Women Who Break the Rules:

Intersectional Inequalities in Pregnancy and Childbirth Experiences in Zambia

Abstract

Despite the popularity of intersectionality as a theoretical lens to explore health inequalities in high-income countries, intersectional health inequalities in low and middle income countries have been under-researched. Through field observations and 42 in-depth interviews, this study aims to examine the relevance of intersectionality for understanding maternal health inequalities in Zambia, and the mechanisms through which this affects maternal healthcare access barriers and disrespectful care in childbirth.

Analyses suggest that women's experiences of care-seeking in pregnancy and childbirth are strongly affected by the extent to which they are able to follow social norms and health facility rules. This is in turn determined by the overlap of their gender, age, and marital status, as well as by their "healthcare patient" identity. Health facility rules, which are represented as technical and morally neutral, emanate from and reinforce these social norms, which worsen pregnancy and birth experiences for already disadvantaged women.

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Background

Intersectionality theory, originating from Black Feminist work in the United States, highlights the importance of overlapping axes of oppression in shaping health outcomes (among others) in high-income countries (Crenshaw, 1989; McCall, 2005). However, little is known about whether and how intersectionality is experienced in LMICs (Larson, George, Morgan, & Poteat, 2016). This matters for knowledge and for policy, in that inadequate attention is currently paid to multiply-disadvantaged women, whose health and healthcare experiences may be worse than what is implied by the sum of their disadvantaged identities (Green, Evans, & Subramanian, 2017). This may be particularly important for maternal health, a strongly gendered field where women's different identities are understood as biological or social risk factors whose effects on health outcomes or healthcare access are usually analysed in an independent and additive way respective to other factors, in both quantitative and qualitative research (Gabrysch & Campbell, 2009; Thaddeus & Maine, 1994).

This study aims to examine the relevance of intersectionality for understanding maternal health inequalities in Zambia, and the mechanisms through which being located at the intersection of multiple disadvantaged identities affects maternal healthcare access barriers and disrespectful care in childbirth relative to more advantaged women.

Zambia is a lower-middle income country with a fertility rate of 5.3, an average proportion of facility delivery of 64.2% (2008-2014), and a maternal mortality ratio of 224 per 100,000 live births (2015) (Central Statistical Office, Ministry of Health, & ICF International, 2014; MMEIG, 2015). While inequalities in facility delivery have been decreasing since 2002, the absolute difference between facility delivery rates for the 20% richest and 20% poorest was still almost 50 percentage points for the period under study (2008-2013) (Central Statistical Office et al., 2014). This study was conducted in Luapula Province, an under-served province in Zambia with lower levels of access to health facility delivery (HMIS, personal communication), and more specifically in Mansa district, the capital of Luapula Province, which combines rural and urban locations.

Data and methods

I collected qualitative data in 2018 through in-depth interviews with 42 women who delivered in the previous 12 months, and associated field notes. Respondents were recruited from 9 infant immunisation clinics, held at urban and rural health centres as well as outreach health posts. Recruitment was based on convenience as well as the need to recruit a diverse sample of women according to: age, marital status, education, parity, rural vs urban residence, and socio-economic status. While I attempted to interview both women who had and had not delivered at a health facility, only 4 out of 42 respondents did not deliver in a health facility. Interviews collected information on women's own experiences of pregnancy and childbirth as well as their views on which types of women were more likely to have negative pregnancy and birth experiences, supported by comparisons between intersectional vignettes that combined verbal and visual descriptions (the vignette artwork was commissioned by the study from a local artist, Victor Mwakalombe (Figure 1)).

Interviews were mainly conducted in the Bemba language or more rarely in English, depending on the preference of the respondent, by interviewers who are fluent in both languages. The interviews lasted between 35 and 60 minutes and were conducted in a private location close to the immunisation clinic.

All interviews were transcribed and translated into English by the interviewers and two additional research assistants. I then reviewed the English transcripts together with the transcriber in order to clarify meanings of the translation relative to the original language, as well as socio-cultural references.

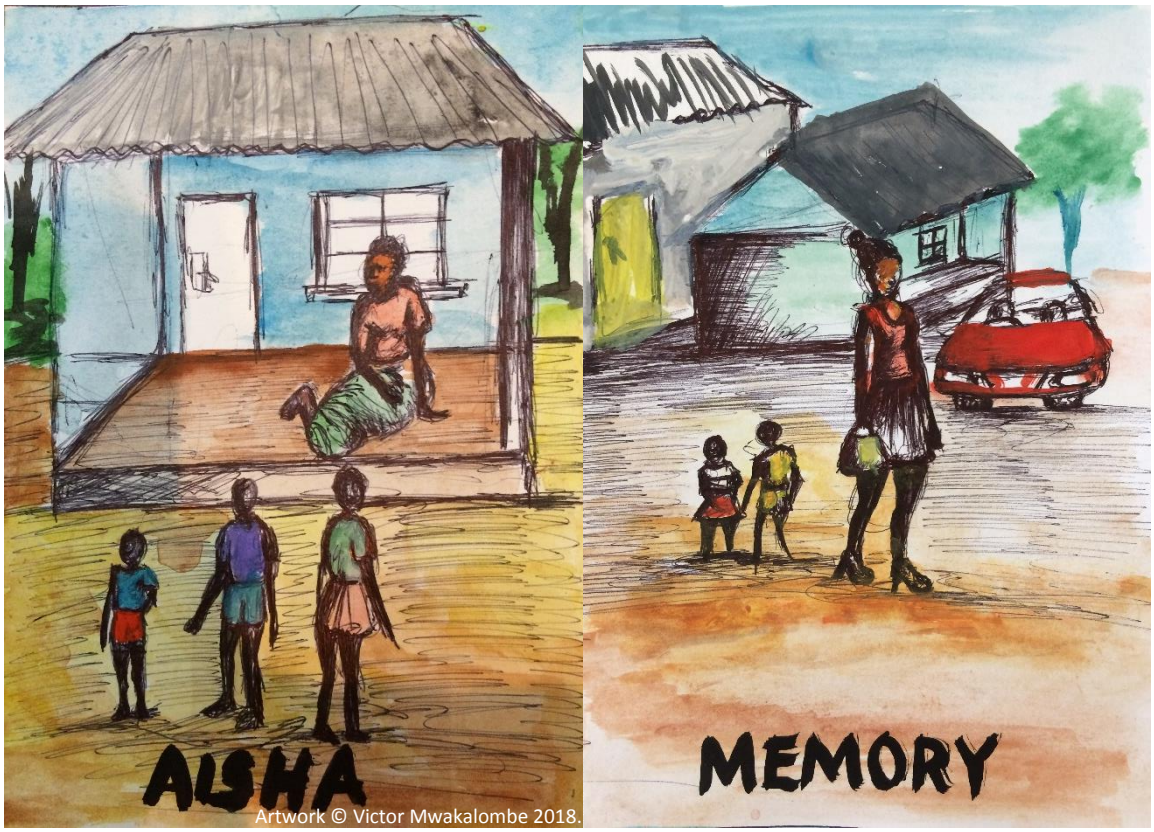

Figure 1: Two of eight intersectional vignettes, commissioned by the study. **Aisha** is 20, she dropped out at Grade 7, she's orphaned, doesn't work, and this is her third child; she lives in a peri-urban area. Each child has been from a different father, and she's not married. The fathers of her other children support her. **Memory** is a 25-year old accountant who lives in Mansa town; she got pregnant from her boyfriend. This is her second child. She has no plans of getting married again, because she was disappointed by her first marriage. She is HIV +.

To facilitate intersectional comparisons, each interview was categorised according to the respondent's characteristics, which were collected at the time of interview: age, education, own work, husband's work, whether the father recognised the pregnancy, marital status, parity, rural or urban, visibly poor, home vs. facility delivery. Transcripts were iteratively coded, using codes that emerged from the main themes of the interview guides and from the transcripts themselves. Codes were grouped hierarchically during the coding process. Memos were written to explore the content of codes, overlap between codes, and similarities and differences in coded content between broad intersectional categories. Analytical relationships between memos were recorded in higher-level memos until a salient story-line emerged. Ethical clearance for this study was obtained from the London School of Economics Ethics Committee and the University of Zambia Biomedical Research Ethics Committee. Quotes have been anonymised.

Preliminary results

Women are required to follow a set of formal and informal rules around sexual relations, reproduction, matrimony and maternal healthcare access, defined and enforced by their social worlds and by health workers using financial (fines) and psychosocial means (disrespectful care, stigma and

social exclusion, and verbal or emotional punishments by relatives). These rules result from strong power differentials between men and women, and between healthcare workers and patients, and are internalised and seen as justified by most respondents. Failing to follow the rules is deemed to endanger the moral order as well as the life of the pregnant woman and that of her baby.

> *"The way we protected ourselves was: when you know that you are pregnant, you are not supposed to continue leaving home, going somewhere else, maybe playing with other men, doing, doing things. That can bring a problem when you are pregnant at home, that's how I protected myself."* Ruth, urban outreach clinic, 04_10_01

An intersectional analysis suggests that women's experiences of care-seeking in pregnancy and childbirth are strongly affected by the extent to which they are able to respect these social norms and health facility rules, which is in turn determined by their intersectional identities. The most salient intersections include that between: gender, being a healthcare patient, age, marital status, and HIV status. Socio-economic status did not emerge as a salient category in this study.

These intersectional inequalities were highly morally charged as a result of young unmarried pregnant women being seen (and seeing themselves) as being responsible for their actions and therefore being legitimately punished for them.

> *"These times most of us girls, we don't pay attention at school but [we] like boys too much. If we pay attention to school, you wouldn't be going to meet with boys after school; if you do that then you want to get pregnant. Most women and your friends will be talking about you … you get pregnant, then you find [that] your friends you were with have finished school. […] You don't finish [school] and you get married as young as I am. So you will be laughed at anywhere you pass like that "We used to go to school together but she was playful and got pregnant" ".* Mary, rural outreach clinic, 04_05_02

Health facility rules, which are supposedly technical and morally neutral, emanate from and reinforce social rules to worsen pregnancy experiences for already disadvantaged women. This is not systematic but is particularly the case when the women breaking social rules haven't atoned for their wrongs or been forgiven by their social world.

> *"They were upset that, "you have wasted my money, you have ended your school on the middle [because the respondent fell pregnant], how much money have I lost, you have disappointed me ending your school on the middle". They yelled and shouted a lot of things, anyway I told them that, "I wronged and that they should forgive me"."* Mwansa, rural outreach clinic, 03_05_02

For example, one of the health facility rules is the requirement to bring one's husband when registering the pregnancy at the health facility. If a young unmarried pregnant woman has not faced the consequences for breaking social rules such as: not falling pregnant until she has finished her education and not having sex outside of marriage, she will not be able to seek authorisation from the traditional leader of her community to register the pregnancy at the health facility despite not having a husband. This may result in her being unable to access services later in her pregnancy. Without the financial, practical and emotional support of her parents or other family members and neighbours, she would also be unable to respect other health facility rules such as: not overworking during pregnancy, bringing the many required items to the facility at the time of the birth, arranging transport to come to the facility on time, etc. In other cases, the pregnant woman will not have broken any social rules herself, but still struggles to abide by the health facility rules as a result of her husband, sexual partner or family failing to provide her with the expected resources.

"He left home when I was pregnant for this child. […] The time to register had arrived. I told him, "let us go and register", it is like he [husband] had already seen another woman, and he did not get that. I went to the clinic and explained, "I do not have [one] to come with to antenatal, to come and register". So, they [health workers] refused, "Awe, unless you come with him", eee. So I stayed, so I came [home], he was not there, he went to [nearby town]. So I went back and told them [health workers], "Awe, help me because he has refused, what am I going to do"? Then they [health workers] refused, so that is how I stayed home, I did not register the pregnancy." Faith, urban outreach clinic, 03_10_03.

Table 1: Preliminary list of rules

Social norms	**Health facility rules** (In red: punishable by $5 fine levied by health workers or traditional leader, or potentially by lack of access to healthcare)
• Don't get pregnant if you are not married • Don't get pregnant if you are still in school • Don't get pregnant if you are too old or too young • Don't get pregnant if you have HIV (especially if you are not married) • Don't be unfaithful to your husband • Don't have an abortion • Don't seek formal retribution against your partner if he did not fulfil his spousal or parental responsibilities • Space your births • Be strong during delivery (eg: don't cry; don't be lazy; don't be anxious) • Follow the health facility rules	• Come with your husband to register the pregnancy • Register the pregnancy early (at 2 or 3 months) • Come to ANC regularly • Don't work too much during pregnancy • Bring items for delivery (bucket, JIK, clothes, plastic sheet, etc.) • Deliver at the health facility • Come to the facility on time for delivery • Don't take traditional medicine to accelerate labour • Come to the facility freshly bathed and shaved • Be strong during delivery (eg: don't cry; don't be lazy; don't be anxious) • Obey health workers' instructions

Discussion and preliminary conclusions

Preliminary results demonstrate that an intersectional analysis can bring value to the study of maternal health in a lower-middle income country context. Even in the absence of more commonly studied axes of oppression such as racism (as expected) or class (not as salient as expected), women's experiences of pregnancy and childbirth were not uniform but profoundly structured by the overlap between age, marital status, and HIV status. These intersections affect both healthcare-seeking and the likelihood of disrespectful care. The paper also demonstrates how these inequalities are produced and reinforced, through social norms that are internalised both by respondents who obey them and respondents who transgress them. Importantly, inequalities are also created by the health system itself, which sets out official and unofficial rules that are understood as being separate from social norms and objectively required for promoting better health outcomes. In practice, however, these interact with social norms to create additional hurdles to healthcare access and unpleasant experiences for women who are most disadvantaged.

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