reduce it solely to equitable healthcare access, healthcare quality, or even respectful maternity care. According to Freedman et al's (2014) definition, disrespect and abuse of women in maternal healthcare includes "specific provider behaviours experienced or intended as disrespectful and humiliating" as well as " systemic deficiencies that create a disrespectful or abusive environment"

(Freedman et al., 2014, p. 915). Disrespectful care's focus on the health worker-woman interaction necessarily omits exclusionary social interactions with other patients, as well as the internalised shame, guilt and suffering that socially excluded women feel when weighing the biomedical benefits of a facility delivery with the high material and social costs required to access it (Spangler, 2011; Spangler and Bloom, 2010). Inequitable experiences of disrespectful care are currently understood, at best, as provider-instigated discrimination rooted in broader societal factors such as gender and economic inequities, but existing studies do not investigate whether the institutions of the health system and the health facility also propagate inequitable experiences (Betron et al., 2018; Bradley et al., 2016). Finally, the definition of disrespectful care focuses on what is consensually deemed to be disrespectful, ignoring any sanctions that women themselves understand as "deserved" in light of "deviating" behaviour.

Recent studies have described the phenomenon of fines being introduced in Sub-Saharan African countries, including in Zambia, to coerce women into giving birth in health facilities, often from the valuable lens of "reversed accountability" (de Kok, 2019; Greeson et al., 2016; Lodenstein et al., 2018; Melberg et al., 2016). One review has previously identified health facility rules as a driving factor of disrespectful care (Bradley et al., 2016). However no studies of which I am aware investigate the relationship between rules, sanctions, and inequitable experiences in pregnancy and childbirth.

In order to explore the mechanisms behind inequitable pregnancy and childbirth experiences, this study uses diverse women's perspectives on their own recent experiences and a theoretical approach that explicitly acknowledges power, Naila Kabeer's (2000) social exclusion framework. Contrary to much of the existing literatures on maternal health inequities and on disrespectful care, which focus on women's characteristics or the health system's shortcomings, this study's findings illustrate that inequities can be created and reinforced by routine institutions: health facility rules governing how women should behave in pregnancy and childbirth. Adding to the literature on reversed accountability and the use of by-laws in maternal healthcare, this study is the first to describe a broad set of health

facility rules from women's perspectives and to analyse how these rules create inequities in maternal healthcare.

1.1 Theory

This study draws on Naila Kabeer's framework of social exclusion (2000), applying it for the first time to the analysis of maternal health inequities. According to this framework, social exclusion or inclusion operates on the basis of different and overlapping forms of disadvantage attached to social groups. Disadvantage can be economic but also cultural or representational. Economic and cultural advantages translate to power, which groups can use, consciously or unconsciously, to further their existing advantages through strategies of inclusion or exclusion. This framework is well suited to the analysis of women's overall experiences of pregnancy and birth, and the inequities therein, by including representational disadvantage in its definition of injustice:

> *Disrespectful behaviour does not represent an injustice solely because it constrains the subjects in their freedom for action or does them harm. Rather, such behaviour is injurious because it impairs these persons in their positive understanding of self - an understanding acquired by inter-subjective means* (Honneth, cited in Kabeer 2000, 84).

The framework also draws attention to how institutions (such as health facilities) operate as potential agents of exclusion. Institutions are posited to govern the distribution of resources (such as access to high quality and respectful maternal healthcare), according to rules that may or may not privilege existing endowments or group belonging. The institutions and the rules do not themselves cause social exclusion. Social interactions and power relations between groups result in the creation of institutions that have the potential to exclude.

Kabeer identifies a range of practices through which groups can use institutions to exclude, in conscious or unconscious ways. Two of them are relevant here. Firstly, 'mobilisation of institutional bias' (Lukes, 1974), defined by Bachrach and Baratz as "a predominant set of values, beliefs, rituals

and institutional procedures ('rules of the game') that operate systematically and consistently to the benefit of certain persons and groups at the expense of others." (Kabeer, 2000, p. 91). For example, institutional procedures such as health facility rules, which apply theoretically to everyone, may have inequitable effects as a result of being easier to comply with for some social groups than others. Secondly, 'unruly practices' (Fraser, 1989; Gore, 1993), which refer "to the gap between rules and their implementation, which occurs in practice in all institutional domains" (Kabeer, 2000, p. 92). In the context of this study, rules could be enforced in a discriminatory fashion, with privileged groups being allowed to flout the rules without sanction.

This study also refers to the concept of "authoritative knowledge" in order to explain how the "rules of the game", and the sanctions for not following these rules, are legitimised. Initially developed by Brigitte Jordan (1997) in her cross-cultural studies of childbirth, authoritative knowledge refers to the knowledge that "counts" in a specific space, and on the basis of which decisions are made. Authoritative knowledge both reflects and strengthens existing power dynamics. In hierarchical settings, even those who are disempowered by the prevailing form of authoritative knowledge participate in legitimising it. Part of the process of establishing a single form of knowledge as authoritative is to devalue other forms of knowing and to label those who "still align themselves with the non-authoritative knowledge […] "as backwards, ignorant, and naïve, or worse, simply as troublemakers"" (Jordan, 1997, p. 56).

1.2 Context

Zambia has a fertility rate of 5.3 and a maternal mortality ratio of 224 deaths per 100,000 live births (CSO et al. 2014; WHO et al., 2015). While the latest measure of the proportion of women who delivered in a health facility was 64.2% (2008-2014) (CSO et al 2014), rates have likely increased in the interim. Inequities in access to facility delivery have been decreasing since 2002, albeit at a slower rate than inequities in access to child healthcare (Assaf and Pullum, 2016). The absolute difference between facility delivery rates in the richest vs. poorest wealth quintiles was almost 50 percentage

points over the 2008-2013 period (CSO et al 2014). The Government of Zambia has made it a priority to reduce these inequities in its National Health Strategic Plans (Republic of Zambia MOH, 2017, 2011, 2005). Many health and health-related reforms have been initiated in Zambia over the past ten years with inequity reduction in mind.

This study draws on data collected in Mansa district, Luapula Province, which was purposively selected because it has one of the lowest averages for facility delivery in the country according to the last available Annual Health Statistical Bulletin of 2013 (39%). Mansa district hosts the capital of Luapula Province and was selected due to high levels of contrast between its urban and rural areas, both in terms of distance to well-equipped health facilities and type of livelihood. Rural residents mostly make a living from subsistence or small-scale farming as well as farming others' fields or selling goods such as home-brewed beer. Urban residents typically either have informal jobs such as roadside sellers, or service industry jobs such as bank clerks, police-women, and teachers. Mansa district has 56 facilities (of which 1 hospital and 6 urban health centres) and 4 ambulances for approximately 258,800 people (Worldpop, 2016). There were only two consultant obstetricians at the time of fieldwork in June 2018, both based in the provincial hospital in Mansa town. There are no doctors in health centres, where deliveries should be conducted by nurses (who may or may not have midwifery training) or clinical officers.

2. Methods

This study focuses on women's perspectives. Many other constituencies, such as women's husbands or families (Kaiser et al., 2019), health workers, health administrators, and policy-makers are highly relevant for explaining women's inequitable experiences of pregnancy and childbirth. However, because the paper is grounded in a thick description of inequities as experienced by pregnant and labouring women, data collection focused on women with diverse and overlapping characteristics instead of comparing women's reports to that of their husbands, families or health workers.

147 The study is based on analyses of 42 semi-structured interviews with women aged 18 or older who
148 had given birth in the previous 12 months. Interviews were conducted in June 2018 and collected
149 information on women's experiences of their most recent pregnancy and birth, as well as their views
150 on which types of women were more likely to have negative or positive experiences. I also took notes
151 during (but did not audio-record) informal conversations with health workers, health volunteers, and
152 two district health officers.

153 The interview guide was initially drafted by the author and adapted in a pre-data collection workshop
154 with the interviewers, according to their understanding of the field site's context. It was progressively
155 modified during data collection in order to further explore themes raised by respondents (such as
156 home delivery, fines, finding money for the birth, etc.), based on daily discussions between the
157 interviewers and myself. The interviews were conducted in the Bemba language by two interviewers
158 from Lusaka whom I trained and supervised, with some respondents choosing to be interviewed in
159 English. I was always present at the data collection site, and present in 4/42 interviews. Interviews
160 lasted between 35 and 60 minutes and took place in an aurally private location, often outside and
161 always within the perimeter of the immunisation clinic.

162 Respondents were recruited from nine child immunisation clinics (including outreach clinics) in rural
163 and urban settings. Recruitment combined convenience and purposive sampling to compare women's
164 experiences from diverse and overlapping social locations (Table 1). Respondents were assigned
165 characteristics by self-reporting, except for the "visibly poor" category, which was determined by the
166 interviewers and myself, using their interview notes about the respondent's attire and appearance.
167 The intention was to capture visual clues indicating poverty relative to the study's context (e.g.: poor
168 quality of chitenge cloth typically used as clothing, torn shoes, un-groomed hair), as opposed to my or
169 the interviewers' relative wealth. While this categorisation cannot measure actual poverty, these
170 markers could have sparked processes of social exclusion. Written or oral informed consent was
171 obtained for all interviews. During the consent process, interviewers stressed that they were not

working with the health facility but that the health workers and the Ministry of Health were aware of our presence. Ethical clearance for this study was obtained from the London School of Economics Ethics Committee [ref. 000576] and the University of Zambia Biomedical Research Ethics Committee [ref. 005-06-17].

Table 1: Sample characteristics

Category	Sub-category	% (n = 42)
Age	18 to 20	17%
	21 to 35	60%
	Above 35	21%
	Not collected	2%
Education	No education	2%
	Some primary education	40%
	Some secondary education	41%
	Some higher education	10%
	Not collected	7%
Marital status	Single, widowed or divorced	26%
	Married to father of child after conception	7%
	Married to father of child prior to conception	67%
Work	Farmer	43%
	Other informal work	10%
	Formal work	7%
	No work outside the home	40%
Parity	1st birth	29%
	2nd to 5th birth	48%
	6th or more birth	24%
Residence	Rural	50%
	Urban	50%
Visibly poor	Not visibly poor	64%
	Visibly poor	36%
Place of delivery	Delivered at home or en-route to facility	10%
	Facility delivery	90%

All interviews were audio-recorded and were transcribed from the Bemba audio recording into English by the interviewers and two additional research assistants. Names of people and places were redacted in the quotes used in this paper and the respondents themselves are referred to with codes. Common

Bemba expressions have not been translated from English – these include “Awe” (“no”/“nothing” or used as an exclamation); “Emukwai” (an expression of agreement or positive emphasis); “Kaili” (“because” or for negative emphasis); “Ba” Sarah (respectful manner of referring to Sarah). Costs are given in Kwacha, the Zambian currency. In June 2018, 10 Kwacha was equivalent to 1 USD.

I analysed the interview data using a simplified grounded theory approach adapted from Corbin and Strauss (2012). Specifically, some codes emerged from the transcripts, while others were informed by the interview guide (which did not pre-suppose any mechanism for explaining inequities). In line with grounded theory, I drafted memos to summarise the content of one or more codes, ask additional questions of the data, and look for differences in coded content between categories, e.g. “married” vs. “not married”. I also explored analytical relationships between memos during the writing process. Unlike a pure grounded theory approach, memos were not drafted for all codes but only for those relevant to a salient mechanism that emerged during the coding process, and which is explored in-depth in this paper. The theoretical perspectives used in this paper did not emerge from this study but neither were they anticipated prior to memo-writing; rather, they were applied during the write-up phase in order to understand the implications of the findings.

3. Findings

This study found that health facility rules form an important part of participants’ experience of pregnancy and childbirth and have inequitable effects. Women with fewer social and financial resources are less able to follow the rules and are therefore more at risk of being subjected to sanctions, or more likely to make significant sacrifices to follow the rules. The authoritative knowledge legitimising the rules also strengthens the view that women with fewer resources are ‘bad women’, while women’s efforts to follow the rules and avoid sanctions reinforces inequitable power relations within and beyond the health facility.

In section 3.1, I describe the health facility rules, as well as the sanctions women were subject to if they broke the rules. I then explain how the rules can be understood as social exclusion processes

206 resulting in inequitable experiences of pregnancy and childbirth in section 3.2. In section 3.3, I explain
207 how the rules reinforce inequitable structural processes through their influence on the moral order
208 and power relations.

209 **3.1 Rules and sanctions**

210 In this section, I explain how I identified the "rules", the scope and nature of this study's evidence on
211 rules, and what the rules and sanctions are. I categorised guidelines for behaviour in pregnancy and
212 childbirth as "health facility rules" according to respondents' reports. In order to count as a rule,
213 respondents needed to say that this behaviour guideline had been communicated by health workers
214 or the health facility. It was not necessary for respondents to: mention any specific sanctions linked
215 to the rule; actively label it as a rule, a law or an order; or for the rule to be mandated by the health
216 system or a traditional authority. Rules mentioned frequently towards the beginning of the data
217 collection process were specifically asked about in subsequent iterations of the interview guide,
218 thereby increasing the likelihood of reporting. The list of rules should not be understood as exhaustive
219 or representative, but as evidence that a set of rules is highly relevant to women's pregnancy and birth
220 experiences in Mansa and, very likely, beyond (see Discussion).

221 *Table 2: Health facility rules*

Category	Rule	n respondents
Resources rules	Bringing materials to the facility when giving birth, e.g.: soap, Jik, dish/tub/bucket, plastic sheet, gloves, nappies, chitenges, clothes for the mother, clothes for the baby	15
	Taking a car or taxi to leave the facility after birth	2
Sexual and reproductive rules	Not having extramarital sexual relations	3
	Not having 'too many' children	2
	Should have sex with the husband during pregnancy	1
Maternal healthcare seeking rules	Giving birth at the facility	16
	Bringing the father of the baby when registering the pregnancy	11
	Not using traditional medicine "for opening the way" in pregnancy or childbirth, which is a mixture of herbs to hasten delivery	7
	Going to the mother's waiting shelter in the last month of pregnancy	4
	Attending ANC	3
	Starting ANC at 2 or 3 months	3
	Coming to the facility promptly when in labour	2

	Taking facility medicine during pregnancy	2
	Coming to the facility for delivery with the "SMAG" (community health worker)	1
Rules during labour at the facility	"Being strong", i.e.: not making noise or crying, and successfully pushing the baby out	6
	Being clean and shaving pubic hair prior to arrival for delivery	6
	Lying down during labour and not moving around the delivery ward	4
	Women's entourage not allowed in the labour ward	3
	Using a bucket instead of the toilet for urine and faeces	3
	Obeying instructions from healthcare workers	3
Lifestyle rules during pregnancy	Not doing heavy work	6
	Staying active	5
	Eating well and observing dietary recommendations or restrictions	5
	"Keeping well", i.e.: providing for and looking after yourself, your loved ones and your home	4
	Clothing restrictions, i.e. wearing a maternity dress, not wearing tight clothes	1

Respondents mentioned 25 different rules (Table 2 & Online Appendix for quotes - (INSERT LINK TO ONLINE FILE A)). The rules can be categorised into five different groups: rules directly linked to resources; sexual and reproductive rules; rules around healthcare seeking for pregnancy and childbirth; rules during labour at the health facility; and other lifestyle rules. Respondents' language around rules included words translated as "must"; "should"; "told"; "have to"; "not allowed"; "not supposed to"; "required"; and "taught". The level of coerciveness implied by respondents' language varied from strong norms to laws (i.e. traditional authorities' by-laws), depending on the respondent but mostly on the rule itself and associated sanctions, if any.

Many of these rules were mentioned by less than five respondents, but three rules were mentioned by 10 or more different respondents: giving birth at the health facility; bringing in-kind materials to the health facility when giving birth; and bringing the father of the baby to the facility to register the pregnancy. Most rules were mentioned across sites, with no specific rural-urban pattern, or whether women had delivered in a health centre or the hospital. The exception is the rule about not having extramarital sexual relations, which was only mentioned by 3 out of 6 respondents from one specific site.

Many respondents described specific sanctions which they had experienced or which they expected to incur if they broke the rules (INSERT LINK TO ONLINE FILE A). Fines up to K50 were charged for

delivering from home, or up to K10 for registering the pregnancy late or not at all. These fines were confirmed in informal conversations with community health workers ("SMAGs") from two sites and with two district health officers.

Women coming without the father of the pregnancy to register at the health facility could be excluded from antenatal registration, unless they received special dispensation from the SMAG or the chief. One urban woman of low socio-economic status who had recently been left by her husband said she was twice turned away from registering her pregnancy due to not having a husband.

Respondents also mentioned the possibility (or the experience of) being shouted at or scolded, being beaten or slapped, or being shamed by health workers if they broke the rules. For example, a respondent reported a situation during an antenatal clinic where women coming without husbands were shamed by being made to sit separately, leading to an altercation with the health workers, who accused them of sexual promiscuity ("*meeting in the grass*").

> *"They said, 'Those with husbands should sit as a couple', us, we sat [with] those who had husbands. Those without husbands sat on their own. Those without husbands, were 4… […] So, they [health workers] said, 'We will only register those with husbands, if you were meeting in the grass, you should go, if they [husbands] were trees, you should go and call the same trees and register with them'." [03-09-01]*

Health workers might also make women feel responsible for negative health outcomes when they did not follow the rules**.** In the quote below, the health worker tells the respondent that she has caused her own illness as a result of not following the rule about doing only light chores during pregnancy:

> *"I got sick, I even went back to the clinic, at the clinic they asked me that, "were you doing any work when you were pregnant?" "Emukwai I was working," "But we don't allow you that's what has caused you to get sick. Medicine, I will not give you any medicine, that is work*

paining, it has brought you sickness. We refuse [don't allow] you [to work] when you are pregnant." [04-09-01]

Sanctions were not the only, or perhaps even the main reason women followed the rules. Both the rules and the sanctions were legitimised by authoritative knowledge, to which health workers had privileged access. Women believed following the rules was the best way to manage the risky event of childbirth. This was partly because they saw the rules as inherently important for their health and their baby, and because following the rules enabled access to health workers with the "right" knowledge as well as drugs and equipment.

As is common in other settings, authoritative knowledge was constructed by framing information exchanges during antenatal care as knowledgeable health workers teaching ignorant pregnant women (Browner and Press, 1996; Jordan, 1997; Sesia, 2004):

"Because it was the first time, I have never had a child so. Like school they must teach me how giving birth is, they shouldn't anger because I don't know. Maybe I can kill the child because I don't know." [04-07-01]

Simultaneously, the rules themselves reinforced authoritative knowledge by outlawing reliance on competing forms of knowledge. For example, women were not allowed to take traditional medicine during pregnancy or labour, or to rely on their own judgement of how far along their labour was when deciding when to come to the health facility for birth.

3.2 Inequitable effects of rules

While respondents typically presented the rules as legitimate, the rules resulted in inequitable pregnancy and birth experiences. This is because not all women had access to the financial and social resources needed to meet the rules, and because the rules were unevenly applied. Inequities in the experience of pregnancy and childbirth were structured according to socio-economic status, rural vs. urban residence, marital status, age, number of children, and how much support could be expected

from one's husband/father of the child or relatives. Respondents' overall vulnerability resulted from the intersection of these characteristics, with extensive links between financial and social resources.

3.2.1 Mobilisation of institutional bias

Women with insufficient resources could either break the rules, believing they were endangering their and their baby's health and risking sanctions, or follow the rules by making costly financial and relational sacrifices. In line with Kabeer's framework (2000), the rules can be understood as a form of institutional bias. While the exclusion is unconscious, the rules are designed to serve an "ideal" patient, excluding women who do not conform to that ideal.

Respondents with limited financial resources described making sacrifices to raise the required funds. One urban respondent in her 20s with two children did piecework in order to survive, often in exchange for food, and did not make enough to "*keep money*" (save). In order to pay for transport to the health facility (around 20K, equivalent to payment for weeding a field), she took out a loan from the woman she sells fritters for, who deducted it from her future earnings. She also accepted in-kind help in the form of baby clothes and nappies from the sister of her baby's father, even though he denied responsibility for the pregnancy. Despite these financial and relational sacrifices, she knew she would not be able to pass as a financially comfortable married woman when she reached the facility: *"Awe there is nothing you can feel [when you reach the facility] because you can steal [in order to look like the married women] so there is nothing you can feel, you just look at them"* [03-07-02]. She chose to make these sacrifices and face potential shame because she was worried about childbirth complications and being made to pay a fine she could not afford for home delivery.

For rural women, gathering sufficient financial resources to follow the rules could require sacrifices taxing their physical resources. A rural married woman in her 20s explained she had to shoulder a heavy workload during her pregnancy in order to store enough food for the post-partum period, which was also, ironically, against the rules:

311 *"I hated work, I just used to work because when I give birth I would stay a lot of days [not*
312 *working] … eating in this village it is food from the bush [so no work means no food]." [04-09-*
313 *01]*

314 Other facility rules required women to be embedded within specific social relationships. Eleven
315 respondents were unmarried or separated at the time of pregnancy and birth, which made it more
316 difficult to follow the rule about bringing the father of the baby to register the pregnancy. While it is
317 feasible for the father to fulfil this duty even if he is not married to the mother, unmarried fathers
318 refused responsibility in 3 out of 11 of these cases.

319 The rule about doing only light chores when pregnant also assumes women can draw on social
320 relationships. Being single would make it harder to follow this rule:

321 *"I – How can someone being unmarried cause them to have a bad pregnancy or experience*
322 *difficulties?*

323 *R – Maybe she was doing difficult chores, others the pregnancy gets destroyed. […] Because*
324 *she wouldn't have anyone to help her." [04-02-02]*

325 Women's access to financial resources depended heavily on their social network, particularly their
326 parents if they were unmarried or their husband if they were married.

327

328 **3.2.2 Unruly practices**

329 The ways in which the rules were applied varied according to women's characteristics. One rural
330 respondent said women "*with names*" (important women), are not punished for delivering at home.
331 An urban respondent of a higher socio-economic status who delivered from home due to a fast labour
332 did not report paying a fine, although health workers *"were not happy because I gave birth at home*
333 *so they had to say a lot 'why didn't you come, you knew that you were in labour…' then I had to explain*
334 *what happened."* [03-03-01]. Another urban woman, who was educated but poorer, delivered from

home due to her husband not being there at the start of labour, and did not mention incurring a fine either. She was delivered by her neighbour, a retired nurse who after delivery went with her and the baby to the facility to explain the situation. The advocacy of the retired health worker likely helped her to avoid a fine or a confrontation with the health workers.

Sanctions also depended on socially constructed expectations about women's level of responsibility and vulnerability. For example, young women were thought to be less able to give birth. As a result, health workers were perceived to be more patient with them during labour. While this flexibility in the application of the rules appears to address underlying inequities, it might impair *"a positive understanding of self"* (Honneth, cited in Kabeer 2000, 84) for young women giving birth. This respondent aged 17 at the time of the birth explains:

> *"Yes I was doubting 'how am I going to deliver', since I was young according to the years I had but they say that if you are 20 years you don't suffer when delivering. I was too young so I doubted on 'how I was going to deliver, are they going to operate me or I will deliver, what will happen'"[03-05-01]*

Several respondents mentioned health workers felt married women should be held to a higher standard in terms of financial preparations for childbirth, because of their presumed greater access to social and financial resources:

> *"…if you are married they get upset that, '9 months [how] can you fail to prepare for the child [or] even things to leave with?'" [04-09-01]*

This ignores the situation of several respondents who said their husbands cannot or will not provide support, despite the gendered norms prescribing that they should. While other respondents said the husbands would be sanctioned as a result, the final responsibility was often constructed as the wife's:

"They [health workers] get upset. They get upset, from the time you get pregnant until you give birth, can you lack even one coin, can't you surely keep that same coin if you see that my man is not serious with what he is doing." [04-10-02]

3.2.3 Rules as social exclusion?

In order for the rules to be understood as a strategy of social exclusion, it is important to show that they originate in unequal power structures. While underlying power structures were not investigated by this study, it is suggestive that women with fewer financial and social resources faced discrimination beyond the health facility as well. For example, women reported being excluded from community groups organised through the church, either as a result of having a non-marital pregnancy or because they lacked financial resources:

"Now, kaili the meetings at Dorcas they see how a person is, that is when they pay attention to her. If we compare [look at] these churches we have, if you do not have anything to give, they do not consider that person." [03-10-03]

As well as universally dropping out of school, young unmarried women frequently reported suffering from being gossiped about and socially excluded because of their pregnancy:

"People talk when you get pregnant, people talk anywhere you pass […]. Yourself you know that yes I am pregnant then you start thinking that it's better I kill myself. You feel ashamed [in front] of people, and then you stop moving about [going out] and stay home." [04-05-02]

Unmarried pregnant women were also likely to experience sanctions from their relatives. Relatives' reactions to their pregnancy included shouting and scolding, chasing their daughter from the house, not speaking to her, and denying her financial support.

These social sanctions were underpinned by a moralised discourse of personal responsibility. Respondents who did not identify themselves as lacking resources emphasised women could always save some money, e.g. from braiding hair, or could ask friends for help, perhaps in exchange for some

work. They perceived women lacking financial resources in pregnancy as lazy or irresponsible. Unmarried pregnant women were described as being sinful, stupid, or too proud.

3.3 Structural effects of rules

Health facility rules not only exclude women with insufficient financial and social resources, but also reinforce the structural processes that underpin inequitable social institutions such as the rules themselves. The moralised discourse around rules provides an additional rationale for community members to label women with insufficient financial and social resources as "bad women", while the imperative to follow the rules puts pressure on socially excluded women to further disempower themselves, thereby widening existing power differentials.

3.3.1 Reinforcing the moral order

Women who struggled to follow facility rules were often constructed as bad women by other respondents, specifically *as a result* of them breaking the rules. From the perspective of authoritative knowledge, this is not surprising, as those who do not align themselves with authoritative knowledge are frequently constructed as immoral (Jordan, 1997, p. 56). The fact that women police other women's compliance with health facility rules suggests that authoritative knowledge potentially reinforces the inequitable moral order beyond the health facility by providing a separate rationale for holding women with fewer resources morally responsible. This is demonstrated by the rule banning home deliveries.

When asked why women delivered from home, or what people said about those who delivered from home, many respondents who had delivered in a health facility made strong moral judgements about those who stayed at home, although some also mentioned practical constraints (money, distance). Women who delivered at home were deemed: stupid, backwards, or ignorant: *"maybe the one that is [gives birth at] home has never been to school, they have never learnt"* [04-07-01]; disrespectful towards the government or the health workers: "*if I delivered from home and the facility is there, it*

405 *means I have disrespected the health workers, like there is nothing they can do*." [03-07-01]; careless:
406 "*these people who deliver from home don't care for themselves*" [03-05-02]; or lazy: "*They say that*
407 *they are lazy because someone can't say that they didn't know, when labour has started, someone*
408 *knows that here labour has started*" [04-04-02].

409 ### 3.3.2 Reinforcing inequitable power relations

410 Facility rules reinforced inequitable power relations between women and others in their social worlds,
411 such as the fathers of their baby, their relatives, but also with regards to health workers and traditional
412 leaders. Unmarried women have less access to the financial and social resources required to meet the
413 rules. In this way, the rules contribute to reinforcing the importance of being married while pregnant,
414 even when marriage is disempowering for the pregnant woman. This 19 year-old living in a rural area
415 was deeply unhappy that her pregnancy and marriage ended her schooling, dashing her hopes of
416 becoming financially independent:

417 *"(laughs) Nurse [referring to the interviewer], can you be okay in this village we live in and at*
418 *the age I got pregnant? I can't work for the government or in my marriage. That is not okay*
419 *because I can't get paid my own money. Even if I was to work for the government, there is*
420 *nothing I can do because I stopped school. […] at this age I was supposed to be in school and*
421 *not married." [04-05-02]*

422 The rule about bringing the father to register the pregnancy reinforces inequitable power relations
423 between men and women by making women dependent on men's willingness to assume paternity.

424 The rules also reinforce inequitable power relations between unmarried mothers and their relatives.
425 Unmarried mothers had to face severe social sanctions and perform their guilt in order to reconcile
426 with their families, upon which they relied to meet facility rules:

427 *"Even if they talk, I just accept that I wronged them. A mistake is made once, the way I have*
428 *made a mistake I will not do it the second time." [04-07-02]*

"At last I asked for forgiveness that what I did I wronged, they listened and forgave me." [03-05-02]

Finally, the rules reinforced inequitable power relations between women and authority figures such as health workers and traditional leaders, who had the power to wave sanctions conditional on women performing their vulnerability. The process of receiving an exemption requires women to reveal personal circumstances that are socially constructed as shameful to people in authority. For example, a respondent reported coming to the facility with no transport money or materials for giving birth as a result of having been left by her husband in pregnancy. Rather than emphasising her entitlement to respectful care, she said the nurses helped her out of "pity" and because they happened to have "good hearts". It was also necessary for the respondent to reveal her circumstances in order to receive assistance:

"I saw the nurse, okay I saw the nurse was not happy comparing [with regards] to what I explained, the nurse felt pity, even if she [nurse] accepted it, it was because it is God's power. [She is one of] those who have good hearts." [03-10-03]

4. Limitations

The following aspects of the research design may have led respondents to more actively legitimise rules and sanctions, and to avoid mentioning their own "transgressions" and the sanctions they experienced as a result: interviews were held within the health facility compound or outreach location; interviewers often had a higher social status than interviewees with respect to their education, fluency in spoken English, material wealth signalled in terms of clothing, and having a formal, white-collar job; some respondents believed the interviewers were health workers and I was a Peace Corps volunteer, a position of potential authority (despite the information and consent process stating the contrary).

The recruitment strategy de facto excluded women whose experiences resulted in the loss of their baby or their life. The study also excluded women younger than 18 years, despite adolescent

453 pregnancy being relatively common in Zambia (CSO et al 2014), for practical reasons linked to getting
454 parental consent. While the experiences of the <18 age group should be explored in future research,
455 most of the respondents aged 18-20 years old self-identified as being "too young" to give birth.
456 Interviewees were assigned the "visibly poor" category at the time of the interview, which may have
457 differed from their appearance at the time of the birth. Furthermore, it is not known whether health
458 workers or people in the community use the same visual cues as the interviewers to determine
459 whether someone lacks financial resources. The "visibly poor" category was used along with many
460 other categories to inform small-n purposive sample selection, and for the initial structuring of
461 analytical comparisons. I identified respondents as "lacking financial resources" in the final analysis
462 solely according to their own accounts.

463 While I attempted to interview both women who had and had not delivered at a health facility, only
464 4 out of 42 respondents did not deliver in a health facility. This may be due to respondents being
465 unwilling to reveal a home birth, women delivering at home being unwilling to speak with us, or to a
466 genuinely low level of home deliveries in Mansa in 2018, a statistic that is not compiled by the district
467 health office. This was not a function of recruiting respondents from immunisation clinics, since only
468 2.3% of children aged 12-23 months have never received a vaccination (CSO et al 2014). Rather, it
469 could be a consequence of home delivery being against the rules and thus stigmatised, combined with
470 our team's perceived connection to authority. This limitation raises questions about the extent to
471 which the rules influence the maternity experiences of all women, as this study claims, regardless of
472 healthcare access. Given that traditional leaders implemented by-laws mandating maternal
473 healthcare access, that health facility rules are socially policed, and that social control is extensive
474 (Phiri and Moland, 2014; White and Jha, 2018), the experience of pregnant women who eluded
475 contact with the health system is very likely to have been structured by health facility rules.

476 **5. Discussion**

While this study did not set out to gather evidence on how the rules affected maternal healthcare access and outcomes, district health officers believed the rules helped to avoid home deliveries and led to fewer maternal deaths. However, this study's findings imply that what works to meet average health targets may not work to reverse health inequities. This is particularly true when health inequities are understood to include wellbeing.

Kabeer's (2000) framework highlights that inequitable power relations are the root cause of social exclusion. While this study did not investigate these power relations in depth, examination of the sociological literature on Zambia suggests that at least three types of power relations are worthy of further investigation in this context: between genders, between the poor and the rich, and between formerly colonized and (neo-)colonial states. These domains are all highly relevant to people's lived experience in Zambia, are in flux, and mutually affect each other (Cole et al., 2015; Evans, 2014a, 2014b; Phiri and Abebe, 2016). This study also suggests possible extensions to Kabeer's analytical framework by showing that health facility rules are not only shaped by social processes, but actively influence these social processes as well. For instance, the pressure to follow the rules or seek exemptions may force women lacking resources to accept a further diminished position in society, also noted in the context of maternal health rules in Malawi (Lodenstein et al., 2018). Similarly, the fact that women who do not follow the rules are constructed as bad women reinforces socially excluded women's perceived immorality outside of the health facility. The role of a moralised health discourse as an engine of social exclusion has recently been documented in other contexts, such as healthy eating in US adolescents (Fielding-Singh, 2019) and the use of social sanctions to encourage hygienic behaviours in a range of settings (Brewis et al., 2019).

This study focussed on women's perceptions of the rules, as well as the actual and expected consequences of these rules for women. Generating evidence on the origin, formulation and application of the rules would require analysis of policy-making and enactment at various levels. In terms of the origin of rules, it is important to note that the rules are not necessarily evidence-based.

For example, the rule about "lying down" during delivery has a long history in former colonial powers (e.g.: Oakley 1984) but is not be supported by available evidence (Gupta et al., 2017). There also appears to be contradictions between official policies at the national-level, and the rules implemented at the facility level. There is no national policy on fining mothers who deliver at home or requiring them to bring specific items for delivery, and Ministry-level officials have condemned these practices in the past (Greeson et al., 2016). There are national directives encouraging male involvement in maternal and child health, but no official sanctions to incentivise this. However, other Zambian studies document the requirement of bringing materials for a health facility delivery (Mulenga et al., 2018; Sialubanje et al., 2014), fines for home delivery (Chibuye et al., 2018; Greeson et al., 2016; Kureya et al., 2016; Phiri and Moland, 2014), and other rules (INSERT LINK TO ONLINE FILE A). Two district health officers in Mansa said they were aware of the fines, and that the district health office works in partnership with traditional leaders, who implemented the by-laws.

The "reversed accountability" literature might help illuminate these apparent contradictions. Health workers, district officials, and traditional authorities are being held accountable for home deliveries and maternal deaths by provincial and national governments, which are themselves under international pressure to achieve quantitative safe motherhood objectives (Austveg, 2011; Storeng and Béhague, 2014). This is well documented by Evans' (2018) ethnographic study of the prioritisation of maternal health indicators within the Zambian health system. Health workers may also face additional material and reputational incentives to achieve quantitative objectives relating to maternal healthcare since results-based financing (RBF) in Mansa district began in 2017, as part of a broader programme and in line with global health policy trends. However, it is interesting to note that health facilities in Mansa collect but do not report the number of home births to the district level. Other studies link these accountability pressures to health facility sanctions directly, covering diverse contexts such as Burkina Faso, Nicaragua, Malawi's Presidential Initiative for Maternal Health and Safe Motherhood, Tanzania's locally funded performance-based financing programme, and Zambia's

Saving Mothers Giving Life project (Chimhutu et al., 2014; de Kok, 2019; Greeson et al., 2016; Kvernflaten, 2013; Lodenstein et al., 2018; Melberg et al., 2016). While there is variation in whether higher levels of governance condemn the use of rules and sanctions to achieve safe motherhood objectives, there seems to be cross-country similarities in the accountability contract. Specifically, lower levels are given the freedom to choose strategies best suited to meet the objective, but typically only insufficient (or no additional) resources to achieve the objective. This is reminiscent of Walker and Gilson's (2004) analysis of nurses as street-level bureaucrats, i.e. workers who enact public policy in the form of routinized practices, in a context that combines discretion over how to accomplish tasks with insufficient resources (Lipsky, 1980; Reckwitz, 2003).

This study's findings also have implications for how we understand disrespectful maternity care. The majority of respondents in this study understood sanctions as deserved punishment for breaking the rules, and only rarely mentioned nurses' personalities or moods as driving factors. Findings also highlight the important role of "institutional bias", which, contrary to "unruly practices", emphasises the inequitable potential of "the rules of the game" themselves, as opposed to their discriminatory or deficient application. In contrast, the current global framing of disrespectful care only includes health system deficiencies and instances of provider behaviours that are identified as disrespectful by victims and others. While Freedman et al (2014) convincingly argue that an initially restricted focus on these aspects of disrespectful care will facilitate progress, we should evaluate whether such a focus is able to address inequitable experiences of disrespectful care.

6. Conclusion

Health facility rules regulating women's behaviour in pregnancy and childbirth result in inequitable pregnancy and birth experiences in Zambia. Women with fewer social and financial resources struggle to meet the rules and must either suffer sanctions if they are unable to follow them, or make costly sacrifices in order to comply. The rules also strengthen social exclusion processes beyond the facility

551 by reinforcing inequitable power relations and a moral order where a lack of financial and social
552 resources is believed to result from personal shortcomings.

553 These findings highlight inequities in women's experience and identify an important mechanism
554 behind maternal health inequities. Policy-makers should develop responses that actively seek to
555 interrupt cycles of social exclusion.

556 **Appendix: Detailed description of the rules**

Rule category	Rule	n respondents	Illustrative quote	Punishments mentioned by respondents	Other Zambian studies referencing this rule
Resources rules	Bringing materials to the facility when giving birth, e.g.: soap, jik, dish/tub/bucket, plastic sheet, gloves, nappies, chitenges, clothes for the mother, clothes for the baby	15	I. What about the health workers, what were they saying? R. What they were saying. The teachings and telling us what to take when going to give birth. You get a bucket, clothes for the baby, 6 chitenges, paper plastic and jik [03-10-01]	Disrespectful treatment, e.g. shaming, shouting, scolding, beating	(Chibuye et al. 2018; Kaiser et al. 2019; MacKeith et al. 2003; Mulenga et al. 2018; Phiri and Moland 2014; Scott et al. 2018; C. Sialubanje et al. 2015; Cephas Sialubanje et al. 2014; Stekelenburg et al. 2004)
	Taking a car or taxi to leave the facility after birth	2	He found the car because to discharge a person, they (nurses) required a car. [03-09-01]	None specifically mentioned	(Mulenga et al. 2018)
Sexual and reproductive rules	Not having extramarital sexual relations	3	R – I know just that ~ you must keep yourself not making marriage in the house. I – But how did you know that that is the way it is supposed to be? R – They teach us at the hospital." [04-10-03]	None specifically mentioned	
	Not having 'too many' children	2	They can't talk, because the children she is having when they are older, and the amount [max. number of children] they give at the health facility, has not yet [been] reached. [04-05-01]	None specifically mentioned	
	Having sex with the husband during pregnancy	1	They were telling us that you are supposed not to refuse to have sex with your husband because you are pregnant. [04-04-02]	None specifically mentioned	
Maternal healthcare seeking rules	Giving birth at the facility	16	The law, I know the way the law is, they don't allow giving birth in the village. All these 3 children I have had, I gave birth from the clinic [04-09-01]	Fines - Amount: K50 - K20	(Chibuye et al. 2018; Greeson et al. 2016; Kureya et al. 2016; Phiri and Moland 2014)
	Bringing the father of the baby when	11	That is what they say: "go together, when a person is pregnant [they] should go with the husband to register the pregnancy" [03-10-02]	Not allowed to register the pregnancy, unless one has an exemption (from a	(Cephas Sialubanje et al. 2014)

Rule category	Rule	n respondents	Illustrative quote	Punishments mentioned by respondents	Other Zambian studies referencing this rule
	registering the pregnancy			nurse, SMAG or chief) & Disrespectful treatment, e.g.: shaming	
	Not using the traditional medicine "for opening the way" in pregnancy or childbirth, which is a mixture of herbs to hasten delivery	7	At the hospital they don't allow, I have never heard that they allow to use African medicine no. [04-10-03]	None specifically mentioned	(Mulenga et al. 2018; Phiri and Moland 2014)
	Going to the mother's waiting shelter in the last month of pregnancy	4	When I was 8 months pregnant, ba SMAG, ba nurse and the doctor came home and said you shift and go to the mother's shelter [03-02-02]	None specifically mentioned	(Chibuye et al. 2018)
	Attending ANC	3	It's been put as law for anyone who is pregnant and after to come for antenatal to know how the child is in the stomach and how it's moving [04-03-02]	Fines - Amount: K10 - K5	
	Starting ANC at 2 or 3 months	3	R – They say you must come when the pregnancy is 3 months, if you do not come at three months then you have to pay money [04-02-01]	Fines - Amount: K10 - K5 & Disrespectful treatment, e.g.: shouting	
	Coming to the facility promptly when in labour	2	They told us, they were teaching us that~ aahh signs of pregnancy that when pregnant when you notice it has become like this, you should do this. […] So, they told us that when you notice your stomach starts paining in that situation, you must go to the nearest clinic or the hospital." [04-08-02]	None specifically mentioned	
	Taking facility medicine during pregnancy	2	R. They were helping by encouraging us to eat and said you should be drinking the medicine, folic acid because if you are not taking those, you cannot be having appetite. [03-02-02]	None specifically mentioned	
	Coming to the facility for delivery with the SMAG	1	We knew because they taught us at the clinic. When we used to come for antenatal that when coming here after you feel stomach pains, you have to ask	None specifically mentioned	(Kaiser et al. 2019)

Rule category	Rule	n respondents	Illustrative quote	Punishments mentioned by respondents	Other Zambian studies referencing this rule
			the SMAG to escort you; you come with them here. [04-06-02]		
Rules during labour	Being clean and shaving pubic hair	6	They said when you come here, mothers should look clean. If you look clean, even the child inside will be clean, the baby movements will be okay. [03-06-02]	Disrespectful treatment, e.g. shouting and shaming	
	"Being strong", i.e.: not making noise or crying, and successfully pushing the baby out	6	They would ask, "have you had a child before?" I said no, she said you should be strong; motherhood is like this and like that. So, you should be strong, if you are not strong you can kill the child so you should be strong; you shouldn't be afraid of anything. [04-07-02]	Disrespectful treatment, e.g. shouting	(Phiri and Moland 2014)
	Lying down and staying put during labour	4	Now the pain was too much so I was going down time and again, so she saw as if I was troubling her according to their instructions that they have put up. [03-09-02]	Disrespectful treatment, e.g. being ignored, shouting	
	Women's entourage not allowed in the labour ward	3	I – Yes, okay so why didn't you ask anyone to escort you? R – Why I didn't tell them? Because they already taught us here who we should come with, it's just those, after they bring me they go back, we just remain with the doctor. [04-02-02]	None specifically mentioned	
	Using a bucket instead of the toilet	3	The nurse said," If you feel like peeing, you should stand and pee in that bucket. If you feel like pooping, you poop in the bucket," I said, "Okay," [03-09-01]	None specifically mentioned	
	Obeying instructions	3	Because they had told me that "if you start doing that, the ambulance is there outside, they will use a knife, so, you should follow my instructions, I like people who follow what I instruct them. If I say, do this, they do, do this, they do, not when I say do this they are refusing to do and do something else". [03-09-01]	Disrespectful treatment, e.g. shouting, threats	
	Not doing heavy work	6	When I went to register at the hospital they stopped us from working hard chores, when a	Disrespectful treatment, e.g. shaming	

Rule category	Rule	n respondents	Illustrative quote	Punishments mentioned by respondents	Other Zambian studies referencing this rule
			woman is pregnant she is not supposed to do hard chores; she is supposed to do light chores because energy finishes. [04-09-02]		
	Staying active	5	They just told us not to sleep too long so that the baby should not move so we can give birth fast" [03-03-02]	None specifically mentioned	
Lifestyle rules during pregnancy	Eating well and dietary recommendations or restrictions	5	[…] not eating slippery things like okra, we have to [eat] vegetables mixed with pounded groundnuts, so that the child can grow healthy. [03-07-01]	None specifically mentioned	
	"Keeping well", i.e.: providing for and looking after yourself, your loved ones and your home	4	They were teaching us – how to prepare for the child when it's born, how to keep yourself, home and how to look after the husband. [04-04-02]	None specifically mentioned	
	Clothing restrictions	1	[…] we went to register at [rural place of clinic]. So what they tell us is that, "each pregnant woman should have a maternity (over dress)" [03-09-01]	None specifically mentioned	

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