

Factors Facilitating the Uptake of Post-Abortion Care Services in Dar es Salaam, Tanzania

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Abstract

Unsafe abortion is associated with health complications which contribute to the global burden of maternal mortality. Post-abortion care is then promoted as a key strategy for addressing complications associated with unsafe, induced and spontaneous abortion. Prompt utilization of post abortion care (PAC) services has high chances of reducing the morbidity and mortality associated with abortion complications. This article employs data from a cross-sectional study in Temeke District in Dar es Salaam, Tanzania, involving 103 women who sought PAC services from health facilities. Qualitative and quantitative approaches were applied in the collection and analysis of data. Random sampling was used to select the facilities, while the respondents were recruited through criterion sampling. A semi-structured questionnaire was administered to women who utilized PAC services when they were about to exit health facilities. A descriptive thematic analysis approach was employed to analyse qualitative information, while descriptive statistics and univariate approaches were used to analyse quantitative data. The findings revealed that the availability of PAC services in the study facilities, sharing of information about one's health status, ability to cater for transport and treatment costs, privacy and less waiting time, as well as availability and reliability of transport for emergency cases were the main factors that facilitated the uptake of PAC services. Also, the findings suggest that in areas where abortion is stigmatized and legally restricted, utilization of PAC services can be enhanced if such services are openly available and affordable. Moreover, privacy and less waiting time may further guarantee the uptake of PAC services. Likewise, there is a need to raise awareness about PAC and the availability of PAC services in Tanzania. Also, efforts should be made to ensure that privacy is maintained throughout the delivery of care to enhance the utilization of PAC services.

Keywords: *post-abortion, care, uptake, services, Tanzania*

1. Introduction

Maternal mortality is regarded as a global public health problem (Shirin & Nahar, 2012). About 13% of maternal mortality in the world is attributed to complications associated with unsafe induced abortion (Singh et al., 2009). In East Africa, over 18% of maternal mortality is attributed to unsafe induced abortion complications (WHO, 2011), while in Tanzania, estimates range between 13% and 25% (Keogh et al., 2015; Woog & Pembe, 2013; MoHSW, 2008). Over 15% of all pregnancies in the world are estimated to end in spontaneous

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abortions (WHO, 2007a; Curtis, 2007). Health problems associated with unsafe induced abortion and spontaneous abortion include shock, infection, haemorrhage and blood clotting (Tesfaye & Oljira, 2013).

Women who experience abortion-related complications need care regardless of whether the abortion was induced or spontaneous (Owolabi et al., 2019). PAC is a package of services offered to women after an incomplete abortion, whether spontaneous or induced. The package has five major elements, namely: (i) treatment of incomplete abortion and complications that are potentially life-threatening; (ii) counselling so as to identify and respond to women's emotional and physical health needs; (iii) contraceptive and family planning services to prevent unintended pregnancies and for birth spacing; (iv) reproductive and other health services that are preferably provided on-site or via referrals to other accessible facilities; and (iv) partnership between the community and service providers to prevent complications, mobilize resources, and ensure that health services meet community expectations and needs (PCC, 2002; Corbett & Turner, 2003; Owolabi et al., 2019).

PAC is promoted as a key strategy for treating complications associated with incomplete or induced abortions (Adinma, 2012). Prompt utilization of PAC reduces the chances of progression to maternal morbidity and mortality (Okonofua, 2006; WHO, 2007b; Singh et al., 2009; Woog & Pembe, 2013). The WHO recommends that a woman who has had an induced or spontaneous abortion should wait for at least six months before conceiving her next pregnancy (WHO, 2007b). Thus, PAC family planning and counselling can lead to increased contraceptive uptake, hence breaking the cycle of repeated unwanted pregnancies and induced abortions (Ceylan et al., 2009; Curtis, 2007; Woog & Pembe, 2013).

Induced abortion is not legally permitted in Tanzania unless it is confirmed that the continuation of the pregnancy will endanger the life of the mother (URT, 1981). The legal restriction has made it difficult to estimate the incidences of induced abortion in Tanzania. However, available information indicates that induced abortion is practised despite the restrictions. A study on incidences of induced abortion and post-abortion care in Tanzania indicates that the rate of induced abortion is 36 abortions per 1,000 women of the reproductive age, which is between 15 and 49 years (Keogh et al., 2015). Hospital-based studies show that up to 60% of the women admitted with abortion-related complications in Tanzania have had induced abortions (Rasch et al., 2000, 2004; Rasch & Kipingili, 2009; Woog & Pembe, 2013). Induced abortions performed in legally restricted settings are likely to end up in complications (Grimes et al., 2006), necessitating the need for PAC services.

The provision of PAC services in Tanzania started after the 1994 *International Conference on Population and Development* (MoHSW, 2008). Since then, various steps have been taken by the government to enhance the provision of these

services. The government removed all barriers to accessing family planning services (Jain et al., 2006); and there has been a scale-up of comprehensive PAC by developing a curriculum on PAC clinical skills to train middle-level health service providers (clinical officers and nurse-midwives) to ensure PAC services are available at lower-level health facilities (MoH, 2002). In addition, the government has been working in partnership with various organizations such as *Engender Health* to provide PAC services and incorporate the use of misoprostol in PAC services (VSI, 2011; Mwanga et al., 2013). All these efforts are geared towards reducing complications associated with abortion, and therefore reduce maternal mortality.

It is evident that in settings where abortion is illegal and stigmatized, access to post-abortion care is difficult. In such settings, a proportion of women suffering from abortion-related complications may not seek care from health facilities due to stigma or the lack of appropriate information about PAC (Keogh et al., 2015; Okonofua, 2006; Singh, 2006). Studies have identified barriers to accessing PAC services to include shortage of trained providers, lack of equipment, restrictive religious and cultural factors, financial constraints, fear of being abused by providers, and legal issues (Araújo et al., 2018; Maternowska et al., 2015; Sully et al., 2018; WHO, 2012; Vlassoff et al., 2012; Mutua et al., 2018). In the same settings, some women requiring PAC may manage to access PAC services despite these challenges.

Although PAC services have been offered in Tanzania since the 1994 conference, available data indicates that for each woman treated for abortion complications, six others who experience abortion complications do not receive care (Keogh et al., 2015). This is enough evidence that there is low utilization of PAC services in Tanzania. For those who manage to seek and access care from health facilities, information about the factors that make them seek PAC services have not been identified, and therefore are poorly understood. Thus, this study investigates factors that enable women to utilize PAC in three health facilities in Temeke District, Dar es Salaam, Tanzania.

2. Materials and Methods

The study was carried out in three health facilities, in Temeke District, Dar es Salaam. It covered the period from June 2014 through February 2015, and it involved 103 users of PAC services. Temeke District was chosen because it has facilities offering PAC services. Moreover, it is a district where low- and middle-income people co-exist. An earlier study in Temeke District (Rasch et al., 2004) indicated that it was feasible to undertake a study of this nature in the area. This study applied a cross-sectional design where both qualitative and quantitative approaches were applied in the process of data collection and analysis.

2.1 Sampling

A random sampling technique was used to select the PAC offering facilities based on the information provided by the then Ministry of Health and Social Welfare in 2011; which indicated that PAC services were being provided in two health centres and two hospitals (all public), and one private facility in Temeke District (MoHSW, 2011). In 2013, one of the health centres was upgraded to a district hospital. At the time of this study, PAC services were being offered in three government health facilities (one health centre, one district hospital, and one regional referral hospital), and one private facility. Thus, two government facilities were selected randomly while the private facility was selected strategically since it was the only facility from the private sector that was offering PAC at that time. Therefore, three health facilities were studied: two public, and one private. For confidentiality, the selected facilities were named A, B and C. The patients were recruited to the study by criterion sampling. This technique was adopted because non-probability sampling techniques are suitable for a sensitive or hard-to-reach population from which a list of all possible elements of the population is difficult to obtain (Berg, 2004). A patient was recruited if she was experiencing abortion-related complications and sought for care from the study facilities regardless of whether the complications were related to induced or spontaneous abortion.

2.2 Data Collection

A semi-structured questionnaire was administered to the participants when they were about to exit the facility. The questionnaire consisted of closed and open-ended questions that facilitated the collection of qualitative and quantitative information. A patient was recommended for an interview after the provider had been satisfied that her condition had improved to respond to interview questions. Patients who were critically ill; those who were under the age of 18 who did not have an accompanying parent, family member or a guardian; and those whose parents/guardians refused consent were excluded. The researcher approached the patient to request her involvement in the study.

Table 1: Response Rate Among Users of PAC Services

Facility	Successfully Interviewed		Refusals	
	n	%	n	%
A	27	65.7	13	32.5
B	47	70.1	29	29.9
C	29	67.4	14	33.6
Total	103		56	
N= 159				

Source: Field survey data, 2014-2015

A total of 159 patients who had received PAC services from the study facilities were recruited. However, only 103(64.7%) were interviewed. In facility A, a total of 40 patients were recruited and only 27(65.7%) were interviewed; in facility B,

67 patients were recruited, and only 47(70.1%) were interviewed; while in facility C, 43 patients were recruited, and only 23 (67.4%) were interviewed. A special place in each study facility premises was identified for conducting the interviews to ensure privacy, confidentiality and freedom during the interviews.

The approval for the study was granted by the Tanzania National Institute for Medical Research (NIMR). Consent to participate in the study was sought verbally from the participants. Patients were informed that their participation in the study would be voluntary, and non-participation would not lead to any consequences related to their treatment. Participants were assigned pseudo-names during the interviews. The interviews were tape-recorded with permission from the respondents. The recorded information was kept securely by the researcher; and the identities of the participants were not revealed in any of the transcriptions.

2.3 Data Analysis

The study used a semi-structured questionnaire with closed and open-ended questions in capturing qualitative and quantitative information. This called for the use of both qualitative and quantitative approaches to organize and analyse the data. Using the two approaches facilitated the integration of qualitative and quantitative information to gain a comprehensive understanding of the topic under investigation. The information collected from open-ended questions was transcribed soon after data collection to avoid stockpiling and forgetting some valuable information. Coding was done with the aid of NVivo 9.0, a software programme that helps to organize qualitative data. Descriptive thematic analysis was employed by using both inductive and deductive approaches. The inductive approach allows research themes to emerge from the data (Thomas, 2006). The deductive approach involved checking the transcriptions from the open-ended questions, and coding them under similar themes. The topmost-level categories formed the main headings, while specific categories came under the sub-headings in writing up the findings. Some quotes were identified from the nodes to illustrate or provide more meaning of the themes that emerged. The Statistical Package for Social Sciences (SPSS) Version 20 was used to analyse quantitative data. Frequency and percentage tables were constructed to indicate the distribution of variables. The mean value was calculated for continuous variables like age. The second level of analysis was univariate where cross-tabulation was done to assess the relationship between the variables.

3. Results

3.1 Characteristics of the Study Participants

The mean age of the users of PAC services was 26.2 years, while the median age was 25 years. Close to half (45.6%) were below 25 years old. Age groups 15-19 and 20-24 represented adolescents and young women, respectively (Table 2).

Table 2: Distribution of the users of PAC services

Characteristic	Frequency (n)	Percentage (%)
Age		
15-19	17	16.5
20-24	30	29.1
25-29	22	21.4
30-34	20	19.4
35-39	14	13.6
Total	103	100
Marital Status		
Single	51	49.5
Married	38	36.9
Cohabiting	14	13.6
Total	103	100
Education		
Primary	52	50.5
Secondary	45	43.7
Tertiary	06	5.8
Total	103	100
Occupation		
Employed	18	17.5
House wife	38	36.9
Self-employed	34	33.0
Student	13	12.6
Total	103	100
Religious Affiliation		
Muslim	52	50.5
Christian	51	49.5
Total	103	100
Place of Residence		
Temeke	98	95.1
Kinondoni	1	1.0
Ilala	3	2.9
Outside Dar es Salaam	1	1.0
Total	103	100

Source: Field survey data, 2014-2015

This finding corroborates earlier studies in Tanzania which showed that most users of PAC services are likely to be under 24 years of age (Rasch et al., 2004, 2009). It also relates to studies in Ethiopia (Kumbi et al., 2008), Nigeria (Henshaw et al., 2005) and Zambia (Likwa & Whittaker, 1996), which showed that users of PAC services are more likely to be under 25 years; and that having a high proportion of younger women seeking PAC services may be associated with improvement in their care-seeking behaviour (Sathar et al., 2013). Other studies

have found that younger women are at greater risk of suffering from abortion complications than older women (WHO, 2013), but they are more likely to delay seeking PAC services (Bruyn & Packer, 2004).

Close to two thirds (64.4%) were not married, while only 36.9% were married. These results are similar to findings by studies in Ethiopia (Demtsu et al., 2014), Nigeria (Henshaw et al., 2005) and Zambia (Likwa & Whittaker, 1996). Studies elsewhere have shown that women who are married are more likely to seek PAC services than unmarried women (Sathar et al., 2013; Gebreselassie et al., 2010).

About half (50.5%) had primary education, 43.7% had secondary education, and only 5.8% were educated beyond secondary school. Women's formal education may have a positive impact on the utilization of PAC services. A study in Pakistan revealed that education contributed to high acceptance of PAC services (Azmat et al., 2012). Formal education may lead to formal employment and, therefore, increase women's ability to pay for PAC services (Wariki et al., 2015; Svanemyr & Sundby, 2007). On the other hand, women may have formal education but their lack of information about PAC services could prevent them from utilizing the services (Okonofua, 2006).

3.2 Factors that Facilitated Seeking PAC Services

The study investigated factors that enabled users of PAC services to seek care. Availability of PAC services in the study facilities; sharing of information about one's health status; ability to cater for transport and treatment costs; privacy and less waiting time, and availability and reliability of transport emerged as the main enabling factors.

3.2.1 Availability of PAC Services

This study found that the users of PAC services sought such care because the services were available. However, about a third of them (32%) sought care elsewhere before visiting the facilities covered in this study. Less than a third (30.3%) sought care from pharmacies, (27.3%) from a public health centre, (24.2%) from a public dispensary, and 18.2% from a private dispensary. Some of those who visited the pharmacy reported that they had purchased some painkillers and decided to seek care from the studied facilities after finding that they did not fully recover after taking the drugs. The following submissions provide more details.

"I had bought some medication from a pharmacy for pain relief but later I decided to come here (Facility B) for thorough treatment" (User of PAC Services, 23 Years, Not Married).

"My problem started four days ago. I bought some pills from the pharmacy which I used for three days, but I did not get any relief. I had to inform my mother about my condition so she brought me to this hospital" (Facility A User, 20 Years, Not Married).

"The painkillers I had bought from the pharmacy didn't help, so I decided to come to this facility (Facility C) for further treatment" (User, 34 Years, Married).

The lack of equipment and experts were some of the factors that affected the effectiveness of the facilities the respondents visited, as elaborated by the following quotes:

"I visited a public health centre, where they informed me that they couldn't handle my case because they did not have the necessary equipment. They referred me to this facility" (Facility A User, 29 Years, Married).

"I went to a government dispensary but they referred me to this facility (Facility B) because they thought my condition needed a specialist" (User, 37 Years, Married).

"I visited a public dispensary but I was informed that the dispensary did not have a specialist to attend to my problem. A friend who gave me an escort advised me to come here" (Facility C User, 26 Years, Not Married).

"I attended a private dispensary and the doctor informed me that I was supposed to be hospitalized but they had no specialist to help me. They advised me to come here" (Facility B User, 24 Years, Not Married).

The responses above show that the users of PAC services sought care from the facilities covered by this study because PAC services were available. Some of them sought care from private or public facilities that were under-equipped. This finding is consistent with findings of other studies carried out in Ethiopia by Melkamu et al. (2010) and Kumbi et al. (2008), which found that the lack of equipment and experts of PAC services was among the inadequacies that lower-level facilities were suffering from. Women who need PAC services may be at increased risk of maternal mortality when they move from facility to facility seeking PAC services (Melkamu et al., 2010).

3.2.2 Sharing of Information About One's Health Status

The study findings indicate that knowledge about PAC services among users was poor. Only about a third (34%) admitted that they had not heard about PAC services before. Those who knew about PAC services (43%) had obtained information from healthcare providers, while more than half (54%) had been informed by friends. Therefore, sharing of information about their own health status facilitated access to PAC services. More than half (52.4%) shared information with their partners, while the rest shared information with relatives or significant others. The following quotes illustrate how the sharing of information enabled the utilization of PAC services.

"I decided to tell my sister about my condition; after which she advised me to go to the hospital because the painkillers I had been using did not help. She advised me to come here for proper treatment" (User, 20 Years, Not Married).

"I called a friend and informed her about my condition because I remembered a year before she had experienced the same health condition. She advised me to seek treatment here because she had also been treated in this same facility. I have heard people talking about 'kusafishwa' (evacuation) and today I have experienced it" (User, 31 Years, Married).

This finding suggests that sharing information about one's health status may increase the uptake of PAC services. It became apparent that those who were married were more likely to share information about PAC services with their partners than those who were not married. Similar findings were observed in Indonesia by Wariki et al. (2015) where almost all women who sought PAC services discussed their health status with their partners. Some of the partners even recommended the type of facility to consult. This corroborates findings of a study by Melkamu et al. (2010), which found that, in Ethiopia, approval to seek PAC services was sought from partners or family members. On the other hand, Sathar et al. (2013) found that some married women who could pay for PAC services had higher chances of making their own decision in seeking care without consulting their partners. This implies that being married does not necessarily guarantee that a woman is going to get support from her partner in seeking PAC services. This finding concurs with some studies such as by Vlassoff et al. (2012) and Azmat et al. (2012), which report objection from partners as a barrier to accessing PAC services upon sharing one's health status.

3.2.3 Ability to Carter for Transport and Treatment Cost

Another factor that facilitated the seeking of care in the facilities was the ability to pay for the services. It was found that treatment cost was covered by different people, for example, partners covered 45.6%, parents covered 3.9%, friends/relatives covered 10.7%, facilities covered 6.8%, and sometimes a patient herself covered 33% of the cost. Users' ability to pay, therefore, was dependent on financial support from partners, parents, relatives, or friends. The majority of users of PAC services who were housewives and those who were students had their transport cost met by their partners (51.4% and 58.3%, respectively). On the other hand, those who were not married and shared information about their health status were more likely to secure financial support from their partners and parents. This is in the following testimony:

"I live in the Coast Region, and unfortunately I do not have children, and I did not have money to meet hospital costs. All my relatives live here (Dar es Salaam) so I decided to come to this facility because I knew I would get support from them. My relatives have paid for the services" (User, 36 Years, Not Married).

Another user of PAC services testified how sharing information about her health status had enabled her to have access to PAC services. She said the following:

"As I told you, I had to tell my sister that I was sick and I did not have money to foot the hospital bills. She sent me some money through M-Pesa (mobile money); so today I have decided to come here for treatment (User, 16 Years, Not Married).

The current study found that PAC services were not being offered free of charge. Almost all women who were interviewed paid for the PAC services. Thus, ability to meet transport and treatment costs facilitated the uptake of the services. Inability to meet transport and treatment costs may hinder utilization of PAC services therefore increasing risks of maternal morbidity and mortality associated with abortion complications.

3.2.4 Privacy and Less Waiting Time

Privacy and less waiting time were among the reasons for seeking care from facilities B and C. Some of them had visited facility C (for other health problems) and, so, they were aware of the privacy and short waiting time issues. The levels of privacy varied in the study facilities. In facility C, privacy was highly maintained compared to facility A and B. Again, in facility B, privacy was highly observed compared to A because in this facility, the ward for PAC patients was being shared by postnatal mothers. Therefore, some of the patients seeking PAC services were uncomfortable talking about their problems in the presence of strangers. The following narratives provide more information on privacy and waiting time.

"I came here because I had been here before and liked their services. The environment is clean and one does not have to wait for too long to be served" (User, 26 Years, Married).

"A friend of mine advised me to come here because there is sufficient privacy and it is less crowded. As you can see, people do not have to spend a lot of time at the reception" (User, 32 Years, Not Married).

"You know what - sometimes you may visit a facility and spend the whole day waiting for service, but there are fewer people here. As far as I am concerned, it is better I spend more money and get the services within a short time" (User, 34 Years, Married).

Privacy also came out as a factor for seeking care from facility B as reported by one user of PAC services who was a resident of Kinondoni District. She had the following to say:

"I decided to come here because I believed I would be more comfortable. You know what - sometimes you meet people at the hospital...they would want to know of your problems...I don't like that" (User, 28 Years, Married).

Privacy is one of the key factors of quality PAC (Webb, 2000). The preceding quote proves that some participants from other districts of Dar es Salaam sought PAC from the study facilities because of privacy. This is an indication that women fear to be stigmatized if heard taking about PAC services. One of the participants admitted that she had avoided going to a facility located in her residence to avoid meeting her neighbours, who might later gossip. Women in need of PAC services would rather prefer facilities that guarantee them privacy, in settings where abortion is stigmatized and criminalized (Payne et al., 2013).

3.2.5 Availability of Transport

The results indicate that the majority of the users of PAC services were from within Temeke District. It took less than an hour for the majority (61.2%) to reach a facility to access PAC services. The most common modes of transport used by the participants included public transport, i.e., commuter buses (57%), motorcycles/tri-cycles (18%), and taxis (17%) (Figure 1).

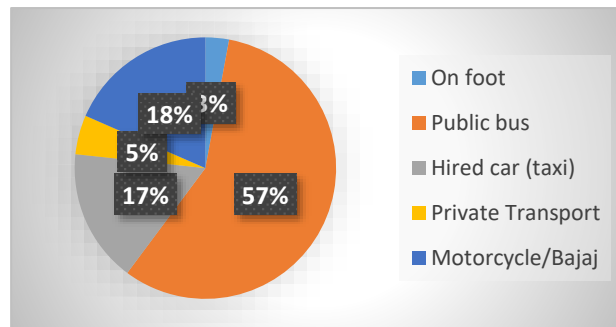


Figure 1: Types of Transport Used to Reach Health Facilities

Source: Field survey data, 2014-2015

The availability of transport in the study area played an important role in facilitating the uptake of PAC services. Vlassoff et al. (2012) has reported that women who are poor and those who live in rural areas are more likely to face transport problems in accessing PAC services. Women in need of PAC services are more likely to reach a facility earlier if it is decentralized, and there is a reliable transport (Fetters et al., 2004). On the other hand, women in need of PAC services may be discouraged from seeking PAC care if the services are far away, and there is no reliable transport (Melkamu et al., 2010).

4. Discussion

Owolabi et al. (2019) notes that the availability of PAC services in the facilities enhances the utilization of such services, and hence reduces the chances of morbidity and mortality associated with abortion complications. Availability of PAC services in the study sites does not simply mean that these services are available in all health facilities at all levels of healthcare delivery in Tanzania. A proportion of women who received PAC services in the study facilities had visited some health facilities but could not get the service. This is an indication of the need to ensure that all the facilities that are expected to provide basic PAC services have the required capacity.

Studies by Mutua et al. (2018) and Astbury-Ward et al. (2012) reveal that stigma and legal reprisals affect disclosure of issues related to abortion and postabortion care. Women who have undergone induced abortion may be willing

to share information to only trusted individuals (Astbury-Ward et al., 2012). Sharing information about one's health status is likely to encourage seeking PAC services, hence reducing the health risks associated with abortion complications.

The ability to cater for transport and treatment costs is likely to increase the uptake of PAC services. Kumbi et al. (2018) found that some of the users of PAC services were turned away because they were not able to pay for such services. Inability to cater for transport and treatment costs might increase the morbidity and mortality associated with abortion complications. Reduced costs or free service, however, may not automatically increase utilization. A study by Demtsu et al. (2014) revealed that some women did not utilize PAC services (although they were being provided free of charge) because they were not aware of its availability; while some were discouraged by providers' attitude.

Adinma (2012) affirms that PAC remains one of the key strategies in managing complications associated with abortion. Haddad and Nour (2009) add that PAC services are also important even in countries where abortion is legal. Therefore, available and reliable services facilitate access to PAC (Fetters et al., 2004). Prompt access to PAC services following abortion complications may reduce the likelihood of progression to maternal mortality. A study by Araújo et al. (2018), in Brazil, found that the lack of money to pay for transport, or the lack of means of transport led to delays in seeking care after experiencing abortion-related complications. Melkamu et al. (2010) further noted that women in need of PAC services may delay or may not seek care if the services are located far away from their homesteads, and if the means of transport are unreliable. Payne et al. (2013) note that in settings where abortion is stigmatized, women in need of PAC services would prefer health facilities that guarantee them privacy. Webb (2000) affirms that privacy enhances the quality of PAC services. A study by Mutua et al. (2018) upholds that trust and confidentiality guarantee delivery of quality PAC, and they can influence utilization of PAC services; while long waiting time may act as a barrier to the uptake of PAC services.

5. Conclusion

Following the preceding discussion, it could be concluded that the utilization of PAC services would be enhanced if the services are available and affordable, and if there is affordable transport means to health facilities. In addition, privacy and less waiting time may influence the uptake of PAC services. An increased uptake of PAC is likely to reduce morbidity and mortality associated with abortion complications.

Therefore, there is a need to raise awareness about PAC services and their availability in the country so as to reduce fear and stigma. This will help to enhance prompt seeking of care after experiencing abortion complications. Concerted efforts should be made to ensure that privacy is maintained throughout the delivery of PAC services to encourage their utilization.

Acknowledgements

This research that led to this paper was funded by a fellowship award by the Consortium for Advanced Research Training in Africa (CARTA). CARTA has been funded by the Wellcome Trust (UK) (Grant No. 087547/Z/08/Z), the Department for International Development (DfID) under the Development Partnerships in Higher Education (DeLPHE), the Carnegie Corporation of New York (Grant No. B8606), the Ford Foundation (Grant No. 1100-0399), Google.org (Grant No. 191994), Sida (Grant No. 54100029), and the Bill and Melinda Gates Foundation (Grant No. 51228). The funder had no role in the design, analysis, and the writing of this paper.

Conflict of interest and the funding

The author declares that she has no conflict of interest and the funding.

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