

1 The costs of 'free': experiences of facility-based childbirth 2 after Benin's caesarean section exemption policy 3

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8 **Keywords:** maternal health, quality of care, Caesarean section, delivery care, exemption policies,
9 user-fees, Benin
10

11 [Abstract](#)

12

13 As one of many similar policies in the region, in 2009 Benin launched a free c-section policy in
14 publicly funded hospitals intended to decrease the barriers to facility delivery and the heavy
15 financial burdens on women and their families. We conducted a qualitative study for eight months
16 between 2012 and 2014 to understand women's experiences of care in maternity wards. We carried
17 out semi-structured interviews with 30 women who had delivered via c-section at five hospitals. Two
18 of these hospitals became case study sites where in-depth research was undertaken that consisted
19 of participant observation in each maternity ward and 32 further interviews with women who had
20 complicated, vaginal and c-section deliveries.
21

22 Overall, women continue to pay for care, both in the form of under-the-table payments to health
23 workers and prescribed payments for services not covered by the policy, though they consider the
24 costs reasonable compared to what the charges were before. Lifting the fees has facilitated
25 conditions for midwives to alert doctors that the procedure might be needed. Partly because c-

1 sections are still feared by most women, in one hospital this led to some women perceiving them as
2 a threat if their labour was progressing more slowly. Implementation of the policy differed greatly
3 between the two case study hospitals. We conclude that some burdens on women's access to care
4 have been addressed but deterrents remain to the improved perception of quality of care on the
5 part of women. Findings detail how important context is to the implementation of the policy, and
6 suggest that similar user-fee removal policies should be accompanied by other measures addressing
7 staff management and quality of care.

8

9 Introduction

10

11 Despite their recent decline, maternal mortality levels remain high in sub-Saharan Africa at about
12 201,000 maternal deaths per year (WHO 2015). Beyond this statistic are the burdens of reproductive
13 health crises occurring during labour and childbirth which can lead to drastic consequences for the
14 health and financial circumstances of women and their families (Fottrell 2010, Borghi 2003), in
15 settings where insurance policies are rare and personal safety nets are not economically robust.

16 Key strategies to reduce maternal deaths include improving access to skilled birth attendance and
17 emergency obstetric care by ensuring that more women can afford childbirth and surgery at well-
18 equipped, adequately-staffed clinics. To achieve this, one widespread approach is to remove user
19 fees or offer fee exemptions for women who deliver in health facilities (Meessen 2011, Richard
20 2013). In 2009, Benin launched a free caesarean section (CS) policy in its publicly funded hospitals, as
21 part of efforts to reach the Millennium Development Goals and alleviate the financial burdens of
22 care on pregnant women.

23 Though CS and other maternal health user fee policies are popular, not enough is known about the
24 implementation processes of these policies (Ridde & Morestin 2011), and there is a dearth of
25 evidence that these policies contribute to reducing access inequity (Dzakpasu 2013). If

1 accompanying measures to cope with increased facility attendance are not incorporated, these
2 policies may even have a negative effect on health provider motivation and quality of care (Hatt
3 2013), though the evidence for this is weak (Witter 2015). After the implementation of a similar CS
4 policy in Mali, women continued to incur considerable expenses for treatment, medicines and
5 transport (Ravit 2015) largely due to prescription of medicines outside of those the policy covered,
6 with almost a quarter of families still paying off related debts ten months after undergoing the CS
7 (Arsenault 2013). Poor, uneducated women were hardest hit.

8

9 In spite of these mixed results, policy makers at local and international levels have pushed for
10 exemption policies and have replicated approaches without evidence that is context specific, a
11 common trend in global health initiatives (Adams 2012). Gaps in effective solutions to improve
12 maternal health outcomes have been linked to a lack of political will and gender inequality (Grepin
13 2013). In research that speaks to circumstances beyond her study site, Chapman (2006) explains
14 reproductive risk in Mozambique as being indelibly permeated by social and economic factors borne
15 out of the historical marginalisation of women – with their reproductive choices and medical care
16 consequently based on personal relationships, social status and stigma.

17 In addition to the financial impact of CS, surgery and childbirth together form a space of heightened
18 vulnerability in West Africa with the exposure to risk and unfamiliar procedures (Jaffré 2003, Holten
19 2013). Encounters in medical facilities can create vulnerable moments for women during labour,
20 occasioning uncomfortable interactions, disrespect and abuse (Bohren 2015). Particularly in Benin,
21 maternity wards have been places of tension, submission and negotiation between women and
22 health workers as they navigate delivery care (Grossman-Kendall 2001, Saizonou 2006, Behague
23 2008, Hurni 2011). Beninese women have their own ideas about what constitutes good quality of
24 care, emphasising respectful care alongside positive medical outcomes, but are more likely than not
25 to feel that they cannot demand improved treatment (Behague 2008).

1 Hospitals themselves serve as a microcosm of the relationships and dynamics between all involved
2 (Van der Geest & Finkler 2004, Long et al 2008) through the intersection of health, risk, technology,
3 resources, and power dynamics. Relationships between health workers and patients are further
4 impacted in low-resource settings when care giving is in part undertaken on the basis of “social
5 recognition” and status of patients (Jaffré & Suh 2016), due to scarcity of staff, energy and morale.
6 As such, how externally imposed policies are enacted is particular to the settings into which they are
7 introduced, and user fee exemption initiatives can be interpreted and in varying ways depending
8 on their context.

9 What is it like to give birth by CS in the context of Benin’s free CS policy? This study was undertaken
10 as part of a larger evaluation of user fee removal policies in Africa (FEMHealth) (Witter 2016). This
11 paper reports on the anthropological component which investigated women’s experiences of CS in
12 referral hospitals three to four years after the start of the exemption policy, while also bringing
13 provider perspectives and other contextual factors of the hospitals into consideration. Specifically,
14 we explored how the CS policy shaped health workers’ and patients’ perceptions of and experiences
15 with quality of care. We also aimed to identify remaining barriers to treatment.

16

17 Methodology

18

19 Study setting

20 Almost nine out of ten pregnant women in Benin delivered in health facilities in 2012, contributing
21 to a remarkably high facility childbirth rate for the region (UNICEF 2013). Yet, the lifetime risk of
22 maternal death remains problematic at 1 in 51 suggesting issues with quality of care (WHO 2015).
23 Influenced by the Bamako Initiative’s cost recuperation agenda, Benin’s healthcare system, in
24 addition to being funded by local government and foreign donors (SHOPS 2013), also relies on its

1 consumers to pay for services. Prior to 2009, a CS at publicly funded hospitals officially cost patients
2 between 56,500 CFA and 115,985 CFA (CERRHUD 2014) (the CFA is fixed to the euro, making this
3 range between 83 and 175 euros), an expense that greatly exceeded monthly wages of several
4 professions (for example, the salary for a new middle-school teacher was about 36,000 CFA/month).
5 Of the official costs, the new policy covers the consultation, procedure, necessary medications,
6 hospitalisation and post-operative surveillance (Kounnou 2013). Costs for other pregnancy
7 complications and neonatal care are not included. Following the recommendations of an evaluation
8 by the Ministry of Health in 2008, hospitals were reimbursed 100,000 CFA by the government for
9 each CS performed. Hospital directors communicated to the policy's administrating agency that
10 some considered this sum insufficient to cover their CS costs, while others that are subsidised or
11 operate with lower expenses were able to make a profit.

12 [Conceptual background](#)

13 We undertook ethnographic research to capture pregnant women's experiences of quality of care,
14 including the related costs and any financial barriers, when delivering in referral hospitals after the
15 implementation of the user fee removal policies.

16 Underlying this study is the notion that perceptions of quality of care are culturally constructed and
17 contextually specific, informed by previous experiences and exposures, and not static either in time
18 or within groups of individuals. The quality of care frameworks that guided fieldwork and analysis
19 (Hulton 2007; Filippi 2004), emphasise that quality of care is multi-faceted and that its appraisal
20 should be considered from the points of view of the various actors involved in delivering and
21 receiving medical care (figure 1). It also highlights that quality of care exists within a circular process,
22 in that just as the critical components to its delivery influence quality of care, these dynamics can in
23 turn also be impacted by the provision and experience of care.

1 (figure one moved to appendix)

2 Data collection

3 The study was completed in two phases. The first phase in 2012 involved interviewing at their home
4 30 women who had a CS within the past 30 days in five referral hospitals throughout the country (six
5 women per site), asking about their delivery care choices and their experiences with CS covering
6 topics such as quality of care, costs, medical explanations given, consent for procedures, care-
7 seeking pathways, and delays. We selected women for interview randomly from the hospital's CS
8 register; there were no refusals.

9 After preliminary analysis, further qualitative investigations were undertaken for 2.5 months in two
10 of the five hospitals in January-July 2013. The hospitals were chosen to represent both public and
11 associative (meaning they were funded in part by private sources) contexts and different sizes,
12 geographical locations and urban/rural clientele. The aim of this phase was to triangulate women's
13 narratives of what they experienced with health workers' explanations for their treatment alongside
14 an external observer's viewpoint. The methods involved participant observation in the maternity
15 and labour wards carried out by 1-3 researchers over five weeks (nights and days), including daily
16 informal conversations with patients, companions and health workers carried out alongside their
17 regular work tasks and during breaks; and recorded semi-structured interviews with women who
18 had CS, near-miss and uncomplicated deliveries. In addition to general observation of care practices,
19 communication, payments and the other rubrics present in our conceptual framework presented in
20 figure 1, fieldworkers also focused on following the trajectory of ten women per site from admission
21 to discharge and took notes on their experiences. In the process of "hanging out" in the maternity
22 wards, fieldworkers introduced themselves and asked patients if they agreed to be interviewed
23 formally later at home, between one week and one month post discharge, in order to understand
24 their perceptions alongside the observed activities. Fieldworkers stayed in the community for four
25 weeks after observational fieldwork for interviews, and only interviewed women that they had met

1 during their time at the hospital. While we spoke to many women and families casually, we sampled
2 women for recorded interview based on the extent to which we could observe their experiences at
3 the hospital and as far as they represented a diverse range of ages, number of children born, and
4 pathways to the hospital, in addition to the type of childbirth they had. Most interviews lasted
5 between 30 minutes and one hour and were conducted one-on-one, but during some a family
6 member participated to add further impressions about her hospital stay and details about payments.
7 Table 1 shows the breakdown of women interviewed according to type of delivery.

8 Female Beninese sociologists with experience carrying out observations in maternity wards and skills
9 in the local languages conducted the interviews and observations. They carried out interviews
10 primarily in Bariba, Peulh, Fongbe and Mina languages. In addition, authors ILL and LK also spent five
11 weeks in the focus hospitals for participant observation and regular supervision visits. Our research
12 team was also in contact with the national agency in charge of implementing the CS policy, which
13 allowed for insights into its monitoring and evaluation.

14 [Analysis](#)

15 We digitally recorded, transcribed and translated all interviews, which we then coded with NVivo
16 software according to a detailed inductively created thematic tree. We coded all daily field journals
17 and other notes and reports and generated annotated coding documents separately, per site. For
18 the interviewed women whose care was followed we triangulated data by studying interview
19 transcripts, field notes and any additional reporting. The impact of the exemption policy and other
20 themes that emerged through fieldwork and coding were written up in analysis reports. We
21 presented these results back to maternity teams along with the overall project results in 2014 at
22 day-long dissemination workshops at each hospital, and integrated health workers' feedback into
23 subsequent analysis.

1 Ethical approval

2 The study gained approval from Benin's National Ethics Committee for Research in Health and the
3 London School of Hygiene and Tropical Medicine ethical committee. All interviewees provided
4 written consent, and permission was obtained from facilities to work on their premises.

5

6 Findings

7

8 Two hospitals, two contexts

9 The five hospitals are all referral facilities in the south, central and north of Benin. The two case
10 study hospitals have distinct profiles.

11 Hospital A is in the north of the country, not far from the Nigerian border. It is located in an urban
12 centre with a population of about 70,000, and draws patients from rural and urban areas hundreds
13 of kilometres away, and sometimes from across the border. Many patients were either Bariba or
14 from the Peulh ethnic group, historically a nomadic group from which few people in the region go on
15 to become health workers. While the Peulh language is spoken by some health workers, and some
16 Peulh speak French or Bariba, language barriers between patients and health workers persisted.
17 Women interviewed at this hospital were between eighteen and 39 years old, and worked as
18 salaried staff, vendors, artisans and housekeepers in the rural and urban local area. Their gravidity
19 and parity were between one and ten. All but one was married or living in a partnership, and were
20 predominantly Muslim. Over half had not completed a primary education. The four women
21 experiencing near-miss were Muslim, uneducated and housekeepers.

22 Hospital A is categorized as "associative". During fieldwork, the hospital could afford to and chose to
23 pay bonuses to its hospital staff in the form of two extra months' salary per year. Before and after
24 the policy, the hospital charged 20,500 CFA for uncomplicated vaginal deliveries, in order to

1 encourage women to first seek delivery care in area health centres, which normally charged about
2 5,000 CFA. Hospital B is located in an urban area transport hub in the south of the country. It is not
3 uncommon for the obstetricians working in the operating theatre to have their own private practice
4 or employment at private area clinics, placing a strain on demands for their time. The director of this
5 hospital claimed to the government agency in charge of administrating the CS policy that the
6 100,000 CFA government stipend did not cover the full cost of a CS.

7 During observations in Hospital B, health workers were on strike, the union having taken sides on an
8 internal dispute between the administration and a member of staff. This was an isolated event,
9 independent from the strikes that Benin's public hospitals regularly undergo for improved pay and
10 working conditions, though the tension between the administration and medical departments was
11 not atypical for the hospital. These hierarchical issues were also found within the maternity team.
12 "*Everybody is boss here,*" a visiting Beninese doctor told us, referencing the unresolved disputes and
13 struggles she observed that resulted in squabbles amongst team members. The strike was officially
14 "unlimited, without a minimum service" Tuesdays-Thursdays every week, with normal service
15 resuming Friday-Monday. However, a skeleton staff remained present in the maternity mid-week
16 and carried out delivery tasks in the labour ward. The strike was most noticeable on the pre- and
17 post-labour wards, with some midwives claiming they were just doing "*the minimum*" and women
18 complaining that apart from the morning rounds they were left in the wards without any
19 monitoring. During this period there seemed to be an enforced autonomy by the patients to run
20 their lives in the maternity ward, with minimal surveillance. The exact delineation between strike
21 behaviour and non-strike behaviour was somewhat blurred, and seemed to both mimic and
22 exacerbate typical relations. The maternity head, who did not strike, stated that midwives were
23 making their own decisions about how (not) to work because they thought they could get away with
24 it. Other hospital staff expressed the opinion that some health workers were taking advantage of the
25 strike to do subpar work and extend their non-working hours.

1 The women interviewed at Hospital B were under 40 years old (average age 28) with most having
2 one to three children, though one had nine. Three out of 21 were single. All but two had at least a
3 primary level education, with three having further education past high school. Their occupations
4 included being salaried staff, businesswomen, vendors, students and artisans. Most resided in the
5 urban area, and about an equal number were Christians as were Muslims.

6

7 [Women's views of the CS procedure](#)

8 Among 62 women who had delivered either vaginally or by CS across the five hospitals, 46 knew of
9 the free CS policy before coming to the hospital. They had heard of it through radio and television
10 ads and word of mouth.

11 Women understood CS as a procedure in which the doctor opens the abdomen to take out the baby,
12 when women are not able to deliver the baby themselves. Women stated that CS saved both the
13 lives of women and babies when vaginal delivery was impossible. Even given the understanding of
14 the positive effects of the CS, it was overwhelmingly feared and regarded as an act to be avoided if
15 possible. In our interviews, both fear of complications and fear of CS were brought up independently
16 from each other.

17 *When one speaks of the CS, it's about the fear for the stomach, because...*
18 *[silence] ... because birth is something you should do yourself and you're told that*
19 *you can't, that they have to open your belly with a knife. Aah! A woman is not a*
20 *chicken that you can just slice open every time! You could die during the*
21 *operation because the health workers are just humans and can make mistakes*
22 *too. – HA/CS/25yrs/urban/housekeeper*

23 In Benin it is common for women to have full anaesthesia when undergoing a CS, and many women
24 singled out being put under and losing consciousness as a main deterrent.

1 In addition, in Hospital A, the northern site, women explained that opening the body, and being
2 unconscious, created opportunities and entry points for unwanted spirits to enter, tarnishing their
3 lives afterwards.

4 Beyond the actual act, the CS held undesirable repercussions and was found to weaken women
5 physically, psychologically and socially. Even women who had not had a CS this time remarked that
6 painful CS wounds left them dependent on others during the healing process, indebting them to
7 outside help to carry out chores. Beyond this, care for the wound was cumbersome and incurred
8 extra costs. Some women spoke of feeling diminished; different from women who delivered
9 vaginally, having been too weak or considered incapable of performing the basic duty of a woman's
10 body. It was also understood that a CS could impose an involuntary limitation on the number of
11 children one could have afterwards. Some women described the CS as "*an insult*".

12 However, six women stated a more ready acceptance of CS. One woman with previous complicated
13 labours found that the pain of the CS wound was preferable to the suffering experienced during
14 vaginal delivery. There was a perk to being unconscious and waking up and seeing one's baby. For
15 the others, previous vexatious obstetric experiences – either their own or someone else's – coloured
16 their attitudes. These negative events shaped by either maternal death or poor treatment in the
17 labour room led them to elaborate on the positive aspects to CS, rather than focusing on the
18 negative. The women expressing these viewpoints all lived in peri-urban areas in the south of the
19 country.

20 [The financial costs of delivery](#)

21 Women paid markedly less for CS after the institution of the policy, with some costs remaining for
22 medications and procedures not covered by the policy, and under-the-table payments to health
23 workers. The FEMHealth study found that women paid on average 42,335 CFA (64.54 EUROS) per CS
24 at hospitals across the country, a sum that includes informal costs (Witter 2016). It is a sum far

1 above the procedure being “free” to women. (Notably, women with non-CS deliveries paid an
2 average of 40,707 CFA (CERRHUD 2014).)

3 *Overall perceptions of the cost of CS*

4 One afternoon, one of us sat outside the admission room at Hospital B with a newly arrived
5 pregnant woman. She had come from the other side of town, having to arrange for her last
6 ultrasound to be done at another clinic because of the strike. Her baby was in breech, and her CS
7 had been scheduled for that day. “Yes, CS is free,” she said, but nevertheless, she had budgeted
8 between 50,000 and 60,000 CFA for the procedure, saving money over the last months for potential
9 complications. Adding up medications, materials and special payments to the midwives, there was
10 nothing free about this procedure, she sighed.

11 Still, she was in a fortunate position – the doctor had scheduled her CS, giving her time to prepare
12 both psychologically and financially, and both she and her husband had decent jobs in the city and
13 could scrape together the money, even if this sum did represent about a month’s salary. In contrast,
14 attending a private clinic in the urban centre would run her about 400,000 CFA, she said, placing that
15 alternative even further out of reach. Her estimate actually was not far off from the average post-
16 policy cost in Benin for women’s CS expenses, as cited earlier (ibid). This was her second pregnancy
17 and CS at this hospital since the implementation of the policy, and she said she was basing the
18 estimate on her previous delivery. CS costs were considered greatly reduced compared to pre-policy,
19 which was embraced by all informants.

20 *Affiliated costs to CS delivery: bribes, extra charges, and complicated care*

21 While the reduction in fees was welcomed, many informants mentioned that a number of costs still
22 remained for medications or for newborn care, amounting to considerable expenses. The items
23 related to childbirth that were most frequently cited as still incurring charges were painkillers,
24 antibiotics, wound dressings and infusions. Confusion around which materials and services should be
25 paid for – apparently both on the part of the staff as well as the patients – created some sense of

1 tension amongst clients who were confronted with unclear charges. In addition to these official
2 costs, the many unofficial costs experienced by women undermined trust in the hospital and health
3 workers. The below quote from a woman who started her journey at a health centre before being
4 referred to Hospital C, highlights the additional difficulty of multiple points of care causing confusion
5 as to who should be paid, and for what.

6 *She [the midwife] only placed a catheter but she told me to get at least 50,000*
7 *CFA ready before our trip to the hospital. My husband said that he didn't have the*
8 *money, and so she told him to give her 30,000 CFA instead. She'd give 5000 to the*
9 *doctor and the same to the others who would care for me. At that time, my*
10 *husband didn't know that one shouldn't pay anything. He only knew afterwards,*
11 *when he heard the CS was free and had already given the money – it hurt him a*
12 *lot... – HC/CS/22yrs/student*

13 Bribes were considered to be both overt and covert. According to interviews and observations, at
14 times unsanctioned payments were outright demanded, while at others a degree of subterfuge was
15 employed to hide their real purpose. In addition, payments were not necessarily always linked to
16 actual medical care. A husband complained:

17 *It has created too much robbery. I'll give you an example: I was asked to buy a*
18 *two-litre bottle of bleach. Given we're at the hospital, what's it for? Afterwards I*
19 *asked a midwife about it, and she told me that during the operation, liquid [bodily*
20 *fluids] splashed onto her clothes and that she had to go home to wash them.*
21 *These are permanent employees! They have a salary! If the mechanic fixing your*
22 *moped gets oil on his tunic, is he going to tell you to bring extra money for bleach*
23 *in addition to his service charge?? – Husband of CS patient*
24

1 All five sites had their particular “bribe” culture, with staff at Hospital B having a notoriously bad
2 reputation for asking for extra payments. Here, we were told by companions, midwives were taking
3 advantage of the “discount” women received on their CS by charging extra under-the-table
4 payments.

5 In addition to payments being asked for without receipts (at all hospitals), at Hospital B there were
6 also charges for “presenting the baby” to the family – for which the midwife received 2000 CFA upon
7 bringing the newborn out to the waiting area for a first glimpse. Pressure to pay these charges was
8 covert, with companions in a few cases stating they feared lack of attention from the midwives or
9 diminished quality care if they were to protest.

10 *They treated me well, but there was one midwife who went to take money from*
11 *my husband outside. The other midwives didn't know about it. As she was*
12 *heading out, I told her not to bother my husband because we already had so*
13 *many expenses. She told my husband to give her 9000 CFA for the care that I*
14 *received. My husband gave her 8000 CFA. If it wasn't her own invention, she*
15 *wouldn't have accepted the 8000 CFA. Afterwards, she told me that all the*
16 *midwives who participated in my delivery should get 1000 CFA. Everyone here*
17 *knows that now that CS is free, and still, she took 8000. –*
18 *HB/CS/43yrs/urban/vendor*

19 At Hospital B, midwives informed us that their salaries were not high enough for the amount of work
20 they did. In discussions and observations with staff, it appeared that there was a solidarity amongst
21 shift-mates and that bribes were specific to certain wards and departments within the maternity
22 unit.

23 Our team had the impression that while some bribes and overcharging were certainly being
24 committed at Hospital A, they were somewhat less frequent, less extortionate and more covert than
25 at Hospital B. The administration at Hospital A took known instances of corruption seriously. For

1 example, the director called a special staff meeting to address a patient’s complaint that she had
2 been incorrectly charged for the insertion of Norplant – a service which normally cost 2500 CFA, but
3 for which a midwife had charged 7000 CFA and pocketed the extra. Nevertheless, interviews
4 revealed numerous instances of false charges, with women only speaking about them afterwards
5 amongst their family and in these interviews, generally feeling without recourse to protest in front
6 of the health workers.

7 *Burdensome costs of complicated non-c-section deliveries*

8 It is notable that costs for vaginal deliveries featured during observation and interviews with women
9 who did not have CS. In particular, we witnessed scenes of despair and distress amongst companions
10 due to expensive treatments and hospitalisation for near-miss deliveries that did not result in a CS.
11 Costs continued to mount over the days, and sometimes there were foetal deaths or extensive
12 newborn care that families had not anticipated nor budgeted for. Conversations with families living
13 through these encounters emphasised the precariousness of their situations, and the captivity they
14 felt when trying to give the best care they could afford to their family member. The brother of a
15 hospitalised woman with eclampsia whose baby died in labour, raw from days spent worrying about
16 swelling debts, scoffed when the free CS policy was mentioned. *“She almost had a c-section; we
17 didn’t know it would come to this.”*

18 **Rose, surgical nurse in maternity ward, Hospital B**

19 Before training as surgical staff and moving to the city, Rose had worked as a midwife in smaller
20 towns for 20 years. The discipline inspired her as she had had difficult pregnancies herself and was
21 never “one of those women who simply arrived, delivered, and left again”. For her, this line of work
22 was an opportunity to serve and help people. She says that since the CS policy has come into place,
23 the operating theatre organised a CS kit with the essential supplies for surgery that previously
24 women needed to pay for. Now she simply grabs a kit and is ready to perform without the delay of
25 waiting for families to return from the pharmacy (even though sometimes, due to stock-outs, the
26 kits are not complete). She loves working with her surgical team and vouches for them, saying they
27 do not ask for bribes from patients, but can’t speak for other units in the maternity department. “It’s
28 a problem for your conscience... each person must decide themselves what to do.” However, after
29 probing, she added, “The hotelier lives off of the hotel... he tastes every soup before serving it...
30 healthcare won’t exist without it” referring to how under-the-table payments can be second-nature
31 in the hospital landscape in which she works.

32

1 **Zena, CS patient, Hospital A**

2 Zena, a 26 year old vendor and mother of two, went into labour when she was visiting relatives in
3 Nigeria and promptly began the journey back to her home village in Benin, which didn't have a
4 health centre. After subsequent stops at two health centres, the second recommended that she
5 immediately go to Hospital A due to having had a previous CS. By the time Zena arrived at Hospital A
6 at 9pm, her uterus had ruptured and she was unconscious and bleeding. Within 2.5 hours, the
7 necessary staff was assembled and began her CS. A slight delay in care had occurred upon her
8 arrival, when her companions were supposed to pay 2,000 CFA to start a file in the maternity ward –
9 a point that was emphasised by a midwife afterwards when discussing Zena's treatment. Those who
10 brought her did not have the money; the funds arrived with her husband a half hour later. While she
11 was examined, the steps for her CS were not put into place until the required paperwork had been
12 completed. The doctors were not able to save her uterus or baby, but otherwise the surgery was
13 smooth. The family had been informed that they would have to pay 80,000 CFA for the procedure,
14 but upon discharge a health worker from one of the referral centres showed up to ask her for 15,000
15 CFA, which was all they paid (in addition to the 8,000 CFA for medication and 2,000 CFA consultation
16 fee to the hospital). Zena had not heard about the CS policy until after the procedure, and realised
17 only later that the 15,000 her family paid did not go to the cashier and that they should have
18 obtained a receipt for it.

19
20 [The ease of performing CS under the new policy](#)

21 Whereas once they dreaded having to tell a woman or her family that she would need a CS, since
22 the policy initiation, midwives now felt a sense of relief. One midwife at Hospital B cited her
23 experience working in rural clinics before the policy's introduction, where every time she prescribed
24 a CS she realised that she was introducing a tremendous burden onto a family. In addition to the
25 substantial surgical costs, the transport to the referral hospital would also need to be quickly
26 organised. She recounted that there were times when she had told a family that they should prepare
27 for a CS in the morning and they did not return, disappearing either out of despair or to search for
28 money, leaving the pregnant woman alone and the health workers in a limbo regarding the next
29 steps for her treatment. With the policy, health workers uniformly expressed that they felt more at
30 ease and with more room to manoeuvre in case of the need for a CS. In Hospital B, the main
31 observed delay between the decision to do a CS and the act of carrying it out was surgeons'
32 availability. In addition to the strike, organisational difficulties with night shifts, internal
33 communications between the team, and the fact that some surgeons kept private practices that
34 demanded their attention meant that surgeons did not always arrive in time to be able to conduct a

1 CS within the 30 minutes that are considered to be acceptable between decision and act (Boehm
2 2012). Arguments were observed between ward staff and surgeons in terms of arranging the CS
3 schedule conveniently. Whereas in Hospital A, many senior health workers were housed on campus
4 which, combined with the extra salaries and distance from any other urban centres, meant that they
5 were more readily available when on call. There also seemed to be a different sense of commitment
6 and dedication to the maternity ward at Hospital A, with senior hospital staff and visiting medics
7 coming back to check on patients even when not on shift.

8

9 [Consent and information given to women about their state of health](#)

10 Navigating through differing conceptualizations of informed consent in health care can be tricky.
11 Often, in the case of an emergency CS, health workers may decide that they do not have the time to
12 either explain or inform the pregnant woman or her family of the procedure deemed necessary to
13 save her or her baby's life. The medical indication and risks involved with a CS may also not be
14 interpreted in the same way by medical professionals and patients. In addition, expectations for
15 appropriate "consent" can differ among contexts, as our research shows. Across the five hospitals,
16 women said that in cases where their CS was pre-scheduled, midwives or doctors explained the need
17 for the CS and obtained their consent. However, in the case of unplanned CS, about half the women
18 said that either they or their families had been informed of the need for a CS (though they were not
19 asked if they would prefer to have one).

20 The other half said that they were not informed that they would undergo a CS. *"They didn't explain*
21 *anything to me – I knew it when I saw her take the razor in her hand to shave me,"* lamented a
22 woman, referring to the practice of shaving the pubic area in preparation for sterilization and
23 incision.

24 Even with the language barriers in Hospital A, the majority of these latter cases were in Hospital B,
25 where communication tensions between staff and patients were well documented during

1 observations, even without language barriers. However, notably, more instances to this effect were
2 *observed* at Hospital A than were referred to in the interviews (we specifically asked questions about
3 the information they received and whether they consented to the procedure), suggesting that the
4 absence of information about procedures in this northern setting was not unexpected on the part of
5 women, and perhaps signaling a greater distance between patients and health workers.

6 Interviews with women revealed confusion surrounding reasons for CS and other procedures, and a
7 desire to understand why decisions had been taken. Both those who were and were not informed
8 stated that they would prefer to be informed about the CS, but delicately, so as not to become
9 stressed. Being *informed*, instead of *asked*, suffices for a number of women, but being surprised and
10 ambushed with the CS was not received well, and added to the ill perception of power dynamics
11 within the delivery experience for many.

12 When maternity teams were presented with these results at dissemination sessions, some midwives
13 admitted to intentionally withholding information about the CS "*in order not to set off a crisis*" for
14 the women when they prepared them for the procedure. Health workers insisted that they were not
15 being careless or domineering. They asserted that they were actually continuously assessing in
16 which circumstances it would be appropriate to ask for consent or to give information, in order to
17 potentially avoid an emotional shock for the woman, making what could be a routine procedure into
18 a stressful one for both woman and health professional. Midwives made these comments about
19 their own practices, with the caveat that they could not speak for the practices of their colleagues,
20 who, they said, may well have made other judgment calls about a woman's right to know the
21 medical procedures she was undergoing.

22

23 [Impact on perceptions of quality of care and healing](#)

24 The absence of paying official fees for CS appeared to influence perceptions of care for some
25 women. We asked women to compare their current delivery experiences with past experiences, and

1 companions also shared impressions of the changes that had occurred in the facility since the
2 introduction of the policy. They attributed a variety of circumstances specifically to CS officially
3 becoming cost free.

4 The most common comment women and companions made was that the quality of care had
5 declined since the introduction of the policy. Specifically, the most common citations were
6 “negligence” and a lack of care and effort to help women deliver vaginally. Midwives were said to be
7 more engaged in deliveries and post-delivery care before the procedure fee was removed.

8 *For me, the policy is to save the life of the mother and the child. It's a good policy,*
9 *it helps the population a lot, but those who work in this area need to properly do*
10 *their job. There's too much neglect of patients. It's created too much extortion*
11 *and midwives are searching for any and all ways to create expenses, it's not*
12 *good... – HE/CS/32yrs/housekeeper*

13 Women compared their recoveries to those of previous pregnancies and in three instances said that
14 their wounds took longer to heal than past wounds did. In one case it was possible to speak to
15 midwives about this, who explained that the woman had experienced a vaginal tear that she may
16 not have had during her previous delivery. Another woman at Hospital A had an infection at her CS
17 incision which she also compared to “before the policy”. Due to a stock-out of their regular steriliser,
18 health workers were using iodine to clean the wounds during this period, considered by medical
19 staff to be a less effective antiseptic that may have contributed to an increase in infections.
20 Nevertheless, it is notable that a small subset of respondents articulated an association between the
21 policy and its repercussions on their bodies and healing, seeking explanations in the economic arena
22 for poorer outcomes.

23

1 CS perceived as a threat

2 We compared the reason for CS that women articulated with the reasons documented in their
3 medical files. In about 80% of the cases these were the same, even if different terms were used for
4 medical indications. Others said they did not know why they had a CS, or gave different reasons for
5 why they were operated, which could lead to misunderstandings for the medical necessity of the
6 procedure.

7 Amongst women in Hospitals A and B, CS were valued for their life-saving capacities, even if they
8 were not the preferred mode of delivery. However, in Hospital B, we also encountered women who
9 felt as though midwives used CS as a mechanism for control over them, through threats and
10 manipulation.

11 Observations and interviews there revealed the impression that midwives sometimes acted
12 desultorily in the labour ward without prioritising care to labouring women and giving them the
13 attention they felt they deserved. Again, many women used the term “neglect” when describing the
14 care they received.

15 Some clients at Hospital B made a link between the CS being gratis and the perceived lack of desire
16 on the part of midwives to give attention to arduous labours or stressed women. These women
17 argued that now that there was a way for midwives to forgo difficult labours, they could choose to
18 free themselves of them and pass responsibility on to the operating theatre, at the cost of women
19 losing the opportunity to deliver vaginally.

20 While the full dynamics between midwives and obstetricians were not explored, we observed
21 numerous occasions in which midwives exercised authority in terms of scheduling, treatments and
22 logistics over certain doctors in Hospital B, where midwives had considerable say in determining
23 women’s delivery. Affiliated health professionals in the labour ward made similar observations. A
24 visiting resident commented on the striking difference in this hospital compared to other places she
25 had worked: “*They are operating on women in disorder!*” she exclaimed, going on to explain that in

1 her opinion, the CS performed were not all medically necessary. Another meeting was observed
2 where a former midwife on rotation as part of her medical school training told the head of the
3 labour ward that she should spend more time in the ward, as women were being abandoned and
4 many CS could be avoided if they were given more attention during labour.

5 These comments fit into a general context of women's perceived lack of ideal social care already
6 outlined in this paper in terms of bribes, support and information-giving – whether they had a CS or
7 not. While technical care was often praised, women differentiated between medical skills and social
8 skills, as our conceptual framework highlights. Criticism for lack of care was also heard regarding
9 general care in labour.

10 *The health workers there have a bad spirit. They work well, yeah, and the medical*
11 *treatment is good and I appreciate that. But if you don't know anyone there, you*
12 *will die... That one midwife is not someone you want to come across if you're in*
13 *labour, she's very mean. I was lying down because my back hurt. When I asked*
14 *her if I could change my position, she responded, "Go ahead, but you think if you*
15 *fall I will pick you up?" But I was in pain, everywhere! My labour was long, and*
16 *she offered no help. For me, the way you speak to people matters a lot in terms of*
17 *care giving ... but this ... they are lacking in this and it ends up spoiling everything.*
18 *They are good at things but at the end of the day they ruin everything with their*
19 *attitude and their hurtful remarks, it's not good.... – HB/nonCS/40yrs/vendor*

20 Even with these viewpoints, instances were witnessed at both hospitals in which particular health
21 workers portrayed gentleness and sensitivity towards patients undergoing CS. In one instance in the
22 operating theatre, the obstetrician consoled and joked with a fifteen year old student clearly anxious
23 before the procedure, until she smiled and appeared more at ease. At another, faced with a
24 pregnant woman with obstructed labour needing a CS and her companions without a mutual
25 language, the attending doctor took it upon himself to search for thirty minutes to find someone

1 who could translate and explain the need for an operation in the small hours of the night before
2 proceeding, when he could have saved himself time and won sleep by simply initiating the
3 procedure.

4

5 Discussion

6 Our findings depict experiences of CS in maternity wards in Benin after the removal of fees as a
7 contentious arena, creating further space for doubt, tension, fear, and discomfort as well as
8 possibility, relief, joy and ease. The policy introduction has allowed health workers to prescribe CS
9 with the knowledge that they are not creating impossible financial situations for women and their
10 families, and women welcome paying much less for this potentially lifesaving procedure than they
11 would have before, when a CS diagnosis automatically meant a hefty, sometimes debilitating,
12 charge.

13 However, our results show that instituting new policies can create grounds for further areas of
14 disparity and tension, inciting care to be delivered subpar – in terms of coercion, consent, costs and
15 poor communication. Even if the policy is recognised by patients as being a “*breath of oxygen*” for
16 their expenses, the common practices of bribery and corruption – having a long established history
17 in the hospitals – seemed to take on a more open and institutionalised role. Our interviews show
18 that women are actually sophisticated consumers of health care and aware of the power that
19 mistreatment has in diminishing their voices and rights in the hospital setting.

20 The bribes, lack of information about medical treatments and procedures, extra charges for non-
21 authorised materials or services at multiple points of care giving, and impatience and neglect
22 experienced by women are all emblems of provision of care lacking respect. In both hospitals, the
23 notion of informed consent and the involvement of women in the decision-making for their
24 treatment are markedly lacking. Such neglectful care practices seem practically endemic in
25 governmental delivery care in sub-Saharan Africa and other settings (Bohren 2015, d’Ambruso

1 2005). These issues, now commonly addressed in advocacy as *disrespect and abuse* or *respectful*
2 *care* are gaining more visibility in recent years. The White Ribbon Alliance recently launched a
3 campaign raising awareness of women’s rights in childbirth (in which bribes and neglect are
4 specifically condemned), and the UN made respectful delivery care a decree in August 2014. Others
5 are involved in its conceptualisation (Freedman & Kruk 2014) and measurement (Vogel 2015), in
6 efforts to find solutions for this pervasive problem.

7 While the CS policy addresses questions of access and provision-of-care for specific medical
8 indications, the “experience of care” rubric in our quality of care framework has not seen
9 improvement. In fact, our informants indicate that one study hospital has likely seen it worsening. As
10 many have pointed out (Renfrew 2014), global level or State efforts generally first address access to
11 delivery care, and only thereafter consider measures for the improvement of the quality of service
12 delivery in these facility settings. These provisions are then at the mercy of the hospital.

13 *The interplay between policies and hospital environments*

14

15 The health workers and administration of the case study hospitals demonstrated their own ways of
16 responding to this externally imposed policy. As Sullivan (2012) argues in her study of an HIV clinic in
17 Tanzania and the global policies that shaped its structure, hospitals become both local and
18 governmental at the same time through their enactment of care. Other research in health policy
19 demonstrates that health workers will adapt to new policies by finding strategies to implement them
20 in ways that allow them to circumvent rules they do not consider constructive, to maintain practices
21 or to advance their positions as a response to navigating change (Suh 2014, Magrath 2012).

22 These ideas in our context mean that the infrastructure of material care – including the
23 implementation of the free CS policy – is dictated by the State, but its manner of interpretation and
24 implementation is local depending on the actors and ethos in each setting. Institutional labour and
25 delivery care, then, are inextricably linked to “social and organisational dimensions” (Jaffré 2012),

1 where to improve maternal morbidity and mortality one must understand how they are embedded
2 in the broader system.

3 As our conceptual framework indicates, quality of care is made up of both the provision of care and
4 the experience of care. Hospitals have their own cultures of enacting quality; through recognising
5 patients, staff and companions and making a public, state biomedicine – and the care it embodies –
6 visible, which plays out on how quality of care is lived and experienced (Street 2011). We see that
7 staff at the two hospitals act within their institutional structures to respond to the externally
8 introduced policy – with differences playing out in elements of respectful care, delays and
9 perceptions of the need for CS.

10 In Hospital B, the introduction of the policy appeared to exacerbate the problems that health
11 workers and patients already experienced in the maternity ward previously. Bribes and extra
12 payments were perceived to no longer be as “under the table” as they were before, and inattentive
13 care was common. Alarming, with the removal of the financial barrier, women felt that the CS
14 could be used as a threat against them and as a mechanism of control over their delivery experience.
15 Task-division between departments was a continuous negotiation, with complications constructed in
16 the “in-between” (Jaffré 2012); in the cracks that develop when there is no cohesive structure
17 through which staff can pull together with united intention. Staff focused their responsibilities within
18 their own immediate domain, rather than integrating themselves into the larger functioning of the
19 maternity ward mechanism and fostering collaboration between services (Litorp 2015a). Hospital
20 staff were going through a strike, a mechanism to mark their displeasure with their work
21 environment where they felt unfairly disadvantaged.

22 In Hospital A, many health workers spoke fondly of the director, recounting stories of being invited
23 for rounds of beers with him at the end of the workweek at a simple street bar, and considered him
24 as taking special care of the maternity team due to his specialisation in obstetrics and gynaecology.
25 Hospital A, benefiting from this strong leadership and the financial comfort of being able to profit

1 from the CS policy rather than clocking losses, was able to institute the policy without increasing
2 under-the-table-payments, the feeling of CS being used as a threat, or increases in instances of
3 disrespect and abuse. Health workers were motivated by the hospital administration with
4 supplementary salaries, and while the hospital was not a bed of roses for health workers across the
5 board, the underlying tensions that were witnessed at Hospital B were not palpable.

6 Numerous studies make the case for competent “stewardship”, or governance, as being key to
7 moving healthcare and health facilities forward (Figueras 2012). As outlined by Witter (2014),
8 effective stewardship can improve leadership and guide maternity teams through the
9 implementation of new initiatives. Where policies offer a larger room for interpretation and
10 implementation, the results will depend more on the steps of individual actors, who may not always
11 act in the best interest of the public. In these scenarios, of which the Benin CS policy is one, effective
12 stewardship that can guide the adaptation of the policy to the needs of the local health system and
13 also to all involved actors, is critical to its success. Solid stewardship is also required in presenting a
14 strong front in negotiations and advocacy outside of the hospital within the larger health system.
15 United, these two functions could serve to take care of its health workers, and by extension, its
16 patients.

17 Clinical audits conducted by maternity teams have been encouraged as ways forward in reviewing
18 procedures surrounding adverse outcomes (WHO 2004), but these depend on skilled facilitation in
19 order to foster an open, non-judgmental atmosphere that will lead to honest discussions with
20 fruitful insights into shortcomings and possible solutions (Graham 2009, Armstrong 2014). Case
21 reviews that include documenting and sharing the pregnant woman’s narrative of delivery care can
22 personalise the appraisal and offer hospital staff insight into both her experience as well as their
23 own, as they reflect on the consequences of their actions and seek solutions to the limitations in
24 their workplace (Lewis 2003). These audits foresee not only technical quality of care being improved,
25 but the empathetic element to interpersonal interactions as well.

1 *Improving attention to midwifery*

2 It is important to note that the midwives are acting within a hierarchical structure and may perceive
3 themselves as having limited options in order to perform their job well and swiftly. Their motivations
4 may be to keep complications and problems to a minimum in hopes of keeping their positions
5 (Litorp 2015b). While this study appears to cast midwives in a negative light, the problem is likely
6 deeper than the engrained behaviours we observed. Often these are rational choices taken and
7 calculated within a sense of insufficient alternatives for positive behaviour. Challenging working
8 conditions, including delayed salaries, staff shortages and lack of equipment or resources will also
9 have an effect on workers' attitudes (Mrisho 2009). Further research and consultation of Beninese
10 midwives' experiences should be undertaken with the aim of understanding how care-giving and
11 care-receiving can become a more positive experience for all involved.

12

13 **Conclusion**

14 Even with the cost barrier removed, a woman's experience of giving birth by CS in Beninese hospitals
15 can be a challenging, if life-saving, experience, influenced by where she delivers. It is not enough for
16 a policy to be implemented to meaningfully improve access to quality of care in maternal health.
17 Instead, *how* it is implemented will make a crucial difference in the way the policy benefits women
18 and families.

19 In this respect, policies need to be accompanied by measures that offer greater information,
20 guidance and regulation, as well as external supervision. Leadership in hospitals should be
21 cultivated, in order to develop managers who have the best interests of their staff and patients in
22 mind and the skills to carry out these priorities.

23 Importantly, implementation of the CS policy served to exacerbate underlying problems in hospital
24 communities, which through their irregular practices show themselves to offer subpar delivery care
25 – already a central feature of maternal experience. This area should be addressed through creative

1 approaches to eliminate the hierarchical and tense conditions that are the signature of many
2 relationships in maternal health care in Benin, so that when access and equity issues are tackled
3 through policy, the interpersonal and social aspects of care do not suffer on their account.
4 This study also questions the appropriateness of exemption policies that ease the financial burdens
5 of just one subgroup of pregnant women. Other States have chosen to fund schemes that cover all
6 delivery care or move entirely towards universal health coverage, aiming for equitable access. Not all
7 States are able to underwrite all medical costs at this point, nevertheless, what we do see is the
8 need for local, context-specific policy-making in health care in order to ensure that programs have a
9 chance at realizing positive change.

10

11 Acknowledgements:

12 The authors would like to thank the women, families and health workers in the fieldwork hospitals.
13 We would also like to thank Nicole Dari and Arielle Fagbité for assistance with data collection and
14 the rest of the FEMHealth team for discussions and support throughout this research. This research
15 was funded through the European Union Seventh Framework Programme (FP7/2007-13) under
16 grant agreement no 261449.

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