
**BETWEEN DISCOURSE AND PRACTICE : TARGETED FREE
ANTENATAL CARE FOR PREGNANT WOMEN IN BOUAKÉ
(CÔTE D'IVOIRE)**

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Abstract: In a context where targeted free healthcare policies seek to improve equity in maternal health, it is important to understand how these schemes are perceived and experienced within local health facilities. This article examines the social reception of free antenatal consultations in Bouaké (Côte d'Ivoire) through a qualitative study conducted in April 2025 in a public health facility. The research is based on 28 semi-structured interviews with pregnant women, healthcare workers, and accompanying men selected through purposive and convenience sampling. The results reveal a gap between officially free services and everyday practices, marked by fluctuating fees, resale of supplies, costly prescriptions, and unclear communication. These dysfunctions generate mistrust toward providers and weaken the relationship of trust, contributing to reduced antenatal care uptake, particularly in early pregnancy.

Keywords : Targeted free healthcare, antenatal consultations, maternal health, social reception of health policies, institutional trust, Bouaké (Côte d'Ivoire).

**ENTRE DISCOURS ET PRATIQUES : GRATUITÉ CIBLÉE DES
SOINS PRÉNATALS À BOUAKÉ (CÔTE D'IVOIRE)**

Résumé : Dans un contexte où les politiques de gratuité ciblée des soins visent à renforcer l'équité en santé maternelle, il est essentiel de comprendre comment ces dispositifs sont perçus et vécus au sein des structures sanitaires locales. Cet article analyse la réception sociale de la gratuité des consultations prénatales à Bouaké (Côte d'Ivoire) à partir d'une étude qualitative réalisée en avril 2025 dans un établissement public de santé. La recherche repose sur 28 entretiens semi-directifs menés auprès de femmes enceintes, d'agents de santé et d'hommes accompagnants, sélectionnés selon un échantillonnage raisonné et de convenance. Les résultats révèlent un décalage entre la gratuité officiellement annoncée et les pratiques quotidiennes, marquées par des frais fluctuants, la revente de fournitures médicales, des prescriptions coûteuses et une communication ambiguë. Ces dysfonctionnements alimentent une méfiance envers les prestataires de soins et fragilisent la relation de confiance,

contribuant à une baisse du recours aux consultations prénatales, notamment en début de grossesse.

Mots-clés : Gratuité ciblée des soins, consultations prénatales, santé maternelle, réception sociale des politiques de santé, confiance institutionnelle, Bouaké (Côte d'Ivoire).

Introduction

In Côte d'Ivoire, the policy of targeted free healthcare has been promoted as a key mechanism for improving access to maternal health services. Health professionals often present it as a guarantee that pregnant women can receive care without financial constraints. This political commitment is supported by a legislative framework, notably decree n° 2019-498 of 12 June 2019, which institutionalizes the targeted free provision of certain healthcare services and paraclinical examinations for pregnant women and children aged 0 to 5 years (République de Côte d'Ivoire, 2019).

This policy extends an initiative launched in 2012 in a post-crisis context with the aim of reducing financial barriers to healthcare access, particularly for vulnerable populations. The scheme covers antenatal consultations, childbirth, postnatal care, biological tests, ultrasounds, and the management of obstetric complications (Gouvernement de Côte d'Ivoire, s.d.). It also aligns with Côte d'Ivoire's international commitments in global health, particularly the Sustainable Development Goals (SDGs), especially SDG 3, which aims to ensure healthy lives and promote well-being for all (United Nations, 2015).

However, significant gaps have emerged between official standards and everyday practices within the health system. Lack of awareness of the policy among users, informal payments despite the announced free care, drug shortages, limited postnatal follow-up, and weak community accountability raise questions about the system's capacity to guarantee the proclaimed equity and universality.

The city of Bouaké, the country's second largest urban centre, illustrates these tensions. According to the Rapport Annuel sur la Situation Sanitaire (RASS), the maternal mortality rate there reached 1,833.9 deaths per 100,000 live births in 2020 (Ministère de la Santé et de l'Hygiène Publique, 2021). In North-East Bouaké, postnatal care coverage, although improving, has remained very low, increasing from 1% in 2008 to only 8.6% in 2019 (Diomandé, Kouassi, Koffi, and Traoré, 2023). These figures reflect persistent structural challenges and call for a critical examination of the real conditions under which targeted free healthcare policies are implemented.

This raises a central question: how is the policy of free antenatal care perceived and experienced in practice by pregnant women and health professionals within local healthcare facilities? Addressing this question requires attention not only to the economic dimension of access to care but also to its symbolic, relational, and social dimensions. Accordingly, this research explores the gap between the officially announced policy of free care and the representations, practices, and adjustments it generates among pregnant women, health workers, and relatives within a concrete local context..

1. Methodology

This study has adopted a qualitative approach because it provides access to the depth of lived experiences, social representations, and individual strategies that

public policies, particularly targeted free antenatal care, generate in practice. The objective has not been to measure the effectiveness of the policy through statistical indicators but rather to understand the tensions between institutional prescriptions and the lived realities of the actors involved.

To achieve this objective, we have used semi-structured interviews, which are particularly suited to capturing participants' discourses and experiences. The interviews have been conducted face to face in a confidential setting within a prenatal care unit of a public healthcare facility in Bouaké, and sometimes outside the facility by appointment, during April 2025. Participants have provided informed consent, and all interviews have been recorded with their authorisation and subsequently transcribed.

Sampling has varied according to actor categories. For health workers (two midwives, two nursing assistants, and one obstetrician) and men (seven partners or relatives of pregnant women), purposive sampling has been used in order to reach actors directly involved in prenatal care practices or decision-making processes. For pregnant women, convenience sampling has been applied by approaching them during prenatal consultation visits. In total, sixteen pregnant women have participated in the study.

Overall, twenty-eight semi-structured interviews (sixteen pregnant women, seven men, and five health workers) have been conducted until information saturation has been reached.

For the analysis, we have adopted Marc Corbière's (2020) descriptive interpretative approach combined with thematic content analysis. This method has enabled the identification of implicit meanings, action logics, and contradictions within participants' discourses. The most representative verbatims have been selected to illustrate shared experiences while respecting participants' confidentiality.

Finally, the cognitive dissonance theory (Festinger, 1957) has been mobilised to interpret the tensions between institutional messages promoting free care and women's concrete experiences of payment, which generate discomfort and may reshape their relationship to antenatal care.

2. Results

2.1. A proclaimed free care, but hardly perceptible by pregnant women

Free prenatal care, although displayed in health facilities and regularly announced by the authorities, seems to encounter very different realities on the ground. In Bouaké, the pregnant women interviewed express profound incomprehension towards a policy whose effectiveness appears limited, even contradictory. Health workers themselves admit that this free care largely depends on the availability of supplies, and that shortages result in costs that patients must bear. This section highlights how this situation creates an atmosphere of confusion, mistrust, and sometimes abandonment of care.

2.1.1. Officially free prenatal consultations but charged on the ground

In the health facilities surveyed, prenatal consultations are often subject to unexplained payments despite the policy of free care. This contradiction between institutional promises and everyday practices creates confusion and weakens women's trust in the healthcare system. To illustrate this uncertainty, a pregnant woman describes the unpredictable expenses she faces during consultations: « *Every day you come, there is a new price, even you yourself don't know who is telling the truth.* » (K.A.E, SEMI-STRUCTURED INTERVIEW, FEMALE, 2025). This testimony highlights a pricing instability that erodes women's trust in the healthcare system. The impossibility of anticipating costs and the absence of a clear explanation of what is truly free lead to progressive disengagement, especially for women with limited resources. The very idea of free care becomes blurred and is perceived as misleading communication.

This observation is also shared by health professionals, who themselves acknowledge the counterproductive effects of these practices on service attendance: « *What spoils the situation currently is that there are health centres where things that are free become paid for. So, when these women see that, it discourages them, and it can make them think they are being robbed.* » (K.Y, SEMI-STRUCTURED INTERVIEW, OBSTETRICIAN, 2025).

These contradictions create suspicion toward healthcare staff and weaken the trust necessary for regular pregnancy follow-up. As a result, the idea of free care is increasingly perceived as uncertain or misleading.

2.1.2. A free service conditioned on the availability of medical supplies

Another element emerging from the interviews concerns the dependence of free care on the availability of medical supplies. When these materials are not delivered by the State, healthcare workers report that they procure them themselves and resell them to patients. A midwife clearly explains this financial adjustment mechanism to which she and her colleagues are subjected: « *The booklet is made at 500F, the gloves at 200F and the albumin at 500F. It must be said that when the State sends this equipment, that's when the women no longer buy and we give it to them free of charge.* » (C.B, SEMI-STRUCTURED INTERVIEW, MIDWIFE, 2025). Although this practice aims to maintain service continuity, it creates confusion among women who often ignore the origin of the equipment. As a result, free care appears uncertain and dependent on local conditions rather than guaranteed by the State.

2.1.3. A standardised fee imposed on women on entry into certain facilities

In some cases, billing is organised as a single fee covering consultation, supplies, and tests. This cost, presented as unavoidable, contradicts the principle of free care. A nursing assistant explains the components of this payment: « *When a woman arrives at the health centre, she pays 1,500F for the consultation. The test strip and gloves are not free because we buy them. [...] Since the Treasury pays, we cannot make it free.* » (S.M, SEMI-STRUCTURED INTERVIEW, NURSING ASSISTANT, 2025).

This statement shows how payment is justified by internal management constraints. However, the absence of clear explanations about what is covered or

not increases confusion among patients. As a result, prenatal care proclaimed as free is often perceived by women as uncertain and dependent on the conditions of each facility. This situation reinforces mistrust and financial insecurity.

2.2. Health practices that blur the boundaries between care and commodities

Beyond unexpected fees in facilities supposed to offer free services, the survey also reveals strong tariff confusion. Costs vary from one facility to another and sometimes between patients, creating a perception of arbitrariness. This ambiguity fuels doubts, suspicions of dishonesty, and occasionally tensions within couples.

2.2.1. Variation in costs from one day to another, perceived as injustice

Interviewed women report that the same care can be charged differently depending on the day or the patient. One participant describes the difficulty of explaining these changes to her partner: « *When you come, it is not even the same money you will pay. Every day there is a new price. Like that, if you explain to the man, he thinks you are lying.* » (T.A.E, SEMI-STRUCTURED INTERVIEW, WOMAN, 2025).

This testimony shows how the absence of clear pricing makes it difficult for women to anticipate expenses and justify them to their partners, sometimes creating mistrust and tension within households.

2.2.2. Price Differences for the Same Service, depending on the Patient

In addition to daily variations, some women highlight disparities in treatment between patients, especially when they attend consultations together. The feeling of injustice is even stronger when they notice they pay different amounts for the same service, without explanation from healthcare workers. A participant in a focus group denounces this practice, which she finds incomprehensible: « *Often you go with your friend, for you they take 2,000F. For her, it can even be more and it's the same thing they give us both. When you ask, they will explain a lot of things but you yourself don't understand anything.* » (K.A.T, SEMI-STRUCTURED INTERVIEW, WOMAN, 2025).

This testimony confirms that tariff variability, when not based on any clear scale for beneficiaries, is interpreted as a lack of transparency, even as an abuse of power by healthcare workers. This price opacity undermines trust in the system and fuels rumours that caregivers set prices at their own convenience.

2.2.3. Medicines resold at higher prices than in urban pharmacies

In some rural facilities, healthcare workers resell prescribed medicines at prices higher than those in city pharmacies. Women often realise this when comparing prices and may choose to change health centres to obtain fairer costs. One participant explains this strategy: « *It's the cost because for the same medicine prescribed here, when you go elsewhere in another centre to pay, the prices are not the same. So, these women prefer to pay for transport to go where they are honest with them.* » (K.S, SEMI-STRUCTURED INTERVIEW, WOMEN, 2025).

This testimony shows that the choice of a health centre increasingly depends on economic trust rather than proximity. Women may travel further to avoid what they perceive as unfair practices. A similar perception is expressed by a male participant:

« The prescriptions we give to our women here with prices marked on them, when you go to the city you see that it's not the same price. Since we're in the

bush, they're not honest with us. They increase everything, so it doesn't encourage because a woman who sees that clearly prefers not to go there anymore and prefers to pay for her transport to go to the city at the same time.
» (K.N, SEMI-STRUCTURED INTERVIEW, MAN, 2025).

This testimony reinforces the perception of a two-speed system in which inhabitants of peripheral areas feel marginalised. The experience of tariff injustice becomes collective through comparison and word of mouth, calling into question the universality of access to care promoted by public policies. Beyond the cost itself, the absence of clear and fair price regulation contributes to declining attendance at prenatal consultations. Women feel less protected by the health system and increasingly exposed to variable commercial practices. This situation blurs the boundary between care and commodity, turning the consultation into a space of uncertainty rather than security.

The following section examines how this confusion around free care is reflected in the mother-child health booklet, an essential monitoring tool that is also subject to resale practices

2.3. The mother-child health booklet : between irregular supply and commercialisation

The mother-child health booklet is a key tool in pregnancy monitoring. It symbolises the pregnant woman's entry into the formal healthcare system and centralises essential medical information. Normally provided free of charge by the State during the first prenatal consultation, it represents the principle of equitable access to care. However, field results in Bouaké show that this booklet has become a problematic object. Stock shortages, resale practices, local paid production, and uncertainty about its origin illustrate the broader confusion surrounding the policy of free care.

Healthcare professionals explained that the free distribution of the mother-child health booklet depends on supplies provided by health authorities. When these are unavailable, some facilities resort to locally produced booklets that are sold to patients. A midwife describes this situation :

« Regarding the booklet, at one time the State provided us with the booklets and when women came, we asked them to see the manager who is the PGP and he gave them for free. But, for some time now, the State no longer sends the booklets. It is the Treasury that sends them to us, but since the Treasury pays, we cannot make it free because we have to pay the money back there. »
(K.A, SEMI-STRUCTURED INTERVIEW, MIDWIFE, 2025).

This testimony shows that the free status of the booklet depends on administrative supply systems. When these fail, facilities transfer the cost to patients, transforming a tool meant to guarantee access to care into a paid item.

Most pregnant women, however, do not understand why the booklet is free in some centres but paid in others. This inconsistency reinforces their perception of an unclear and unfair system and fuels mistrust toward healthcare providers.

Caregivers themselves acknowledge being caught between the need to maintain services and the lack of resources to guarantee free care. As a result, the booklet sometimes becomes a commercial object rather than a universal healthcare tool.

The following section examines another consequence of this confusion: the postponement of prenatal consultations by women seeking to limit expenses

2.4. Variation in the cost of prenatal consultations and doubt around prescriptions

Beyond the repeated expenses related to prenatal care, women interviewed in Bouaké also reported constant variations in costs between consultations and between patients. These inconsistencies are often combined with prescriptions perceived as excessively priced. When women realise that their expenses differ from those of other patients who received the same care, they feel unfairly treated. This situation fosters suspicion toward healthcare workers and leads some women to seek care in other facilities considered more transparent.

2.4.1. Pricing perceived as incoherent from one consultation to another

In several accounts, pregnant women express their incomprehension at price changes for the same service. These variations, whether due to additional tests or specific prescriptions, are not always explained, which reinforces the feeling of injustice. One woman comments on the difficulty of justifying these discrepancies to her partner: « *When you come, it is not even the same money you will pay. Every day there is a new price. Like that, if you explain to the man, he thinks you are lying.* » (T.A.E, SEMI-STRUCTURED INTERVIEW, WOMAN, 2025).

This verbatim reveals the negative social effect of pricing unpredictability on the pregnant woman. The lack of explanation about cost variations weakens her word and puts her in difficulty within her family environment. Care thus becomes not only an economic burden but also a space of marital tension, where the woman must justify expenses she does not control.

2.4.2. Price gaps between patients, experienced as arbitrary

Women also expressed their unease about situations where, for the same service, prices vary between patients. This perceived inequality feeds the impression of arbitrariness and opacity in tariff management. A participant relates an experience that perfectly illustrates this incomprehension: « *Often you go with your friend, for you they take 2,000F. For her, it can even be more, and it's the same thing they give us both. When you ask, they explain a lot of things, but you yourself understand nothing.* » (K.A.T, SEMI-STRUCTURED INTERVIEW, WOMAN, 2025).

This testimony reflects deep discomfort at a lack of transparency. Caregivers' attempts at explanation do not dissipate the feeling of opacity. For women, these unjustified gaps fuel mistrust and may be interpreted as manipulation or disguised favouritism.

2.4.3. Prescriptions with overpriced medicines, according to women

Another source of frustration concerns prescribed medicines. Some women say they noticed that medicines sold in their health centre cost more than in other facilities or urban pharmacies. This nurtures the idea that healthcare workers, particularly in rural areas, profit from their position for financial gain. One woman clearly expresses this perception and the choices it leads her to make: « *It's the cost, because for the same medicine prescribed here, when you go elsewhere in another centre to pay, the prices are not the same. So, these women prefer to pay for transport to go where they are honest with them.* » (K.S, SEMI-STRUCTURED INTERVIEW, 2025).

The word « honest » is revealing. It expresses the feeling of abuse, an imbalance in the caregiver-patient relationship that goes beyond the medical framework to affect dignity. The woman prefers to travel further to regain a trust relationship, showing a loss of legitimacy of some local facilities. This feeling is confirmed by a man speaking on behalf of his community:

« The prescriptions we give to our women here with prices marked on them, when you go to the city, you see it's not the same price. Since we are in the bush, they are not honest with us. They increase everything, so it doesn't encourage. Because a woman who sees that clearly prefers not to go there anymore and prefers to pay for her transport to go to the city at the same time. » (K.N, SEMI-STRUCTURED INTERVIEW, MAN, 2025).

This statement reflects a collective feeling of territorial discrimination. Residents of rural areas feel disadvantaged because of their isolation, which weakens their trust in local health services and encourages them to seek care elsewhere.

These elements reveal a clear gap between the promise of an egalitarian healthcare system and women's lived experiences. Variations in costs between facilities and patients, combined with unclear explanations and suspicions of price manipulation, create economic insecurity and confusion about the reality of free care.

2.5. Contradictory information on free care and its effects on trust and healthcare utilisation

In several health centres visited in Bouaké, posters announce the free prenatal consultation. However, this institutional communication, far from reassuring women, often contradicts their real experience. The presence of official messages is not enough to compensate for the gap between what is said and what is lived. This contradiction fuels feelings of incomprehension, frustration, even betrayal, and profoundly weakens trust in health facilities.

2.5.1. Institutional communication disconnected from practices

Several women expressed their surprise and dismay when confronted with payments despite posters in centres announcing free care. This situation leads them to question the credibility of official information and to doubt the good faith of healthcare workers. One woman testifies to this contradiction between the posted message and payment demands: « *Often when you go there, it is written that the consultation is free, but when you go, they tell you to pay. Even the gloves, they make us pay for the pack. But if they took too many, it's only two, and then they keep the rest. All this discourages us too.* » (O.R, SEMI-STRUCTURED INTERVIEW, WOMAN, 2025).

This verbatim shows that the contradiction between words and actions causes a double dissatisfaction: on one side, incomprehension at the unexpected payment, and on the other, suspicion of abusive practices regarding material distribution. The act of « *only giving two gloves* » while keeping the rest of the pack is seen as a form of unjust appropriation, casting doubt on the system's transparency.

2.5.2. The ambiguity of the message on free care fuels scepticism

The women interviewed struggle to distinguish what is truly free and what is subject to payment. This confusion stems not only from a lack of oral explanation

but also from an absence of concrete reference points on the limits of coverage. One pregnant woman expresses this growing uncertainty:

« They say when you're pregnant to come, that it's free, but when you come, it's not free. Often, we go, they give us a free booklet, but often others go, and it becomes paid, so we ourselves don't know what we're supposed to do. Because we are here, we don't know anything about it. So, we don't know if they're stealing from us or if it's the truth. Yet, they stuck on their board free prenatal consultation, but it's not that, huh. When you want to talk, they say it was before. » (O.M, SEMI-STRUCTURED INTERVIEW, 2025).

This testimony highlights the fragility of institutional discourse when not accompanied by clear explanations. The alternation between announced free care and actual billing feeds a generalised doubt. The woman no longer knows if she is a victim of a scam or legitimate administrative reality. This ambiguity sustains a climate of misunderstanding where care is no longer perceived as a guaranteed right but as an à la carte service subject to shifting rules.

2.5.3. Mutual misunderstanding affecting the caregiver-patient relationship

This discordance in representations of care between patients and caregivers results in confrontations. Some women, seeking explanations, encounter curt or evasive answers, which deteriorates the quality of the relationship and strengthens mistrust. A healthcare worker bitterly recalls such a situation: « *It must be said that these are the informations the government spreads, huh, because we tell them that the consultation is free, and when she comes, she realises that nothing is free. We tell her: pay for gloves, because I also paid. Well then, it becomes a confrontation between her and us. Either I'm lying.* » (O.F, SEMI-STRUCTURED INTERVIEW, MIDWIFE, 2025).

The caregiver appears caught between government discourse and field realities. This situation creates tensions that weaken mutual trust and undermine the professional authority needed to ensure effective prenatal follow-up.

These testimonies show that confusion around free care is not only related to costs but also reflects a broader crisis of communication and trust. The gap between institutional discourse and women's experiences leads to uncertainty, postponement of care, and sometimes rejection of local health facilities. Prenatal care, meant to reassure women, may instead become a source of disillusionment.

3. Discussion

3.1. A proclaimed free service, but hardly perceptible by pregnant women

In a political context where free prenatal care is presented as a guaranteed right by the Ivorian health authorities, particularly through Decree No. 2019-498 of 12 June 2019, our study reveals a deep gap between institutional discourse and lived practices in Bouaké. This discrepancy appears through three main elements: persistent billing, conditional free care, and opaque pricing practices.

The first aspect concerns the continued billing of prenatal consultations despite their official designation as free. Women report systematic and unpredictable fees during consultations, generating a feeling of injustice. This finding echoes the work of A. FAYE et al. (2022, p. 89), who show that in Senegal nearly half of women receiving prenatal care in rural areas had to pay for services that were officially free. TRAORE et al. (2021, p. 103) in Burkina Faso also highlight that unclear communication about what is covered creates confusion about free care.

The second aspect relates to the conditional nature of free care, which applies only when medical inputs are available. In cases of shortages, caregivers procure materials themselves and resell them to patients, creating unofficial monetisation. D. ZOMBRE et al. (2023, p. 57) observed that 62% of Ivorian health facilities surveyed reported frequent stock-outs of gloves, booklets, or test strips. DIARRA et al. (2021, p. 116) similarly identify supply chain failures in Mali as a key factor behind illegitimate billing.

The third aspect concerns the establishment of standardized tariffs in some facilities, where consultations, supplies, and tests are grouped into a single opaque fee. This practice was also observed by KONE et al. (2023, p. 49), who show that unannounced prenatal packages encourage subjective interpretations of the real cost of care. In the DRC, according to an analysis by Le Monde (2024), health workers have sometimes adopted intermediate pricing strategies to compensate for financial constraints.

Overall, although free care is legally established, it appears in practice as uncertain and discontinuous. It is often perceived as an inapplicable norm and a broken promise, generating disillusionment and weakening adherence to maternal healthcare services.

These findings fit into a dynamic of institutional cognitive dissonance, where the gap between what is announced and what is practised creates confusion in the perception of the healthcare system. The inconsistency between stated free care and lived reality contributes to a rupture of trust and to a gradual process of de-institutionalisation of the right to care (L. FESTINGER, 1957; WARIN, 2006; GIRAUD, 2010).

3.2. Health practices that blur the boundaries between care and commerce

In the health facilities investigated in Bouaké, prenatal care is increasingly perceived by pregnant women not as a guaranteed right but as a monetised service with uncertain contours. The fluctuation of consultation costs is a major source of concern. Women report unpredictable and unexplained fees, forcing them to justify variable expenses to their partners and sometimes provoking mistrust within couples. This instability fuels a sense of injustice.

Similar observations have been made by DIARRA et al. (2021, p. 116) in Mali, where 91.7% of pregnant women postponed their first consultation due to unclear information regarding fees. However, our study highlights an additional dimension: beyond financial barriers, these practices create conjugal tensions. Women thus face a dual burden, both economic and relational, revealing the intersection between healthcare commodification and family dynamics.

Price variation also occurs among women receiving identical services within the same facility. Several participants denounced unjustifiable discrepancies in payment, which generate indignation and deep mistrust toward healthcare staff. NIANG et al. (2023, p. 89) in Senegal similarly show that the absence of clear pricing discourages healthcare utilisation, particularly among vulnerable women. In our case, tariff inconsistency reinforces perceptions of arbitrariness and favouritism.

This situation produces a form of cognitive dissonance, where the promise of free care contrasts with everyday experiences of payment. These contradictions blur reference points and gradually erode women's trust in the health system and in the intentions of caregivers.

Finally, commodification is also reflected in the resale of medicines within certain health facilities, often at prices considered excessive. This parallel market, sometimes managed by healthcare workers themselves, creates uncertainty among patients and encourages avoidance strategies. LUSAMBA (2022, p. 74) in the DRC similarly observed that resale practices constitute informal deviations that exacerbate inequalities in access to care.

Beyond the financial issue, women experience these practices as forms of deception and betrayal by those meant to protect them. This ethical and symbolic dimension, rarely captured in quantitative studies, represents one of the key contributions of our qualitative approach.

Overall, the practices observed in Bouaké reveal that the blurring of boundaries between care and commerce undermines the foundations of the caregiver–patient relationship. By highlighting the social, conjugal, and symbolic effects of this commodification, our study contributes to expanding the analysis of healthcare non-utilisation by integrating subjective and locally grounded dimensions.

3.3. The maternal and child health record booklet: between medical right and market commodity

Field data analysis shows that the *carnet mère-enfant*, originally intended as a free public health tool, is increasingly becoming a commercial product in several health facilities in Bouaké. This shift is linked to irregular state supply, which leads some facilities to reproduce the booklet locally for sale. While the booklet symbolises women's entry into the formal healthcare system, it becomes governed by market logics, blurring the boundary between the right to health and commercial transaction.

Similar situations have been reported in other contexts. MPUTU et al. (2021, p. 101) note that in several West African countries, supply chain failures force health facilities to adopt paid alternatives. Likewise, DIALLO & S. S. TOURE (2022, p. 59) show in Guinea that the sale of originally free booklets has become common in disadvantaged urban and rural areas. However, these studies focus mainly on management issues rather than on the social perceptions of women.

Our findings highlight that for many pregnant women, paying for the booklet represents a symbolic betrayal of the promise of equitable access to care. This ambiguity undermines the credibility of health institutions and contributes to a growing climate of mistrust toward the healthcare system.

More broadly, the commercialisation of the *carnet mère-enfant* generates confusion regarding the free care policy. Uncertainty about the booklet's origin, price, and distribution criteria leads women to question why some receive it free while others must pay. Zinsou and Hounkpe (2023, p. 87) similarly observe in Benin that disparities in access to monitoring tools fuel rumours and suspicions of corruption in health facilities.

However, our study shows that these ambiguities also have behavioural consequences. Doubts about the legitimacy of the booklet's price may weaken trust in health workers and lead some women to distance themselves silently from the healthcare system.

This commodification also affects healthcare providers, who are caught between their public service mission and the need to finance booklet reproduction. In the absence of official regulation, they often seek reimbursement from patients. Adjah

and KOULIBALY (2024, p. 122) highlight similar tensions between medical responsibility and survival strategies in under-resourced facilities.

Our research further demonstrates that this situation alters how caregivers are perceived by patients, who struggle to distinguish between medical and commercial roles. This blurring of roles weakens the caregiver–patient relationship and fuels suspicion about the integrity of the system. The booklet, which should function as a tool of trust, thus becomes a marker of exclusion.

3.4. The variation in CPN costs and the emergence of doubt surrounding prescriptions

One of the main findings of our study concerns the inconsistency of costs applied to antenatal consultations, both from one day to another and between patients. This pricing instability generates confusion and financial stress for pregnant women, especially as these differences are rarely explained. It weakens their ability to anticipate healthcare expenses and reinforces economic insecurity.

Similar observations have been made in other contexts. MAIGA & TRAORE (2023, p. 45) show that the absence of price standardisation constitutes a major barrier to regular antenatal care in Burkina Faso. Likewise, MPUTU & S. S. KALALA (2021, p. 92) in the DRC demonstrate that price ambiguity often leads to the postponement or abandonment of care in public health centres. However, Ouedraogo and Konaté (2022, p. 64) suggest that some variations may reflect adjustments to clinical needs.

Our findings indicate that the main problem lies not in price variation itself but in the absence of clear explanations and regulation. This lack of transparency reinforces perceptions of injustice and links pricing inconsistency to women's social vulnerability and their gradual withdrawal from care.

The perception of injustice becomes stronger when two women receiving similar services in the same facility are charged different amounts. Such situations are often interpreted as favouritism or manipulation, seriously undermining trust in healthcare personnel. NIANG et al. (2023, p. 89) similarly show in Senegal that a lack of transparency in cost management fuels mistrust and rumours of corruption in community health centres.

Conversely, Assandé and M. BROU (2021, p. 110) note that some pricing differences may result from occasional subsidies granted to vulnerable women. However, our study focuses on the viewpoint of beneficiaries and shows that the absence of public justification for these disparities remains the central source of mistrust.

Another sensitive issue concerns the cost of medicines prescribed during antenatal consultations. Many women report that medicines are sold at higher prices than in town pharmacies, particularly in rural areas, which creates a feeling of exploitation and encourages some women to avoid local health centres.

This situation has also been documented by LUSAMBA (2022, p. 74), who shows that the unregulated resale of medicines in public facilities contributes to declining use of primary healthcare services in several Central African countries. TRAORE & K. BAMBA (2023, p. 138) in Côte d'Ivoire also emphasise the role of stockouts and irregular supply chains as structural causes.

Our study complements these explanations by highlighting the symbolic consequences of these practices. When actions contradict the promise of free care,

patients may interpret the health system as deceptive, producing a form of institutional cognitive dissonance and weakening trust in healthcare institutions.

Overall, price variation, unexplained discrepancies, and the feeling of manipulation contribute to a gradual breakdown of trust between pregnant women and healthcare facilities. This situation transforms the perception of antenatal care from a public health service into a space of financial uncertainty. Our findings therefore call for a rethinking of free healthcare policies grounded in the lived experiences of beneficiaries.

3.5. Contradictory information on free care and its effects on trust and healthcare-seeking behaviour

Field findings reveal a clear disconnect between institutional messages displayed in Bouaké's health centres and the realities experienced by pregnant women. Although free antenatal care is publicly promoted, women are still required to make unexplained payments. This contradiction generates frustration and undermines trust in the health system. Similar observations have been made by B. KAMAGATE & DIARRA (2022, p. 58) and Soumaré and NDIAYE (2023, p. 105), who link such dissonance to disengagement from maternal health services. Some authors offer a different interpretation. A. BATIONO & S. S. KINDA (2021, p. 139) suggest that persistent doubt may result from low literacy levels among beneficiaries. However, our findings show that even literate women develop scepticism when written messages contradict their lived experiences. This indicates that the problem lies less in access to information than in inconsistencies in policy implementation.

A second issue concerns the ambiguity surrounding the services actually covered by the free care policy. Many women report confusion about what should be free and what must be paid for. This lack of clarity creates suspicion, reinforced by contradictory experiences during consultations. Similar findings were reported by DIALLO & I. I. BARRY (2021, p. 122) in Mali and by J. GOMEZ & F. F. SAGNA (2024, p. 67) in Côte d'Ivoire. Other scholars attribute this confusion to internal communication problems within health teams. For instance, A. NGUESSAN (2022, p. 88) suggests that inconsistent information among health workers contributes to misunderstandings. Our study goes further by showing that the coexistence of conflicting messages within the same setting creates a perceptual rupture that prevents coherent appropriation of the policy.

The gap between institutional discourse and daily practices also destabilises the relationship between women and healthcare professionals. Caregivers often lack the means to explain why certain services presented as free still require payment. This situation places them in a defensive position and weakens interpersonal trust. Similar tensions are reported by YAO & M. M. KOUASSI (2023, p. 92) and KOULIBALY (2021, p. 111). Our study shows that this situation produces a dynamic of mutual disengagement between patients and healthcare providers. Instead of functioning as a space of mediation and protection, healthcare becomes a site of confrontation. This transformation contributes to what can be described as a desymbolisation of care. Ultimately, the contradiction between the institutional promotion of free care and the persistence of payments leads to a collapse of trust. What discourages women from seeking care is not only the cost itself but also the feeling of deception. As a result, some women gradually distance themselves from the healthcare system. This erosion of trust reflects a process of cognitive dissonance between public norms and social reality. Women come to interpret free

care not as a failing right but as an illusion maintained by the system. This perspective helps explain why adherence to maternal health policies weakens even when some services are effectively free.

Conclusion

The qualitative study conducted in Bouaké on the targeted free antenatal care policy reveals a significant gap between institutional intentions and the lived experiences of beneficiaries. Although free care is promoted as a pillar of maternal health policy, many pregnant women perceive it as vague, inconsistent, or even illusory. Variable billing, the resale of supposedly free supplies, and ambiguous communication contribute to this perception and weaken trust in health centres. These contradictions reduce adherence to antenatal care and sometimes push women towards delayed or risky alternatives. The main contribution of this study lies in shifting the focus from technical evaluation to the analysis of social perceptions. By integrating the perspectives of women, men, and healthcare workers, the research highlights the tensions and misunderstandings surrounding the implementation of this policy.

However, the study has several limitations. The qualitative approach, while useful for understanding lived experiences, does not allow measurement of the statistical scope of the observed phenomena. In addition, convenience sampling among women attending consultations may have excluded the most marginalised profiles, particularly those who no longer use health services. The research was also limited to a single public healthcare facility in Bouaké, which may restrict the generalisability of the findings. Since Bouaké includes other districts such as the North-West and South districts, future studies should collect comparative data from these areas to better capture contextual variations. Future research could combine qualitative analysis with large-scale quantitative surveys. A quota-based sampling strategy including women who avoid health services would help identify exclusion or self-reliance mechanisms. Extended participant observation in health facilities could also provide deeper insight into everyday interactions between staff and patients. From an operational perspective, several recommendations emerge. Health centres should clearly define and publicly display the services included in the free care package, ideally through visible charts translated into local languages. The State should also ensure regular supply of materials to prevent shortages that encourage informal resale. Community monitoring mechanisms involving user representatives could help report unauthorised billing practices. Continuous training of health workers on ethics, transparent communication, and public service values is also essential to rebuild trust between professionals and patients. Finally, a toll-free number or accessible mediation channel could allow users to report complaints and resolve disputes more effectively. In conclusion, free healthcare cannot be reduced to a decree or a public notice. Its effectiveness depends on coherent practices, adequate resources, and transparent relationships between institutions and users. The right to maternal health will only be fully realised when policies systematically integrate the perceptions and experiences of the populations they aim to serve.

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