FACTORS ASSOCIATED WITH UTILIZATION OF POST-ABORTION CARE (PAC) SERVICES IN TANZANIA: A CASE STUDY OF TEMEKE DISTRICT OF DAR ES SALAAM

By

Evaline Gabriel Mcharo

A thesis submitted in the fulfilment of the requirements of the award for the degree of Doctor of Philosophy in Population Studies at the Population Studies and Research Institute of the University of Nairobi

November, 2016

DECLARATION

This thesis is my original work and has not been presented for a degree in any other university.

Candidate: Evaline Gabriel Mcharo

Signature ________________ Date ______________

This thesis has been submitted with our approval as university supervisors.

Prof. Lawrence D.E Ikamari

Signature ________________ Date ______________

Prof. Alfred Otieno Agwanda

Signature ________________ Date ______________

ACKNOWLEDGMENTS

First and foremost, I thank the Almighty God for providing me with strength, courage and enthusiasm to embark on this work. I would like to thank the Consortium for Advanced Research and Training in Africa (CARTA) and University of Dar es Salaam-Dar es Salaam University College of Education (UDSM-DUCE) for the financial and material support. My heartfelt appreciation goes to my supervisors, Prof. Lawrence Ikamari, Prof. Alfred Otieno Agwanda of the University of Nairobi and my external advisor, Prof. Daniel Smith of Brown University-USA for their relentless technical support, encouragement, and advice throughout my study. Their constructive criticisms brought this work this far.

My thanks go to the National Institute for Medical Reserch (NIMR) for granting a permission to undertake this study in Temeke distict. I would like to thank the Regional and District Medical Officers and all government officials of Temeke and Ilala districts for permitting me to undertake the study in their health facilities. In addition, I am indebted to the management and healthcare providers who rendered me with exceptional and timely assistance during data collection. Special thanks go to Dr Adam, Dr Immanuel, Dr Mwinami, and Sister Lyimo on behalf of all the healthcare providers who participated in this study.

Furthermore, I owe special thanks to the participants who provided information for this study. I thank very much the users and the non-users of PAC services who despite their health conditions accepted to participate in this study. The information they provided made this research meaningful. Special thanks go to the focus group discussion participants and key informants. Their contribution to this study is highly appreciated.

I appreciate the tolerance of my lovely daughter Neila during my absence. It is my prayer that one day she will reach this far. I would like to thank my father Gabriel Mcharo, my mother Bertha Masao, my siblings Sophia, Samwel, Maria, Adeline, Elizabeth, Mama Jr, Daudi and our own lawyer Simon for their material and moral support.

I am greatly indebted to the family of the Late Mr. Martin Anael Moshi for taking care of my daughter when I was away for my studies. Grace Moshi, Anael, Mecku, Edna, Boss, Upendo Mafude, Lucy, Juliana, Judy, Sandra, Siah, Khadija, Jane and Muddy provided moral and material support which contributed to the completion of this work. Though it was my wish for late Mr. Martin Anael Moshi to witness this achievement, I believe that whenever he is, he is celebrating my success. I will never ever forget those kind and encouraging words from him. May His Soul Rest in Eternal Peace.

I am grateful to Dr. Cresencia Massawe, Dr. Anne Khasakhala, my *mlamu* Dr. Linda Nyondo Mipando, Elizabeth Mbwana, Dunia Othman, Philbert Mrema, and the Ubungo crew. Each of them made a unique contribution towards the successful completion of this work and they will always have a special place in my heart. My friends in Kenya, Fortunata Muthoni, Ruben and Peter, thank you for being there for me during the lonely times.

I am thankful to the Watson Institute for International Studies of Brown University of USA for providing me with a placement at the institute. Thank you all for the support and the love you provided me during my stay. I sincerely thank my workmates at UDSM-DUCE and all staff members at Population Studies and Research Institute of the University of Nairobi for the support they provided me during the entire period of my study. I also acknowledge the support I received from the CARTA Cohort-2 Fellows. May God bless them in their future endeavors.

DEDICATION

I dedicate this work to my lovely daughter, Neila, for her perseverance, to my parents for valuing and advocating girl child education, to my siblings and to the Late Martin Anael Moshi, a father and a friend.

ABSTRACT

This study investigated the factors associated with the use of PAC services in Temeke district of Dar es Salaam Tanzania. Specifically, the study sought to identify the characteristics of the users of PAC services and factors that facilitated and those that hindered utilization of the services. The study also investigated the perceptions of the providers and the users about the quality of PAC services. Furthermore, the study sought to establish and document the perceptions of the community on abortion and PAC services.

The study was guided by the 1995 Andersen's framework of healthcare utilization. The design of the study was cross-sectional and quantitative and qualitative data collection methods were used. The min study approach used was qualitative for objective one, two and three which was supplemented by exit interviews to identify the characteristics of the users of PAC services. Exit-interviews, in-depth interviews, focus group discussions and direct observation were used to collect information. Purposive sampling was used to recruit the study participants. The study conducted a survey among 103 exit clients for PAC services and 16 providers in three health facilities. It conducted 10 FGDs among community members, in-depth interviews among 7 key informants and in-depth interviews among 6 women who experienced abortion complications but did not seek PAC services. Descriptive statistics were used to analyse the quantitative information while thematic analysis was used to analyse the qualitative information.

About 45 percent of the users of PAC services were below 25 years. About 64.1 percent were not married, 61.3 percent did not have any formal employment while 12.2 percent were still attending to school. About half (50.5 percent) had primary education, 43.7 percent had secondary

education and only 5.8 percent had tertiary education. Almost all the users of PAC services who participated in the study were from within Temeke district.

From the analysis of the exit interviews data, the users of PAC services identified sharing of information about the health status, having received financial support from relatives and friends to carter for transport and treatment cost, availability of PAC services, privacy, short waiting time and the availability of transport as the factors that facilitated their seeking of care. In-depth interviews with the non-users of PAC services indicated that fear of being arrested by the police for having an illegal induced abortion, fear of the negative reactions by the providers and lack of money for the treatment as the main factors that hindered their utilization of PAC services from health facilities.

The quality of PAC services being provided was being perceived to be good by the providers and the users. However, the high cost of the services, inadequate staff, inadequate on-the-job training, inadequate equipment and supplies and lack of privacy were some of the concerns raised by both the providers and the users of PAC services. The perceptions of the community on induced abortion were negative but their perceptions on PAC services were positive.

This study concludes that PAC services can be acceptable in settings where abortion is illegal and stigmatized. Women with abortion complications will utilize PAC services regardless of their age, marital status or their socioeconomic backgrounds. Their utilization of PAC services will depend on the extent to which the services are available, well known, affordable and there is available, reliable and affordable transport. PAC services should also be of high quality. The quality of the services depends largely on adequate staff, adequate and properly functioning equipment and supplies and services that guarantee users' privacy.

The study therefore recommends that measures should be taken to ensure that PAC services are known to the users, are affordable and accessible and are of high quality. Quality PAC services will entail increasing the number of health facilities offering PAC services, having adequate number of staff and having functioning equipment and supplies all the times. Providing regular on-the-job training to the providers is also important to enhance quality of the services. Privacy during the delivery of PAC services should be considered for enhancing quality and continued use of care.

Raising the level of awareness about PAC services and the importance of seeking care promptly following abortion complications is important to reduce fear of being arrested by the police and fear of the negative reactions by the providers. This study did not recruit enough sample size for the non-users of PAC services in order to make generalizations. The study also did not establish the influence of the community's perceptions about abortion and PAC on the utilization of PAC services. Therefore, this study also recommends further research on these areas.

TABLE OF CONTENTS

DECLARATION ii

ACKNOWLEDGMENTS iii

DEDICATION v

ABSTRACT vi

LIST OF TABLES xiv

LIST OF FIGURES xv

ABBREVIATIONS AND ACRONYMS xvi

CHAPTER ONE: GENERAL INTRODUCTION 1

1.1 Introduction 1

1.2 Statement of the Research Problem 4

1.3 General Objective 6

1.4 Research Questions 6

1.5 Study Objectives 6

1.6 Study Justification 7

1.7 Scope and Limitations of the Study 9

1.8 Organization of the Thesis 11

CHAPTER TWO: THE CONTEXT OF THE STUDY 14

2.1 Introduction 14

2.2 Population Size and Composition 14

2.3 Reproductive Health Situation 15

2.4 Induced Abortion 16

2.4.1 Causes of Induced Abortion 17

2.4.2 Morbidity and Mortality Associated with Induced Abortion 19

2.5 Provision of PAC Services 20

2.5.1 Policies and Programs on PAC Services 22

2.6 The Structure of the Health Care Delivery in Tanzania 23

2.7 Temeke District 24

2.7.1 Population 24

2.7.2 Economy 24

2.7.3 Literacy Level 25

2.7.4 Health Services 25
2.8 Conclusion 26
CHAPTER THREE: LITERATURE REVIEW 27
3.1 Introduction 27
3.2 Abortion and Maternal Mortality 27
3.3 The Origin and Rationale of PAC Services 29
3.3.1 Quality PAC Services 31
3.4 Empirical Studies on Factors Influencing Utilization of PAC Services 32
3.4.1 Individual Level Factors 33
3.4.2 Community Level Factors 41
3.4.3 Health System Factors 44
3.5 Theories and Models on Health-Seeking Behaviour and Utilization 49
3.5.1 Deterministic Models 49
3.5.2 Pathway Models 51
3.6 Conceptual Framework 53
3.7 Operational Framework 54
3.8 Summary of the Literature Review 55
3.9 Definition of Key Terms 57
CHAPTER FOUR: METHODOLOGY 60
4.1 Introduction 60
4.2 The Design of the Study 60
4.2.1 The Study Approach 61
4.3 The Study Area and Justification 63
4.4 The Study Population, Inclusion and Exclusion Criteria 64
4.5 Sampling Procedures 66
4.5.1 Criterion Sampling 67
4.5.2 Snowball Sampling 68
4.6 The Sample Size 68
4.7 Data Collection Instruments 69
4.7.1 Exit-Interviews 69
4.7.2 In-Depth Interviews 70

4.7.3 Focus Group Discussions 71
4.7.4 Direct Observation..73
4.8 Data Quality Assurance 74
4.9 Ethical Considerations and Approval 74
4.10 Methods of Data Analysis..76
4.10.1 Analysing Qualitative Information..76
4.10.2 Analysing Quantitative Information..77
CHAPTER FIVE : FACTORS FACILITATING AND THOSE HINDERING UTILIZATION OF PAC SERVICES..78
5.1 Introduction..78
5.2 Characteristics of the Users of PAC Services..79
5.2.1 Age..81
5.2.2 Marital Status..81
5.2.3 Education 82
5.2.4 Occupation..83
5.2.5 Religious Affiliation 83
5.2.6 Place of Residence..83
5.3 Factors that Facilitated the Seeking of PAC Services 84
5.3.1 Sharing of Information About One's Health Status 85
5.3.2 Financial Support..90
5.3.3 Availability of PAC Services 92
5.3.4 Availability of Transport 93
5.3.5 Privacy and Waiting Time..95
5.4 Factors that Hindered the Utilization of PAC Services 96
5.4.1 Discussion of the Case Studies..99
5.5 Conclusion 102
CHAPTER SIX: PERCEPTIONS OF THE PROVIDERS AND THE USERS ABOUT THE QUALITY OF PAC SERVICES..104
6.1 Introduction..104
6.2 Perceptions of the Providers on the Quality of PAC Services..104
6.2.1 Availability of the Staff 104

6.2.2 Method and Place of Uterine Evacuation 106
6.2.3 Availability of Essential Equipment and Supplies 108
6.2.4 Water and Electricity Supply 109
6.3 Perceptions of the Users on the Quality of PAC Services 110
6.3.1 Providers' Sex 111
6.3.2 Post-Abortion Care Counselling 112
6.3.3 Post-Abortion Care Family Planning 115
6.3.4 Youth-Friendly Post-Abortion Care Services 117
6.3.5 Facility Location and Set-Up 118
6.3.6 Waiting Time 119
6.3.7 Cost of PAC Services 120
6.3.8 Satisfaction with Care 122
6.4 Conclusion 123
CHAPTER SEVEN : PERCEPTIONS OF THE COMMUNITY ON ABORTION AND PAC SERVICES 125
7.1 Introduction 125
7.2 Defining Induced and Spontaneous Abortion 125
7.3 Community's Perceptions About Induced Abortion 127
7.3.1 Negative Perceptions on Induced Abortion 127
7.3.2 The Perceptions of the Providers About Induced Abortion 132
7.3.3 Positive Perceptions About Induced Abortion 134
7.3.3 Perceptions About Spontaneous Abortion 136
7.4 Perceptions About PAC Services 137
7.4.1 Absence of PAC Services May Lead to Maternal Mortality 138
7.4.2 Not all Abortion Complications are Due to Induced Abortion 139
7.4.3 Induced Abortion is Sometimes Reported as Spontaneous Abortion 140
7.3.4 The Right to Access Care 141
7.4.5 Negative Perceptions on PAC Services 144
7.5 Conclusion 145

CHAPTER EIGHT: SUMMARY, CONCLUSION AND RECOMMENDATIONS 147

8.1 Introduction...147

8.2 Summary of the Results 148

8.3 Conclusion 150

8.4 Recommendations..152

    8.4.1 Recommendations for Action 152

    8.4.2 Recommendations for Further Research 155

REFERENCES..156

APPENDICES 173

Appendix I: Research Permit and Consent Forms 173

Appendix II: Research Instruments 180

LIST OF TABLES

Table 4.1: The Response Rate Among the Users of PAC Services 69
Table 5.1: Distribution of the Users of PAC Services by Facility 78
Table 5.2: Percent Distribution of the Users of PAC Services According to Their Socioeconomic and Demographic Characteristics 80
Table 5.3: A Cross Tabulation of Whom the Users of PAC Services Shared Information About their Health Status by their Socioeconomic Characteristics 86
Table 5.4: A Cross Tabulation of the Users of PAC Services Decision to Seek Care by Their Socioeconomic Characteristics 88
Table 5.5: A Cross Tabulation of the Characteristics of the Users of PAC Services by Who Paid for their Treatment Costs 91
Table 6.2: Proportion of the Patients Who Received Counselling After Treatment Per Their Characteristics 113
Table 6.3: Proportion of the Users of PAC Services Offered a Family Planning Method According to Their Characteristics 115
Table 6.4: Perceived Affordability of PAC Services Per Study Facility 121

LIST OF FIGURES

Figure 3.1 A Conceptual Framework for Factors Influencing Utilization of PAC Services 53
Figure 3.2 A Modified 1995 Andersen's Model of Healthcare Utilization 55
Figure 5.1 Mode of Transport Used by the Users of PAC Services to Reach to a Health Facility 94

ABBREVIATIONS AND ACRONYMS

ACQUIRE	Access Quality and Use in Reproductive Health
AU	African Union
CARTA	Advanced Research and Training in Africa
CHWs	Community Health Workers
GBV	Gender Based Violence
D&C	Dilate & Curettage
EmOC	Obstetric Emergencies
FBO	Faith Based Organization
FGDs	Focus Group Discussion
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
ICDP	International Conference on Population and Development
ICPD-POA	International Conference on Population and Development Plan of Action
HBS	Household Budget Survey
ICMA	International Consortium for Medical Abortion
IPAS	International Pregnancy Advisory Services
KIs	Key Informants
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MoF	Ministry of Finance
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
MoPEE	Ministry of Planning, Economy and Empowerment

MSH	Management Sciences for Health
MVA	Manual Vacuum Aspiration
NPERCHI	National Package of Essential Reproductive and Child Health Intervention
NBS	National Bureau of Statistics
NGO	Non-Governmental Organization
NIMR	National Institute for Medical Research
OCGS	Office of the Chief Government Statistician
PAC	Post-Abortion Care
PCC	Postabortion Care Consortium
PHSDP	Primary Health Services Development Programme
PPH	Postpartum Haemorrhage
PRB	Population Reference Bureau
RCHS	Reproductive and Child Health Section
RCO	Regional Commissioner's Office
SDGs	Sustainable Development Goals
SPSS	Statistical Package for the Social Sciences
SRECO	Shinyanga Regional Commissioner's Office
STI	Sexually Transmitted Infection
TDHS	Tanzania Demographic and Health Survey
TFDA	Tanzania Food and Drugs Authority
TFR	Total Fertility Rate
TRA	Theory of Reasoned Action
UDSM-DUCE	University of Dar es Salaam-Dar es Salaam University College of Education

UN	United Nations
UNFPA	United Nations Population Fund
URT	United Republic of Tanzania
USAID	United States Agency for International Development
VSI	Venture Strategies Innovation
WHO	World Health Organization

CHAPTER ONE

GENERAL INTRODUCTION

1.1 Introduction

Post-abortion care (PAC) is a package of services offered to women after an incomplete abortion due to spontaneous or an induced abortion (Adinma, 2012). In developing countries, spontaneous abortion is manly caused by malaria, HIV/AIDS and physical violence (Curtis, 2007). Induced abortion is caused by factors such as unintended pregnancies due to low contraceptive uptake (Lauro 2011; Guttmacher 2012) and economic hardships (Rash *et al.,* 2000b, Silberschmidt and Rasch, 2001). Induced abortion whether safe or unsafe may result to complications (Haddad and Nour, 2009). Complications resulting from induced abortion may include genital tract sepsis, hemorrhage, trauma to the cervix, and trauma to surrounding organs such as intestines or bladder and uterine perforation (Okonofua, 2006). Women who have experienced a spontaneous abortion may experience some of the above complications, therefore needing emergency care (Curtis, 2007).

PAC is promoted as a key strategy for treating the complications of incomplete or induced abortion (Adinma, 2012). PAC services remain important in countries where the law permits abortion because the occurrence or non-occurrence of complications is determined by the legality of abortion and other factors such as the qualifications of the healthcare providers and gestational age (Haddad and Nour, 2009). PAC is also a necessary service to women who have experienced a spontaneous abortion (Curtis, 2007). The overall aim of PAC is to reduce maternal morbidity and mortality due to abortion complications and to improve sexual and reproductive health and the lives of women (Adinma, 2012).

PAC has five major elements, namely: (i) treatment of incomplete abortion and complications that are potentially life-threatening; (ii) counselling in order 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 to ensure that health services meet community expectations and needs (PCC, 2002; Corbett and Turner, 2003).

Globally, over 13 percent of maternal mortality is estimated to be associated with complications associated with unsafe abortion (Singh *et al.,* 2009). In East Africa, 18 percent of maternal mortality is associated with unsafe abortion complications (WHO, 2011). In Tanzania, estimates show that 13-25 percent of maternal mortality is associated with unsafe abortion complications (Keogh *et al*., 2015; MoHSW, 2008; Woog and Pembe 2013). Maternal morbidity and mortality due to abortion-related complications are the easiest to prevent (Haddad and Nour, 2009; Rasch *et al.,* 2008). However, abortion-related complications have remained the leading causes of maternal mortality (Thiam, 2006).

At global level, about 15 percent of all pregnancies end in spontaneous abortion (Curtis, 2007). However, spontaneous abortion rarely causes death (WHO, 2007a). Hence, it is evident that the observed high maternal mortality rate in Africa due to abortion-related complications is largely a result of unsafe induced abortion (Okonofua, 2006). Therefore, concerted efforts are needed to address the consequences of unsafe induced abortion.

There is a great chance of reducing morbidity, mortality and associated adverse health impacts related to abortion if women experiencing abortion-related complications receive right care timely (WHO, 2007b; Okonofua, 2006; Singh *et al.,* 2009; Woog and Pembe, 2013). The risk of maternal mortality due to unsafe abortion complications depends on among other factors, women's readiness to seek care timely, the quality of care they receive at the facility, including the qualifications and non-judgmental attitude of the providers, and the method used to induce abortion (Haddad and Nour, 2009). Complications related to miscarriages and unsafe abortion can be reduced if the community is informed and educated about the impacts of delays in seeking care following abortion complications (ACQUIRE, 2007).

The benefits of PAC services transcend reducing the risk of maternal mortality (Woog and Pembe, 2013). PAC family planning and counselling can lead to increased contraceptive uptake and therefore break the cycle of repeated unwanted pregnancies and induced abortions (Celyan et *al.,* 2009; Curtis, 2007; Woog and Pembe, 2013). The fertility of a woman who has experienced abortion complications may resume as early as two weeks after treatment (Curtis, 2007). In addition, the WHO recommends that women who have had an induced or a spontaneous abortion should wait for at least six months before the next pregnancy (WHO, 2007b). Therefore, PAC family planning and counselling are important for preventing an immediate pregnancy following an induced or spontaneous abortion.

The need to address the adverse effects of complications due to induced abortions by providing PAC services has been on the international agenda. For example, the need to provide quality PAC services was discussed in the 1994 International Conference on Population and Development (ICPD) held in Cairo. The international community at that conference agreed that

PAC was one of the strategies that should be implemented to reduce maternal morbidity and mortality in countries with restrictive abortion laws (UNFPA, 1995). The target of the former fifth Millennium Development Goal (MDG) was to reduce maternal mortality by two-thirds (2/3) by 2015 (UN, 2012), but many developing countries have not been able to reach this target. The current Sustainable Development Goal (SDG) 3 target is to reduce maternal mortality ratio to less than 70 per 100,000 live births by 2030 (UN, 2015).

In Tanzania, PAC services have been provided since the 1994 ICPD. Since then, the government has made efforts to strengthen PAC as a way to address maternal mortality associated with abortion-related complications (MoHSW, 2008). The efforts include removing all barriers to accessing family planning services (Jain *et al.,* 2006), scaling up comprehensive PAC by developing a curriculum on PAC clinical skills to train middle-level health service providers (i.e. clinical officers and nurse-midwives) to ensure PAC services are available at lower-level health facilities (MoH, 2002). Another effort includes working in partnership with various organizations such as EngenderHealth to provide PAC services and incorporating the use of misoprostol in PAC services (VSI, 2011; Mwanga *et al.,* 2013). The utilization of PAC services is still low in Tanzania despite the above efforts (Keogh *et al.,* 2015).

1.2 Statement of the Research Problem

The rates of induced abortions are high in Tanzania (36 abortions per 1,000 women aged 15-49 and 21 abortions per 100 live births) (Keogh *et al.,* 2015). Between 13-25 percent of maternal mortality in Tanzania is estimated to be associated with unsafe abortion complications (Keogh *et al.,* 2015; MoHSW, 2008; Woog and Pembe, 2013).

Although PAC services have been provided in Tanzania since the 1994 ICPD, available data show that in every one woman treated for abortion complications in Tanzania, six others who experience abortion complications do not receive care (Keogh *et al.,* 2015). This is an indication of a low utilization of PAC services in Tanzania. Factors which hinder women from seeking PAC services are not well known. In addition, information about the characteristics of women who use PAC services in health facilities, and factors which facilitate or hinder their use of PAC services have not been identified and therefore poorly understood.

The Government of Tanzania is in the process of decentralizing PAC services to be available at lower level health facilities to be provided by midlevel providers (Nielsen *et al.,* 2009). A recent study shows that there are only less than 8 facilities in Tanzania which are providing PAC services per 100,000 women (Keogh *et al.,* 2015). Decentralization alone does not guarantee access to PAC services in Tanzania unless a combination of factors related to access and quality of services and involvement of the community are taken into consideration (Mwanga *et al.,* 2013). Currently, there is lack of information about the quality of PAC services. There is lack of information on the providers' and users' perceptions of quality of PAC services offered in health facilities in Tanzania. In addition, little is known of the community's perceptions of abortion and PAC services in Tanzania.

Several studies have been conducted on abortion and PAC services in Tanzania. The previous studies have focused on various aspects of abortion and PAC such as the proportion of women admitted in health facilities due to unsafe induce abortion (Rasch and Kipingili, 2009); induced abortion among adolescents (Rasch *et al.,* 2000; Silberschmidt and Rasch, 2001); PAC family planning (Rasch *et al.,* 2004; Rasch and Lyaruu, 2005; Rasch *et al.,* 2008); PAC and voluntary

HIV counselling and testing (Rasch *et al.,* 2006) and incidence of induced abortion and PAC (Keogh *et al.,* 2015). Little attention has been paid on factors which facilitate or hinder utilization of the PAC services. This study seeks to make a contribution in this direction.

1.3 General Objective

The study aimed at establishing the factors that affect the use of PAC services in Temeke district.

1.4 Research Questions

The study focused on the following research questions.

(i) What are the characteristics of the users of PAC services?

(ii) Why some women who experience abortion complications seek PAC services from health public or private facilities while others do not?

(iii) How do healthcare providers and PAC clients perceive the quality of PAC services?

(iv) How do the community members perceive abortion and PAC services?

1.5 Study Objectives

To address the above question, this study had the following specific objectives:

(i) To identify the users and non-users of PAC services and factors that facilitate and those that hinder the use of PAC services

(ii) To establish the perceptions of the providers and users of PAC services on the quality of PAC services

(iii) To establish and document the perceptions of the community on abortion and PAC services

1.6 Study Justification

Mortality due to abortion complications can be easily prevented if women who suffer from complications seek care as soon as possible and that they receive quality care when they reach the facility (Okonofua, 2006). Therefore, understanding factors which may facilitate or hinder utilization of PAC services is very important. The knowledge about utilization of PAC services can be used in improving the provision of PAC services in the country.

The need to understand the characteristics of women who utilize PAC in Tanzania is twofold. Firstly, demographic characteristics like sex and age represent biological necessities suggesting the possibility that people will need health services. Social factors such as education and occupation determine the social status of an individual in the community, the ability to cope with various problems and the ability to mobilize resources to deal with the emerging problems (Andersen, 1995). Therefore, it is important to understand these characteristics and how they can influence utilization of PAC services.

Secondly, induced abortion may be an issue for all women of reproductive age (Kidder *et al.,* 2004) however, its prevalence and consequences may vary substantially between sub-groups of women (with respect to their age or socio-economic status) (Bankole *et al.,* 1999; WHO, 2013). Women in each sub-group may have some unique and specific challenges in accessing PAC services (WHO, 2013). Therefore, obtaining information on the characteristics of the users of PAC services can be used to target women in need of PAC services. It can also help to identify appropriate strategies to reach women in need of PAC services (Kidder *et al.,* 2004).

Generally, provision of quality healthcare services ensures continuum of care. Thus, the assessment of the quality of healthcare services should take into considerations users' views,

perceptions and experiences (Shaikh, 2005). Research on the perceptions of the users of PAC services on the quality of PAC services in Tanzania is important. It may determine whether users will continue seeking and using the services. It may also provide input to health planners to address deficiencies in the existing health services (Rasheed *et al.,* 2012), thereby showing avenues for improvement.

Users' perceptions on the quality of care is an important measure for assessing patterns of communication such as the ability of the provider to give proper medical information and involve the client in making decisions about care. Clients' feedback can be used to choose from among the alternative methods of providing and organising care (Fitzpatrick, 1991). Therefore, clients' involvement in assessing quality of care may help to bring about the overall improvement in quality of care (Shaikh, 2005).

As indicated earlier that for every woman treated for abortion complication in Tanzania, 6 others who suffer from abortion complication do not receive PAC services. Reasons for not using PAC services among these women are not well known. Understanding the reasons for non-use of PAC services in Tanzania may help in designing appropriate programs to encourage women to use PAC services in case of complications. Seeking PAC services following abortion complications may reduce the risks of maternal mortality resulting from the complications (Okonofua, 2006). Documenting the reasons for non-use of health services is important for policy makers and may shed light on the possible factors that influence people's choice of health services (Baltussen and Ye, 2006).

Healthcare providers are important stakeholders in the delivery of PAC services in Tanzania. Thus, it is important to understand their attitudes on abortion and PAC services. Providers attitudes may influence health-seeking behaviour of the users of the health care services (Shaikh, 2005). Furthermore, their attitudes may influence their willingness to provide abortion-related services (Harries *et al.,* 2009). Providers who have a judgmental and discriminatory attitude on abortion may lead to women receiving low quality services because women may opt for non-formal sources of care or delay seeking care (Likwa *et al*., 2009; Webb, 2000; Melkamu *et al.,* 2010; Shah and Åhman, 2004).

Studies suggest that there is a possibility of increasing utilization of PAC services if the community is involved in finding the solution to unsafe abortion (Thiam, 2006); AQUIRE, 2007). Linking the community with the providers of PAC services is regarded as the first element of PAC services (PCC, 2002). Evidence from Bolivia and Kenya show that community involvement in abortion and PAC issues led to reduction of stigma, raised awareness of abortion complications and raised the knowledge of family planning (Curtis *et al.,* 2010). Therefore, it is important to understand community's perceptions on abortion and PAC services given the fact that utilization of PAC services is substantially low in Tanzania.

1.7 Scope and Limitations of the Study

This study was carried out in Temeke district of Dar es Salaam from June 2014 to February 2015. It was conducted in three health facilities referred to in this study as Facility A, Facility B and Facility C. Facilities A and B are public health facilities. One of the facilities is a district hospital and the other is a regional referral hospital. The two facilities provided 24-hour PAC

services. Facility C is a private dispensary. It offers reproductive health services and PAC services inclusive. This facility offered health services for 12 hours.

Information for this study was obtained from the users of PAC services, non-users of PAC services, providers of PAC services, key informants and community members. The findings of the study may not be generalizable regarding the utilization of PAC services in Tanzania due to the number of the health facilities and the total number of the participants involved. However, the information gathered from the study is useful to understand factors associated with the utilization of PAC services in a setting where abortion is stigmatized and legally restricted.

Some of the recruited users of PAC services were not willing to participate in interviews (32.5 percent in facility A, 29.9 percent in facility B and 32.6 percent in facility C). Fear of being arrested by the police and stigma may be among the reasons for their non-participation. Induced abortion is a sensitive topic; therefore, it was a challenge to identify many non-users of PAC services in the community. The study recruited only six non-users of PAC services in the community. The six non-users of PAC services may not represent all the women who do not seek care from health facilities. However, information obtained from them regarding their experiences provide useful insights into possible factors which may hinder the use of PAC services in Tanzania.

Some of the users of PAC services became emotionally distressed during the interview. The providers of PAC services in the respective facilities were requested to assist those who became emotionally and psychologically unstable. Interviewees who became emotionally unstable continued with the interviews after their condition stabilized. The interviews with some the users of PAC services were terminated on the advice of the providers of PAC services.

The initial data collection plan was to spend 26 consecutive days in each study facility. However, on some days there were no PAC clients in the study facilities. In facility A, interviews were conducted in June and July 2014. In facility B, they were conducted in September and October 2014. In facility C, they were conducted in November and December 2014.

Unlike facilities A and B, which offered family planning and counselling to users of PAC services on the same day of the treatment, facility C did not offer family planning and counselling services in the treatment day. Patients seeking PAC services were asked to return to the facility for counselling and family planning within two weeks after treatment. Therefore, the flow of patients for PAC services in facility C posed a challenge in the conduct of the interviews. The same participants were interviewed again after one week for family planning. Other participants did not come for family planning thus reducing the sample size.

This study is basically qualitative in nature. The selection of the health facilities and the participants was purposive. Purposive sampling was adopted due to the nature of the hidden population. At the study facilities, it was not possible to generate a sampling frame because of the nature of the record keeping and the nature of the study. These factors necessitated the adoption of purposive sampling. The adoption of purposive sampling led to a smaller sample size for the study. Therefore, the study did not undertake multivariate analysis.

1.8 Organization of the Thesis

This thesis is organized in eight chapters. Chapter one presents background information for the study. It provides information on the link between abortion, maternal mortality and the need for PAC services. The chapter places the study in the context of international efforts to address issues relating to abortion, PAC and maternal mortality, particularly the 1994 ICPD, the former

MDGs and the current SDGs. The chapter indicates efforts that have been made by the Tanzanian government regarding PAC services since the 1994 ICPD. The chapter also presents the research problem, the objectives, the justification and the scope and limitations of the study.

Chapter two focuses on the context of the study. It looks at specific issues relating to Tanzania regarding abortion and PAC services. It provides information on induced abortion and factors associated with induced abortion in Tanzania. The chapter also provides information on the current estimate of maternal mortality associated with abortion complications in Tanzania. Programs and policies on PAC services are presented. Furthermore, the chapter provides information on the structure of the delivery of healthcare services in Tanzania. The chapter also presents information specific to Temeke district.

Chapter three focuses on the literature review whereby the theoretical background and empirical studies on the factors associated with the utilization of PAC services is presented. It provides an overview of the relationship between abortion, maternal mortality and PAC services. The conceptual framework for ascertaining the utilization of PAC services is also provided. The definition of key terms used in the study are presented at the end of the chapter.

Chapter four presents the methodology used in the study. It describes the design of the study and justification for the choice of design. Secondly, it presents information on the study area and the study the population and the sample size and sampling procedures employed to select the study participants. The chapter then describes the instruments that were used to collect data, discusses data quality assurance and ethical considerations and the methods employed to analyse the data.

Chapter five presents and discuss the basic characteristics of the users of PAC services and factors that facilitated their seeking PAC services. The chapter also presents and discusses factors which hindered the utilization PAC services from health facilities. The conclusion of the chapter is presented at the end.

Chapter six focuses on the perceptions of the providers and the users of PAC services on the quality of PAC services. The chapter discusses how the providers and the users of PAC services perceived the quality of PAC services as per the recommended aspects of quality of PAC services. The aspects of quality of PAC services covered include the availability of the providers, essential equipment and medication necessary for the users of PAC services; method of uterine evacuation; provider's sex; family planning and counselling; facility location and set up; waiting time, cost of PAC services and privacy. The conclusion of the chapter is indicated at the end.

Chapter seven presents a discussion on the community's perceptions on abortion and PAC services. It focuses on how the community defines abortion (spontaneous and induced), their perceptions of women who had an abortion and their perceptions on PAC services. The conclusion of the chapter is presented at the end.

Chapter eight provides the summary, conclusion and puts forward the recommendations for action and for further research. The summary is based on the main findings of the study as per the objectives. The recommendations are targeted to different stakeholders involved in the provision of PAC services in Tanzania.

CHAPTER TWO

THE CONTEXT OF THE STUDY

2.1 Introduction

This chapter provides an overview of the context of the study. It is divided in seven sections. The first section provides the introduction of the chapter. Section two presents information on population size and composition. Section three highlights the reproductive health issues in Tanzania. Section four focuses on induced abortion, factors associated with induced abortion in Tanzania and morbidity and mortality associated with induced abortion. Section five focuses on provision of PAC services and policies and programs on PAC services in Tanzania. Section six provides information on the structure of the health care delivery in Tanzania. The seventh section provides information specifically to Temeke district. The conclusion of the chapter is presented at the end.

2.2 Population Size and Composition

Tanzania is one of the largest countries in East Africa. The 2012 population and housing census estimates the total population to be 43.6 million and an annual growth rate of approximately 2.7 percent about 51.3 percent of the population are females while 48.8 percent are males. Dar es Salaam accounts for 10 percent of the total Mainland population. About 67 percent of this population live in rural areas and 33 percent live in urban areas. The structure of the population is predominantly young, with 44 percent estimated to be under 15 years. Only 4 percent of the population is estimated to be aged 65 years and above. Women of reproductive age (15-45) constitutes 47.2 percent of the total female population while women aged 15-24 constitutes 19.6 percent of the total female population (NBS *et al*., 2014).

2.3 Reproductive Health Situation

Tanzania is still experiencing high fertility though it has slightly declined from 5.7 in the 2004/5 Demographic and Health Survey (DHS) to 5.4 in the 2010 DHS. Early marriages and low contraceptive use are among the factors contributing to high Total Fertility Rate (TFR) (NBS and ICF, 2011). The use of modern contraceptives by women is still low (24 percent) despite the widespread knowledge of at least one method of contraception by men and women. However, currently, married women and men are more likely to know about family planning methods than sexually active unmarried women. The 2010 DHS shows that only 29 percent of all women are using contraceptives. The unmet need for contraception is 26 percent with high levels observed in Zanzibar (35 percent) (NBS and ICF, 2011). Maternal mortality is still high in Tanzania despite the slight decline from 529 deaths per 1,000 live births in 1999 to 432 deaths per 1000 live births in 2012. Therefore, Tanzania was not able to achieve the fifth millennium development goal which aimed at reducing the maternal mortality rate by two-thirds by 2015 (MoHSW *et al.,* 2015).

Gender Based Violence (GBV) persists in Tanzania. It is manifested in different forms such as physical, sexual, psychological and economic violence. The 2005 study by WHO revealed that between 15 and 17 percent of women in Tanzania reported some kind of gender based violence. The GBV was caused by their husbands or partners. About 28 percent of women reported that their first sexual experience was not consensual (WHO, 2005). Another study by the United States Agency for International Development (USAID) indicated that about 21 percent of women in Tanzania experienced some kind of GBV including intimate partner violence, sexual violence and domestic violence (Betron, 2008).

The 2010 DHS shows that about 9 percent of women in Tanzania experience physical violence during pregnancy (NBS and ICF, 2011)**.** Available information confirms that women who experience intimate partner violence may face difficulties using contraceptives, are more likely to use contraceptives secretly, experience a high rate of unintended pregnancy and are likely to resort to unsafe abortion (PRB, 2010). A population-based study on induced abortion, pregnancy loss and intimate partner violence in Tanzania showed that intimate partner violence was found to be associated with pregnancy loss in Dar es Salaam and Mbeya regions (Stöckl *et al.,* 2012).

2.4 Induced Abortion

Sections 219 and 230 of the Tanzania Penal Code indicate that an induced abortion can be performed if it is confirmed that the continuation of the pregnancy can put the life of the mother at danger. The abortion shall be carried with an individual with necessary skills (URT, 1981). Again, sections 150-153 Penal Code state the charges for individuals involved in procuring an unlawful abortion. Section 150 of the Penal Code is concerned with the charges of a person who provides abortion (the abortion provider) unlawfully to a woman. It indicates clearly that;

> *'Any person who with intent to procure miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a felony, and is liable to imprisonment for fourteen years'.*

Section 151 of the Penal Code is concerned with the charges of the woman who has procured an illegal induced abortion. It states explicitly that;

> '*Every woman being with child who with intent to procure her own miscarriage unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatsoever, or permits any such thing or means to be administered or used to her, is guilty of a felony, and is liable to imprisonment for seven years'.*

Section 152 of the Penal Code is concerned with the charges of an individual who supplies anything that can help a woman to have an illegal induced abortion. It states that;

> '*Any person who unlawfully supplies to or procures for any person anything whatsoever knowing that it is intended to, be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, is guilty of a felony, and is liable to imprisonment for three years'* (URT, 1981).

In 2007, Tanzania ratified the Maputo Protocol to the African Charter on the Rights of Women in Africa, especially article 14 (2a) and 14 (b). These articles call for states to provide adequate, affordable and accessible health services to women. Furthermore, the articles call for states to protect the rights of women by authorizing medical abortion due to sexual assault, rape and incest and in circumstances where the life of the mother is in danger (AU, 2003). This provision is yet to be incorporated in the national laws (Woog and Pembe, 2013).

Legal restrictions have made it difficult to estimate the incidences of induced abortions at the community level. Current estimates for induced abortion in Tanzania indicates that the rate of induced abortion is 36 abortions per 1,000 women of reproductive age (15-49) (Keogh *et al.,* 2015). Some studies on abortion and PAC services in Tanzania show that up to 60 percent of women admitted with abortion-related complications are due to induced abortion (Rasch *et al.,* 2000; Rasch *et al.,* 2004; Rasch and Kipingili, 2009; Woog and Pembe, 2013).

2.4.1 Causes of Induced Abortion

Determinants of induced abortion in Tanzania may not be different from those observed in other African countries. Restrictive abortion laws, low contraceptive uptake, gender based violence, economic hardships, religion and cultural beliefs are among the factors which lead to unsafe induced abortion (Jain *et al.,* 2006; Jewkes *et al.,* 2002; Lauro, 2011).

2.4.1.1 Restrictive Abortion Laws

Induced abortion is not allowed in Tanzania unless under certain conditions as noted above. Legal restrictions have led to clandestine abortions which are mostly provided by unskilled providers (Silberschmidt and Rasch, 2001). A study in Tanzania on unsafe abortion in urban and rural areas found that abortions performed by unskilled providers were 40 percent in rural areas and 60 percent in urban areas (Rasch and Kipingili, 2009).

2.4.1.2 Low Contraceptive Uptake

Contraceptive uptake is still low among women in Tanzania despite an increase in the use of modern contraceptives from 20 percent in 2004/2005 to 27 percent in 2010. This rate implies that over 70 percent of Tanzanian women do not use modern forms of contraception (NBS and ICF, 2011). The unmet need for contraception is high. It is estimated that two in five currently married women have an unmet need for family planning (Jain *et al.,* 2006). Studies comparing contraception and abortion within Africa and those comparing Africa and other regions are few, however available information confirms the correlation between high levels of induced abortion with low access to modern contraception (Lauro, 2011).

2.4.1.3 Gender Based Violence

Studies have documented that women who have experienced some form of sexual violence are likely to have an unsafe abortion. A study by Rasch and colleagues on adolescent girls undergoing an illegally induced abortion and treated for complications in Dar es Salaam found that the majority had experienced forced sex especially during their first intercourse (Rasch *et al.,* 2000). This is consistent with findings from the 2002 World Report on Violence and Health,

which indicates that the majority of young women in sub-Saharan Africa experience forced sex (WHO, 2002).

Intimate partner violence is also associated with induced abortion and miscarriage in Tanzania. A population-based survey conducted in Dar es Salaam and Mbeya on induced abortion, pregnancy loss and intimate partner violence found that when factors for induced abortion were compared, intimate partner violence had a stronger influence than other factors such as socio-economic status, age and parity (Stöckl *et al.,* 2012).

2. 4.1.4 Economic Factors

Unsafe abortion in Tanzania is also associated with economic factors whereby women especially adolescents engage in sexual relationships with men in exchange for material things such as clothes, soap and other small gifts (Silberschmidt and Rasch, 2001). Other economic factors include the high cost of raising children, the inability to get contraceptives (Rasch *et al.,* 2008) and the desire to complete formal education (Svanemyr and Sundby, 2007). Other factors associated with unsafe abortion in Tanzania include cultural beliefs, stigmatization and religious fundamentalism. Women who need an abortion are usually scared, feel ashamed and believe they are the exception (Ejano, 2011).

2.4.2 Morbidity and Mortality Associated with Induced Abortion

Estimating maternal morbidity and mortality related to illegal induced abortion is a challenge due to criminalization and stigmatization of abortion. Available evidence shows that some cases of maternal mortality are associated with unsafe abortion. The WHO analysis of the causes of maternal death in 2006 showed that 10-15 percent of maternal mortality in Tanzania is associated

with abortion (Khan *et al.,* 2006). Other estimates show that13-25 percent of maternal mortality in Tanzania is associated with unsafe abortion complications (Keogh *et al.,* 2015; MoHSW, 2008; Woog and Pembe 2013).

A report on a country-wide evaluation of reproductive health needs and rights of young people in Tanzania, since the ICPD in 2003, indicated that nearly a third of hospital admissions associated with unsafe abortion occurred in young women under 20 years of age (Price, 2004). In 2001, estimates in Shinyanga showed that about 38 percent of the admissions due to obstetric complications were associated with unsafe abortion (NBS and SRCO, 2007). Other estimates show that in Zanzibar, Mwanza and Kagera regions abortion complications constitute the majority of hospital admissions (Ejano, 2011). This situation indicates an urgent need to address the problem of unsafe abortion in Tanzania.

2.5 Provision of PAC Services

The Government of Tanzania recognizes the high maternal mortality associated with unsafe induced abortion. The government considers PAC as an essential strategy to address maternal mortality associated with unsafe abortion. Tanzania is among the countries that agreed to implement the ICPD Plan of Action (ICPD-POA) regarding PAC services in 1994. The ICPD-POA stressed on the need to provide quality PAC services among other things (UNPA, 1995). Since then, Tanzania has made deliberate efforts to address the complications associated with unsafe induced abortion.

The government has made deliberate efforts to provide PAC services. However, these services have been limited to district and tertiary hospitals (Wanjiru *et al.*, 2007). It was observed that until 1998, only 5 percent of hospitals in Tanzania were providing PAC services (MoHSW,

2008). Efforts have been made to decentralize PAC services to be available at lower level health facilities Nielsen *et al.,* 2009). Recent estimates show that the current facilities providing PAC services in Tanzania are less than 8 facilities per 100,000 women (Keogh *et al.,* 2015). This information suggests that PAC services are not widely available in Tanzania.

PAC is one of the components of the maternal health care. The Ministry of Health and Social Welfare (MoHSW) is responsible for the provision, monitoring and evaluation of maternal health services. The MoHSW is also responsible for the provision of maternal health education and budget allocation for activities related to maternal health care (URT, 2011). In addition, The MoHSW works in partnership with international organizations such as the EngenderHealth, to provide PAC services in Tanzania with support from USAID (Mwanga *et al.,* 2013). The international organizations support the MoHSW on key areas such as planning, implementation, monitoring and evaluation as well as financial assistance (URT, 2011). In 2007 for example, EngenderHealth through the ACQUIRE project supported the MoHSW to decentralize PAC services in 21 districts. The organization also supports training in Manual Vacuum Aspiration (MVA), addresses equipment and supply gaps and coaches and monitors the providers (Mwanga *et al.*, 2013).

The US AID provides funds for PAC programs to increase access to family planning therefore reducing the incidences of repeat abortions. On the other hand, the USAID does not support the purchase and distribution of MVA since it is used to carry out abortion as well as treating the complications (Curtis, 2007).

In 2002, the MoH developed a PAC clinical skills curriculum aiming at training middle-level health service providers, i.e. clinical officers and nurse-midwives. The PAC curriculum is based

on five elements of comprehensive PAC, national policy guidelines and component and standards for family planning and safe motherhood. The curriculum is used as a reference for pre-service curricular for nurses and midwives. The inclusion of middle-level providers in the training aims at ensuring the availability of PAC services at lower-level health facilities (MoH, 2002).

2.5.1 Policies and Programs on PAC Services

The Government of Tanzania has put forward policies and programs to ensure the provision of PAC services. After the ICPD, the government established the Reproductive and Child Health Section (RCHS) in the Ministry of Health (MoH) to deal with reproductive and child health issues and thus implement the ICPD-POA (MoHSW, 2008). The government also removed all barriers to accessing family planning services such as the requirement for partner consent and previous restrictions relating to parity and age. These changes were reflected in the new national guidelines on family planning issued by the MoH (Jain *et al.,* 2006).

PAC services is considered an essential part in government interventions to address the problem of maternal mortality such as the National Package of Essential Reproductive and Child Health Interventions (MoH, 2000b); the National Package of Essential Health Interventions (MoH, 2000a) and the National Road Map Strategic Plan to Accelerate Reduction of Maternal and Child Death (2008-2015) (MoHSW, 2008).

The National Policy Guidelines for Reproductive and Child Health Services acknowledges that maternal mortality due to abortion complications is unacceptably high therefore calls for the strengthening of PAC services (MoH, 2003b). The fact that the treatment of abortion complications is included in the Standard Treatment Guidelines (STG) and The National

Essential Medicines List (NEMLIT) (MoHSW, 2007), indicates the government commitment to provide PAC services.

In 2007, Tanzania registered for the use of misoprostol, a drug used in treating and preventing postpartum haemorrhage (PPH), making it the second country in Africa to register for the drug. After three years, (in 2011) the government through the Food and Drugs Authority (TFDA) incorporated the use of misoprostol in PAC services as a response to the increased morbidity and mortality associated with unsafe abortion, making it the fifth country in the world to incorporate misoprostol in PAC services (VSI, 2011).

2.6 The Structure of the Health Care Delivery in Tanzania

The healthcare delivery system in Tanzania is divided into three levels, namely the primary, the secondary and the tertiary levels. The primary level comprises community health services, health centres, and dispensaries. It provides the entry point to the health system for over 80 percent of the population (URT, 2006). Services provided at this level include health education and outreach, maternal and childcare and basic laboratory and dental services (Kwesigabo *et al.,* 2012).

The secondary level comprises the district and regional hospitals. They act as the referral points for the primary level facilities. The hospitals at this level can provide higher level expert services and can conduct training for the region and the district. The highest level of care is the national referral and specialized hospitals. They act as the referral for level two and offer services offered at the secondary level but in a more specialized way (MoH, 2003a).

The Government, Faith Based Organizations (FBOs) and the private sector provide health care services. The 2010 Tanzania mainland national health accounts showed that the government owned 95 hospitals, 398 health centres and 3,526 dispensaries. The parastatals owned 6 hospitals, 6 health centres and 168 dispensaries. The FBOs owned 96 hospitals, 103 health centres and 635 dispensaries, while those owned by the private sector comprised 35 hospitals, 56 health centres and 842 dispensaries (URT, Undated). Most people in Tanzania are estimated to be living within 5 kilometers of a health facility although disparities within and between regions still exist (NBS and MoF, 2011).

2.7 Temeke District

2.7.1 Population

Temeke district is the largest municipal district among the three districts of Dar es Salaam region. It is divided into 24 administrative wards (Fairhurst *et al.,* 2012). The 2012 population and housing census shows that Temeke district is the second populous distict of Dar es Salaam region with an estimated population of 1,368,880. Kinondoni district has the population of 1,775,050 while Ilala district has a population of 1,220,610. The 2012 census showed that Temeke had a population of 1,368,881 persons. More than half (51.1 percent) of the population in Temeke were females (NBS and RCO, 2014). Close to half (47.5 percent) of women of reproductive age (15-45) are in the age group 15-24 (NBS and OCGS, 2013).

2.7.2 Economy

Generally, the economy of Tanzania has grown at approximately 7 percent per annum in the past ten years. However, this growth has not been able to reduce poverty to the same extent (Mashindano and Maro, 2011). The 2007 Household Budget Survey (HBS) indicated that the

overall poverty level was 33.6 percent. About 34 percent of the population was falling below the basic needs poverty and 17 percent below the food poverty line (NBS, 2009). Temeke district is estimated to have the highest (29 percent) number of people living below the basic needs poverty line among the Dar es Salaam districts. Kinondoni district has 14 percent while Ilala district has 16 percent. Trade, agriculture and formal employment are the main source of income for Dar es Salaam residents (NBS and RCO, 2014).

2.7.3 Literacy Level

The adult literacy level in Tanzania (15 and over) is estimated to be 78 percent (73 percent of women and 83 percent among men) as per 2012 population and housing census (NBS *et al.,* 2013). Among the three districts of Dar es Salaam, Ilala district has the highest literacy rate (91.7 percent) followed by Kinondoni district (84.7 percent) and Temeke district (84.7 percent) (NBS and RCO, 2014).

2.7.4 Health Services

The 2014 data showed that Temeke district had the total of 387 health facilities. Of these, six (6) facilities were hospitals (3, public, 3 private), eight (8) facilities were health centres (1 public and 7 private) and one hundred and twenty-one (121) facilities were dispensaries (39 public and 82 private) (NBS and RCO, 2014). It was estimated that in 2011 only four (4) facilities were offering PAC services in Temeke distict (MoHSW *et al.,* 2011). The 2014-2015 Tanzania Service Provision Assessment Survey indicates that only forty-four (44) facilities in Dar es Salaam performed MVA three months preceding the survey (MoHSW *et al.,* 2015).

Human resource for health is still a challenge in Tanzania. Data for 2006 showed that the ratio of population per medical doctor and specialized doctors was 1 per 64,000 persons. The ratio of medical assistants was 1 medical assistant per 31,000 persons (NBS and MoF, 2011). The current doctor patient ratio in Dar es Salaam is estimated to be 1:4504.1 in Ilala district; 1:4239.4 in Kinondoni distict and 1:4504.1 in Temeke district (NBS and RCO, 2014). These figures indicate that there is shortage of staff in the health sector.

2.8 Conclusion

Tanzania still experiences high TFR and high population growth. Contraceptive uptake is still low despite the universal knowledge on family planning methods. Induced abortions are performed and contribute to maternal mortality although they are not permitted unless under certain circumstances. The government has made deliberate efforts to ensure the availability of PAC services. However, available data indicate that PAC services are underutilized.

The healthcare system is divided into three levels namely the primary, the secondary and the tertiary levels. Health services in Tanzania are provided by the government and the private sector. Among the districts of Dar es Salaam, Temeke distict is the second populous. However, it has the smallest number of health facilities and shortage of healthcare providers. The poverty level in Temeke is considered higher than in the other districts of Dar es Salaam.

CHAPTER THREE

LITERATURE REVIEW

3.1 Introduction

This chapter provides a review of the literature on PAC services and factors associated with its utilization. It is divided into four main parts. The first part focuses on the relationship between abortion, maternal mortality and PAC; and the origin of and the rationale for PAC services. The second part provides information on empirical studies on factors associated with the utilization of PAC services. The third part focuses on theories on health-seeking behaviour and the description of the framework that guided the study. The summary of the literature review and definition of key terms used in the study are presented in the fourth and fifth sections respectively.

3.2 Abortion and Maternal Mortality

In 2008, an estimated 21.6 million unsafe abortions were carried out worldwide with a large proportion occurring in developing countries. In Africa, the highest rates were observed in East Africa (38/1,000), Central Africa (36/1,000), West Africa (28/1,000) and North Africa (18/1,000). In developed countries, the rate was estimated to be (1/1,000) (Sedgh *et al.,* 2012). In Tanzania, estimates show that the abortion rate is 36/1,000 (Keogh *et al.,* 2015). Most of the induced abortions carried out in developing countries are unsafe (Shah and Åhman, 2009).

Unsafe abortion is caused by several factors such as low contraceptive uptake (Guttmacher, 2012; Lauro, 2011). Low contraceptive uptake is likely to lead to unintended pregnancies and therefore unsafe abortion particularly where induced abortion is illegal (Lauro, 2011). Restrictive abortion laws is another cause of unsafe induced abortion. Restrictive abortion laws force women

to resort to unskilled providers for abortion services (Singh *et al.,* 2009; Grimes *et al.,* 2006). Other factors which may lead to induced abortion are economic hardships, negative attitude on pre-marital pregnancies, desire for formal education and religious beliefs (Braam and Hessini, 2004; Jones and Dreweke, 2011; Svanemyr and Sundby, 2007).

Induced abortions which are performed unsafely are likely to cause complications (Grimes, *et al.,* 2006). The complications associated with induced abortion may be fatal or non-fatal depending on the method used to induce abortion, the skills of the abortion provider, the facilities, the readiness to seek care and the availability and quality of PAC services (Haddad and Nour 2009; Rasch and Kipingili, 2009).

Not all induced abortion complications are treated. Some women who had had an induced abortion may experience complications but do not seek care from health facilities due to fear of being arrested by the police, lack of appropriate information about PAC services, or preference to seek care from untrained providers (Keogh *et al.,* 2015; Okonofua, 2006; Singh, 2006). Untreated complications may lead to anemia, infertility, chronic pain and inflammation of the reproductive tract (Guttmacher, 2012).

Women who experience unsafe abortion complication may die. About 97 percent of maternal mortality associated with abortion complications occur in developing counties compared to 3 percent in countries where abortion is legal (Curtis, 2007). Mortality due to unsafe abortion are mainly caused by severe bleeding or infection caused by unsafe procedure or due to organ damage (WHO, 2012)**.** Deaths due to abortion complications are the easiest to prevent (Haddad and Nour, 2009; Okonofua, 2006). These deaths can be prevented if PAC services are sought

promptly following abortion complications and the care provided is of high quality (Okonofua, 2006; Singh *et al.,* 2009; Woog and Pembe, 2013).

Factors which may increase the risk of maternal mortality among women experiencing abortion complications include delays for recognizing the need for care, lack of equipment at the facility, negative attitude towards abortion, lack of transport and delayed care after reaching the facility (Grimes *et al.,* 2006; Okonofua, 2006). Therefore, prompt seeking of care following abortion complication and receiving quality PAC services upon reaching the facility may help to minimize the risks to maternal mortality (Okonofua, 2006).

3.3 The Origin and Rationale of PAC Services

The concept of PAC was first introduced by the International Pregnancy Advisory Services (IPAS), a United States of America-based NGO, in 1991. It was introduced as a means of reducing mortality and injuries due to unsafe abortion complications. PAC was published by Post-Abortion Care Consortium Community Task Force in 1995. In 1994, the international community (180 states) made a commitment in the ICPD to address maternal mortality related to abortion complications by strengthening PAC services (Adinma, 2012). Section 8:25 of the ICPD-Plan of Action states explicitly that:

> '*in any case abortion should not be promoted as a family planning method; abortion should be dealt with as a public health problem;prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion; women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling; in circumstances where abortion is not against the law, such abortion should be safe; in all cases, women should have access to quality services for the management of complications arising from abortion; post-abortion counselling, education and family-planning services should be offered promptly, which will also help to avoid repeat abortions'* (UNFPA, 1995).

PAC was also emphasized by the International Planned Parenthood Federation at their meeting held in Mauritius in 1994 and at the Fourth World Conference on Women held in Beijing in 1995 (Curtis, 2007). The emphasis on PAC services at these conferences reflects global and regional efforts to address the health risks of unsafe abortion.

The first PAC model was published by the Post-Abortion Care Consortium Community Task Force in 1995 (Adinma, 2012). It consisted of three major elements: emergency treatment of abortion complications, family planning services and a link to reproductive health services (PCC, 2002). The focus of the initial model was on the treatment of abortion-related complications (Corbett and Turner, 2003).

The first PAC model was revised and updated by the Post-Abortion Care Consortium Community Task Force in 2002, whereby two major elements were added namely; community provider partnership and counselling (PCC, 2002). The updated and expanded model reflects both provider and client perspectives. It shifted the focus of PAC services from a treatment-oriented approach to a public health approach, which considers the broad range of sexual and reproductive health needs of women (Corbett and Turner, 2003).

Community and provider partnership is the first essential element of PAC. This is because the community has a potential role to play regarding unwanted pregnancies and successful implementation of PAC programmes. Partnership between the community, trained providers, traditional healers, and lay health workers was recognized as essential for gaining access to sustainable and high quality PAC services (PCC, 2002).

Counselling is considered an essential element because a woman experiencing complications from a spontaneous or induced abortion should not be limited to family planning only. Counselling helps to ensure that the emotional needs of women are taken into consideration by providing PAC services on-site or via referral to other facilities (PCC, 2002). It helps women to manage anxiety, explore their feelings about abortion and assess their ability to cope with their situation (Corbett and Turner, 2003). PAC counselling may lead to increased contraceptive uptake, hence, reducing the chances of unintended pregnancies (Ferreira *et al.,* 2015).

3.3.1 Quality PAC Services

Women with abortion-related complications, whether due to spontaneous or induced abortion have the right to immediate high quality care. They have the right to emergency treatment regardless of their age, political beliefs, ethnic background, marital status or their family size (Rawlins *et al.,* 2001). The provision of high-quality PAC services is one step towards advancing women's rights, particularly their right to health and life (León *et al.,* 2006). The provision of quality PAC was emphasized in the ICPD-POA which states clearly that: "in all cases women shall have access to quality services for management of complications arising from abortion". It was agreed at the ICPD that PAC counselling, education and family planning services should be offered promptly in order to avoid repeated abortions (UNFPA, 1995).

In 1995, Jhpiego[1] developed guidelines which describe the elements of a quality post-abortion programme which recommends that:

- Services are provided safely and efficiently

---

[1] Jhpiego is an international, non-profit health organization affiliated with The John Hopkins University. It is dedicated to improving the health of women and families in developing countries.

- Women are treated in a non-judgmental manner
- PAC family planning services are widely available
- Well-established links to other health care services are ensured

Another aspect of quality PAC services is that they are woman-centred. Woman-centred PAC services means safe and timely services tailored to a woman's medical and personal needs, respectful and confidential care and the right to information, privacy and informed choice. Woman-centred PAC would aim to meet each woman's needs at the time of treatment to ensure that women receive high-quality PAC services that cater for their needs. Healthcare providers will need to take into consideration factors that influence each woman's need for and access to care, including her personal circumstances and her living conditions, in the provision of woman-centred PAC (Hyman and Castleman, 2005).

Youth-friendly PAC services is another aspect of quality PAC services. Adolescents seeking PAC services may have different experiences and needs from adults. They are often vulnerable to unwanted pregnancy and unsafe abortion due to social and economic circumstances, inadequate sex education and access to reproductive health that does not meet their needs. They are likely to have inadequate knowledge and access to contraception and are likely to experience coerced sex. Given their unique challenges, providing youth-friendly PAC may increase access to the services as well as preventing future unwanted pregnancies (PCC, 2002).

3.4 Empirical Studies on Factors Influencing Utilization of PAC Services

PAC services are considered a potential strategy for addressing morbidity and mortality associated with unsafe abortion (Okonofua, 2006; Woog and Pembe, 2013). Women experiencing abortion-related complications may benefit from PAC services upon receipt of the

right care in a timely manner (Sing *et al.,* 2009). Factors that may facilitate or hinder the utilization of PAC services emanate from the individual, community and healthcare system factors as presented below.

3.4.1 Individual Level Factors

3.4.1.1 Age

A lot of literature indicate that younger women are more likely to experience induced abortion (Henshaw *et al.,* 2005: Webb, 2000; Likwa and Whittaker, 1996). Regional variations in the age pattern of induced abortion still exist. Over 25 percent of all unsafe abortions in Africa occur among adolescents (15-19 years) while 42 percent and 33 percent of unsafe abortions in Asia and Latin America respectively occur among women aged 30-44 (Grimes *et al.,* 2006). Unmarried women particularly adolescents have little or no information about counselling, reproductive health issues and contraceptive services especially in countries where abortion is restricted (Shah and Ahman, 2004).

Generally, adolescents are more likely to be seriously affected by complications than older women (WHO, 2013). They are more likely to delay or not seek care for abortion-related complications. The delays or inability to seek care may be caused by fear of health-care providers' attitude, lack of transport, poor knowledge of where to obtain PAC services, lack of money to pay for PAC services (Bruyn and Packer, 2004) and stigmatization (Kumar *et al.,* 2009). Providing youth-friendly PAC may increase access to PAC well as preventing future unwanted pregnancies (PCC, 2002).

3.4.1.2 Education

Formal education attainment empowers women and increases their autonomy which influence their fertility decisions (Jejeebhoy, 1995). Women with formal education are more likely to be aware of the availability of health services. Their education may enhance their socio-economic status which may enable them to seek proper medical care (Chakraborty *et al.,* 2003). Education may facilitate contraceptive use by increasing a woman's economic power and ability to purchase contraceptives. It may further determine their access to safer methods of abortion and the type of PAC services to be sought in case of complications (Svanemyr and Sundby, 2007).

Desire to attain education and career development may lead to postponement of marriage among younger women in places where there are great opportunities for education. Therefore, abortion may be frequent in such settings in case of unintended pregnancy. On the other hand, abortion may be less frequent among younger women in places where early marriages are common and the expectation is to have children (Bankole *et al.,* 1999).

Education may have a positive impact on the utilization of PAC services. The attitude of the community on PAC services is more likely to be positive where its members are educated. A study in Pakistan found that educated members of the community did not have problems with women who were seeking PAC services. Therefore, the acceptance of PAC services in that community was high (Azmat *et al.,* 2012).

A study in Côte d'Ivoire found that women who had formal education and formal employment had the ability to pay for abortion and PAC services at health facilities (Svanemyr and Sundby, 2007). It is possible that formal education may increase health education and health literacy, but this may not always be guaranteed. Some studies have found health literacy to be low among

those with formal education due to the lack of specific health information, misconceptions and misinterpretation, cultural and societal norms, religious beliefs, general lack of and access to information and pressure from peers and institutions (Tomlinson, 2003).

3.4.1.3 Marital Status

There is growing evidence that premarital sexual relations are widely practised in different societies in Africa despite being socially unacceptable (Bennett, 2005). Young and unmarried women are more likely to opt for induced abortion in case of unintended pregnancy in places where the perceptions of society of out-of-wedlock pregnancy is negative (Svanemyr and Sundby, 2007).

Young and unmarried women have greater chances of experiencing difficulties in seeking PAC services in case of abortion-related complications in settings where out-of-wedlock pregnancy is morally sanctioned. A study in Indonesia found that providers showed compassion to married women requesting an abortion, especially for child spacing or due to contraceptive failure (Bennett, 2001). Another study in Indonesia found that young unmarried women were denied menstrual regulation services because of providers' punitive attitude to their marital status, despite abortion being legally permitted. They were sometimes charged more money (four times) than married women in private hospitals (Mundingo, 2006).

In the literature, there are mixed results on the role of the partner in seeking PAC services. In Tanzania, Rasch and Lyaruu (2005) reported that some married men accompanied their girlfriends to a health facility for PAC services after an induced abortion. These women tended to be younger than their boyfriends while some were students (Rasch and Lyaruu, 2005). Being married in a stable relationship does not always guarantee the husband's support for abortion and

PAC services. Some studies have found that married women unable to access PAC services due to their husbands' objection (Azmat *et al.,* 2012; Vlassoff *et al.,* 2012).

Social norms operating in different societies in Africa have put women, especially married women, in a subordinate position. They have to defer to their husbands, elders and mothers-in-law in all issues regarding their lives, including their own health (Sharan *et al.,* 2005). The dominant patriarchal system and the related religious, cultural and legal factors impact adversely on women's reproductive health and decision making, even when they are educated and economically independent (Braam and Hessini, 2004). Caldwell (1996) argues that there should be a marked increase in the degree of women's autonomy if reductions in mortality are to occur in poor societies. Women's morality and behaviour are their own responsibility when they are autonomous. Therefore, they can assume responsibilities including those relating to their own health as well as their children's (Caldwell, 1986).

3.4.1.4 Religion

Religion is among the powerful instruments that may influence an individual's cognition, social attitudes and behaviour (Czachesz, 2011). Religious views on abortion tend to vary (Cochran *et al.,* 1996). However, in most cases abortion is frequently condemned by religious ideologies and teaching (Shah and Ahman, 2009). Believers who belong to highly intolerant or proscriptive faiths tend to view abortion as murder, and hold a strong belief that those who perform abortions and those who obtain abortions are sinners. On the other hand, those belonging to less proscriptive faiths tend to encourage their members to be sympathetic towards such persons and to use their own judgement on abortion issues (Cochran *et al.,* 1996). Some religious beliefs perceive it as a taboo for a woman to expose her body to a stranger, particularly to a male

attendant. In such societies, women may be prohibited from visiting a health facility in case of an illness (Kruk *et al.,* 2010).

Azmat and others (2012) in their study found that religiously minded people or clergy viewed abortion as a grave sin and therefore strongly opposed PAC services. This attitude not only affected negatively the seeking of PAC services by women who were experiencing abortion-related complications but also the providers of PAC services. The clerics considered the PAC providers as murderous, and they always hound them. The study further noted that religion and females' restricted mobility were among the barriers to the utilization of PAC services (Azmat *et al.,* 2012).

Islamic teachings largely emphasize women's restricted freedom. This has been associated with poor mortality outcomes among Islamic societies (Jejeebhoy and Sathar, 2001). On the other hand, in the Christian religion, for example, Roman Catholics are more likely to judge abortion negatively than other denominations (Bègue, 2001). Furthermore, Roman Catholics discourages the use of modern contraceptives (Jones and Dreweke, 2011). These religious teachings may also influence the perceptions and the use of PAC services among the believers in case of abortion complications; given the powerful ability of religion to shape and change people's attitudes and behaviour (Czachesz, 2011).

Studies that associate religion and abortion in Tanzania are rare. However, a study by Rasch and colleagues found that, in Dar es Salaam, 72.2 percent of the 196 adolescents admitted for PAC services following unsafe abortion were Muslim while 27.6 percent were Christian (Rasch *et al.,* 2000). Although Muslims seemed to be in the majority in this study, it should not be concluded that the level of unsafe abortions is high among Muslims. Dar es Salaam is situated along the

Coast where the composition of Muslims society may be higher than in other areas of the country. In contrast, a different study by Rasch and colleagues (2006) indicates that women seek abortion and PAC services regardless of their religious affiliation (Rasch *et al.,* 2006).

Another study in Dar es Salaam indicated that 60 percent of men who were accompanying their partners to a health facility for PAC services were Muslim, 28 percent were Roman-Catholic while 12 percent were Protestant (Rasch and Lyaruu, 2005). The study did not indicate the religious affiliation of the female partner. Thus, it is not known whether they had the same religious affiliation.

Research elsewhere show that women resort to abortion despite their understanding of its religious immorality. A study in Cameroon where 37 percent of the population is Roman Catholic found that women who had had an abortion were more concerned about the consequential health impact of the abortion and how to maintain its secrecy than the legal restrictions or its religious immorality (Schuster, 2005). The desire to limit family size, the unmet need for family planning and unintended pregnancies due to sexual violence, especially in war zones, are among the factors that may transcend the limits of religious teachings on abortion in Muslim-dominated societies (Hessini, 2008).

3.4.1.5 Socio-Economic Status

Socio-economic status which is largely determined by the indicators of income, education and employment is related to health in various ways, including the utilization of health services (Katterl, 2011). Research evidence suggest a strong correlation between socio-economic status and the use of health care services (Kida, 2012). Modern health services are more likely to be utilized by the affluent members of the community (Kevany *et al.,* 2012).

The economic status of a woman may dictate the kind of method to terminate pregnancy and the type of care she can access in case of complications (Braam and Hessini, 2004; Svanemyr and Sundby, 2007). Women who are economically stable are more likely to have better access to less risky methods of abortion. On the other hand, poor and uneducated women who live in rural areas are likely to seek abortion from traditional practitioners. They are likely to face greater risks of experiencing complications and higher chances of not obtaining PAC services (Sigh *et al.,* 2009). Of note, some women who are economically well off who live in rural areas may seek abortion and PAC services in urban areas to avoid stigma and embarrassment (Henshaw *et al.,* 2005).

The probability of poor women suffering from complications from unsafe abortion is 42-67 percent while that of better-off women is much lower, 28-38 percent (Singh *et al.,* 2009). Poor women are more likely to use traditional methods to induce abortion because of poor knowledge of safe procedures or the inability to pay for abortion services (Singh et al., 2010b). They may have poor access to PAC services due to inadequate health facilities offering PAC services (Singh, 2006). A study in Pakistan found that poverty made women opt for abortion and PAC services from a traditional doctor (local *baji*) (Azmat *et al.,* 2012).

3.4.1.6 Severity of Abortion Complications

Andersen's model for healthcare utilization identifies illness characteristics as a need factor that influences utilization of healthcare services (Anderson, 1973). People who perceive themselves as having a poor health status are likely to utilize healthcare services (O'Hara and Caswell, 2012), although this may differ depending on the type of illness and other factors. PAC services

may be available but women may delay or not utilize them because they don't perceive themselves to be severely sick (Okonofua, 2006).

3.4.1.7 Awareness of PAC Services

Induced abortion carries with it some risks regardless of the type of the abortion procedure. The risks of safe abortion depend on the skill of the provider, the gestational age of the foetus and the type of health facility. The risk of unsafe abortion depends on, among other factors, the method used to terminate the pregnancy and the readiness of a woman to seek PAC services (Haddad and Nour, 2009). Abortion-related complications may be severe but women may delay or not seek PAC services due to their poor knowledge of the availability of PAC services or because of stigma (Vlassoff et *al.,* 2012; Kruk, *et al.,* 2010; Shah and Åhman, 2004).

3.4.1.8 Decision Making and Resource Control at Household Level

Women are family care givers but in many contexts are less autonomous on issues regarding their own health (Shaikh and Hatcher, 2004). Some research findings indicate that the objection of the husband, in-laws and other family members is among the factors constraining the utilization of PAC services (Azmat *et al.,* 2012; Vlassoff *et al.,* 2012). This implies that a woman may experience an illness however, the decision to seek help may be made by her husband or other family members. The decision to seek care may further be influenced by those who control the resources at household level. Intra-household resource allocation may have a gender bias, hence affecting women's access to health services (WHO, 2010). On the other hand, women who have ability to pay for abortion and PAC services can do so without informing their partners about their seeking of the services (Sathar *et al.,* 2013; Svanemyr and Sundby, 2007).

3.4.1.9 Place of Residence

A study in Ecuador shows that there is a variation in the use of health care services among rural and urban dwellers (López-Cevallos and Chi, 2010). In Tanzania, rural dwellers are more likely to experience difficulties in utilizing health care than their urban counterparts (NBS and ICF, 2011). Some factors contributing to variation in accessing healthcare services among rural and urban dwellers are the distance to a health facility and the time taken to reach the facility (Awoyemi *et al.,* 2011). In most developing countries, PAC services are limited to urban areas or regional health facilities. Limited health facilities for PAC services in rural areas places rural women at greater risk of morbidity and mortality because of poor access to PAC services (Jain *et al.,* 2006).

3.4.2. Community Level Factors

The decision to use health services is mostly considered an individual choice. However, individual choices are bound by cultural, family and social ties (Shaikh and Hatcher, 2004). Therefore, to ascertain the factors that influence the utilization of health services, it is vital to find out how community factors may impact an individual, hence affecting his/her health-seeking behaviour (Babalola and Fatusi, 2006).

3.4.2.1 Availability of Healthcare Providers

Community-related factors such as the availability of healthcare providers may influence the use of PAC services (Phillips *et al.,* 1998). Inadequate healthcare providers to offer PAC services has been regarded as one of the major barrier in the utilization of PAC services (Grimes *et al.,* 2006). Availability of the healthcare providers does not guarantee utilization of PAC services. Provider's attitude on abortion and PAC services may have a great influence on the utilization of

PAC services (Rehan, 2003). For example, healthcare providers who have negative attitude towards abortion may lead to women receiving poor quality services, or may lead to PAC clients opting for care from non-formal sources (Likwa *et al.,* 2009; Melkamu *et al.,* 2010; Shah and Åhman, 2004; Webb, 2000). Healthcare providers may be available and ready to offer PAC services however fear of the legal prosecution and poor information on where to obtain PAC services may prevent women from utilizing them (Keogh *et al.,* 2015; Singh, 2006; Okonofua, 2006).

3.4.2.2 The Socio-Cultural Context

Attitudes on abortion are one of the most discriminating psycho-social variables in the realm of social judgment (Bègue, 2001). Abortion is considered a taboo in some societies (Tong *et al.,* 2012). In some clans in Tanzania, abortion is opposed on the beliefs that a female member and any sexual partner of a male member would die if attempting an abortion. This is irrespective of whether the abortion is done by a trained provider, or a traditional practitioner or is self-induced (Plummer *et al.,* 2008). In some communities in Zambia, girls who had had an induced abortion are called *kaponya mafumo* (i.e. terminators of pregnancies) and are considered able to infect others. Therefore, some people cannot greet them or share utensils with them (Webb, 2000). Negative social attitudes to abortion may have an adverse impact on women's experience of abortion (Astbury-Ward *et al.,* 2012).

Moral and societal judgments on abortion may lead to stigma even in settings where abortion is legally permitted. The impact of stigma on women may lead to delay in seeking health care, shame, guilt or death (Geary *et al.,* 2012). In Cameroon, one study found that women who had had an abortion reported that public shaming and social control imposed by close friends and

family had a negative impact on their lives. In women's social activities such as dancing, if a woman who has had an abortion showed up, a song indicating her name might be sung as way to shame her. Young and unmarried women may be charged with promiscuity and may even be expelled from the village for procuring an abortion (Schuster, 2005).

The negative perception of abortion may cause women who had an induced abortion to be more fearful of the public knowing about it than the police or courts (Schuster, 2005). The social disapproval of abortion may lead to lack of disclosure of the practice which may increase the burden on the woman (Astbury-Ward *et al.,* 2012). A study in the United Kingdom indicates that the social unacceptability of abortion had a great effect on how women who had had an abortion perceived themselves and how they were perceived by others. Respondents were fearful of disapproval once the significant others, society and the healthcare providers learnt of their acquiring an abortion. In other contexts, abortion is associated with misfortune. The misfortune is believed to affect not only the woman but also other members of the family particularly children (Astbury-Ward, *et al.,* 2012).

Societal disapproval of abortion has made women conceal their need for an abortion. The concealing of abortion may affect how they seek the procedure as well as seeking help in case of complications. Having an abortion at the cost of society's disapproval has led some women to delay seeking care or to give inaccurate information to healthcare providers when they manage to obtain PAC services or losing their lives (Schuster, 2005).

PAC services are likely to receive less support than other health services in settings where society's perception of abortion is negative. Kruk *et al.* (2010) found that the lack of community

support programmes for PAC due to the negative attitude on abortion discouraged women from seeking PAC services despite PAC being widely available in Ethiopia (Kruk *et al.,* 2010).

3.4.2.2 Alternative Sources of Care

Every society has its own cultural beliefs and practices which may exert an influence on health when it comes to illness. The beliefs and practices may lead to people using home remedies, resort to traditional healers, care for themselves, or seek modern treatment when ill (Shaikh and Hatcher, 2004). For certain types of illness, people may seek help from village homeopaths, untrained allopathic doctors, or traditional healers instead of formal sources of healthcare (Ahmed *et al.,* 2000).

Abortion is an issue that is affected negatively by cultural, religious and societal beliefs as noted earlier. These beliefs and attitudes in one way or another may lead to women seeking abortion and PAC services from informal sources. The reasons for women's preference for informal sources of care may include; the cost and availability of the services, the fear of being mistreated by healthcare providers, the perceptions of the community on young women who seek PAC services, lack of confidentiality and privacy and distance to health facilities (Azmat et *al.,* 2012; Vlassoff *et al.,* 2012; Shah and Åhman, 2004; Webb, 2000).

3.4.3. Health System Factors

3.4.3.1 Quality of Services

Peoples' perceptions on the quality of healthcare services may determine whether they will continue seeking and using the services (Rasheed *et al.,* 2012). The literature has highlighted various determinants of the users' perceptions on the quality of health services. The determinants include short waiting time and respect for privacy (Singh *et al.,* 2010a) provider behaviour

(Peters *et al.,* 2002), competency of the healthcare providers, and the availability of drugs (Fomba *et al.,* 2010).

Studies on the quality of PAC services have documented both good and poor aspects. Some of the good qualities of PAC services are: very good MVA practices and providers competent in providing PAC services (Kumbi *et al.,* 2008; Rawlins *et al.,* 2001). On the other hand, some of the documented poor quality of PAC services are long waiting time, inadequate or minimal practice of MVA, inadequate family planning services, lack of privacy, lack of on-the-job training, providers giving inappropriate information to the users of PAC services and unnecessary administration of antibiotics (Kumbi *et al.,* 2008; Rawlins *et al.,* 2001; Jain *et al.,* 2006; Kumar *et al.,* 2009). Women in need of PAC services are more likely to be discouraged from seeking care when the quality of the services are poor and vice versa.

3.4.3.2 Healthcare Providers' Attitudes

The attitudes of the healthcare providers have been identified as among the factors that may hinder or facilitate utilization of health care services. Some providers have a negative attitude or are uncomfortable dealing with abortion cases. Therefore, their attitude may lead to women receiving low quality abortion-related services (Likwa *et al*., 2009). Furthermore, some providers may refuse to provide abortion services to women for reasons of conscience or may even fail to refer them to other facilities (Singh *et al.,* 2009). Adolescents may be affected disproportionally by the attitude of providers on abortion (Likwa *et al.,* 2009; Iqbal and Åhman, 2004; Webb, 2000). They may not seek care for fear of being judged negatively for having an induced abortion (Grimes *et al.,* 2006).

Stigma attached to abortion may have a negative effect on providers' willingness to provide abortion and PAC services. In Ghana for example, stigma prohibits healthcare providers from offering PAC services although they are willing to do so. In both the community and professional sphere, obstetricians and gynaecologists are marginalized. In some instances, their properties are labeled abortion properties. For example, when a PAC service provider has a new car or house, it is labelled 'abortion car' or 'abortion house'. The labelling discourages them from performing an abortion as well as obtaining training for abortion-related services (Payne *et al.,* 2013).

Judgmental attitudes of the provider affect the seeking and utilization of PAC services. Melkamu and colleagues documented that a significant proportion of women in Ethiopia did not seek PAC services due to mistreatment by healthcare providers (Melkamu *et al.,* 2010). In Argentina, a study found that a haemorrhaging woman was denied PAC services after the provider discovered that the haemorrhage was due to an induced abortion. In other instances, women were interrogated and even punished when the health personnel discovered that they had had an induced abortion (León *et al.,* 2006). Elsewhere information shows that PAC clients are charged more and treated harshly (Webb, 2000).

3.4.3.3 Healthcare Providers' Competencies

The competencies of healthcare providers and the availability of PAC services may influence the utilization of PAC services. In Bangladesh, a report on factors associated with access to and quality of menstrual regulation (MR) and PAC services found that inadequate equipment and training of the PAC service providers were among the barriers to the utilization of PAC services (Vlassoff *et al.,* 2012). A study in Ethiopia found that some PAC patients reported to have

visited at least one health facility before obtaining treatment because of shortage of healthcare provides for PAC services (Gebreselassie *et al.,* 2010). The stigma associated with performing an abortion may hinder healthcare providers from providing abortion and PAC services effectively although they may be competent and well trained to offer PAC services (Payne *et al.,* 2013).

3.4.3.4 Healthcare Providers' Sex

The healthcare provider's sex has been documented to have an influence on the use of health care services. Research findings on the influence of providers' sex on the utilization of healthcare services are diverse. However, most of them indicate that women providers are more likely to devote more time to clients and adopt client-centred communication (Jerant *et al.,* 2013).

Women may be prohibited from visiting a health facility in case of illness in settings where women are restricted to expose their bodies to a male attendant (Kruk *et al.,* 2010). In India for example, a study found that male PAC providers are prohibited from conducting a physical examination or invasive and diagnostic therapeutic procedures on women due to societal taboos. Healthcare providers in this community offered pills or injections to women experiencing abortion-related complications, which in most cases were not precise. On the other hand, female providers are socially permitted to provide PAC services, even if they lack the appropriate training. The taboos put the lives of women at greater risk of maternal mortality (Johnston *et al.*, 2003).

3.4.3.5 Type of Health Facility

There are many ways in which an individual can obtain treatment when ill. Some people may practice self-medication or seek help from a traditional healer, private facility or government facility (Msiska *et al.,* 1997). In the context of modern health care, the inherent problem has been how to define private and public health facilities (Birungi *et al.,* 2001). Saksena and colleagues suggest having a common framework for examining all facilities, state and non-state (Saksena *et al.,* 2012). The choice of a type of facility may depend on the socio-economic status, quality of the services and the type of illness (Msiska *et al.,* 1997; Ahmed *et al.,* 2000).

The literature indicates that women may prefer a type of facility formal or non-formal, private or public for abortion and PAC services. The choice of a health facility may be influenced by the providers' attitudes, confidentiality, privacy, distance, perceived quality of services, cost and stigma (Webb, 2000; Melkamu *et al.,* 2010; Iqbal and Åhman, 2004; Payne *et al.,* 2013).

3.4.3.6 Distance to the Nearest Health Facility

Physical accessibility and transportation may have influence the utilization of healthcare services (Littenberg *et al.,* 2006). Long distance to a healthcare facility is likely to influence utilization negatively. Transport costs and proximity to the nearest hospital or health centre are found to be among the strong predictors of healthcare utilization (Fitsum *et al.,* 2011). Long distance to a health facility is cited as one of the factors for the low utilization of maternal health services in Tanzania (Lwelamira and Safari, 2012). Recent estimates show that by June 2013, 79 percent of the population was living within 5 kilometers from a health facility in Tanzania (URT, 2013).

3.4.3.7 Privacy

Privacy is of paramount importance especially where abortion is highly stigmatized. In developing countries, limited PAC resources in the healthcare system affects the utilization of PAC services. Factors such as overcrowded waiting areas (where PAC clients wait along with other patients) and long waiting time are some of the conditions which may discourage women who need PAC from utilizing PAC services (Payne *et al.,* 2013)

3.5 Theories and Models on Health-Seeking Behaviour and Utilization

Theories and models analyzing the seeking and utilization of health services may be divided into two categories namely: The *deterministic model which* focuses on the factors that influence an individual's health-seeking behaviour and the *pathway model,* which describes the steps an individual takes from recognizing an illness to treatment (Mackian *et al.,* 2004).

3.5.1 Deterministic Models

The Health Belief Model (HBM) is among the deterministic models built on the psychological behavioral theory. The behavioral theory assumes that behaviour depends on two major variables: the value placed by an individual on a particular goal and the individual's estimate of the likelihood that a given action will achieve that goal (Janz and Becker, 1984). The HBM model posits that, an individual's decision to act to avoid illness depends on whether he/she perceives himself/herself to be susceptible to the illness. The perceptions include; perceived severity of the illness; perceived benefit of taking some action to prevent the illness and perceived barriers that could impede an individual from taking action regarding the illness; and the belief in one's ability to perform certain behaviour/s (Strecher and Rosenstock, 1997).

Variables such as culture, education level, motivation, experience and skills can influence an individual's perception and health-related behaviour (Strecher and Rosenstock 1997). Cues to action which are things, people or events may move people to change their behaviour. Media reports, mass media campaigns, the influence of others, reminder postcards from healthcare providers and the illness of a family member are some of the cues to action. The HBM model is criticized for emphasizing more on perceptual factors and ignoring personal and socio-cultural norms. Social norms in each culture or sub-culture may have an influence on people's behaviour. Therefore the underlying assumption that health behaviour is rational is problematic (Noh *et al.,* 1994).

Another deterministic model is the Health Care Utilization Model. The model was initially developed by Andersen in 1960s (Anderson, 1968). The behavioural model for healthcare utilization was developed to enhance the understanding of why families use health services, to define and measure equitable access to healthcare and to assist in developing policies that may promote equitable access to care. The main unit of analysis of the initial model was on the family. The initial model assumed that individual's use of medical care is a function of demographic and socioeconomic characteristics of the family as a unit (Andersen, 1995).

This model identifies the conditions that may impede or facilitate the utilization of health care services (Andersen and Newman, 1973). According to the model, access to and the use of healthcare services is determined by three main factors: (1) the predisposing (2) the enabling and (3) the need factors (Aday and Andersen, 1974). The predisposing factors are the individual and the socio-cultural characteristics that exist before the illness. The predisposing factors are divided into three levels: the social structure comprises variables like occupation, education,

ethnicity, social networks, culture and social interactions; the health beliefs comprise attitudes, values and the knowledge people have of the healthcare system; and the demographic characteristics such as age and sex (Bradley *et al.,* 2002).

The enabling factors are personal, community and other factors that influence the utilization of care. These include among other factors the means of accessing healthcare, income, and personal and psychological characteristics. The need factors are those concerned with how individuals assess the illness and succeed in seeking treatment (Anderson, 1973).

The model underwent considerable changes and aspects such as external environment, health system factors, health behaviours and outcomes were added to the original model (Andersen, 1995). The model acknowledges the influence of health system factors such as a policy on the utilization of healthcare services (Hausmann-Muela *et al.,* 2003). This model has been criticized for focusing on an individual's health behaviour and ignoring the impact of the social network on the decision-making process. The model focuses mainly on how a decision to utilize care is made while ignoring why it was made (Mackian *et al.,* 2004).

3.5.2 Pathway Models

Pathway models describe the steps an individual takes from recognizing an illness to seeking treatment. Among the pathway models are Schuman's (1965) and Igun's (1979). Suchman's model postulates five steps which represent major transition points and involve new decisions about the future course of medical care. These five steps are (1) the symptom experience stage, (2) assumption of the sick role stage, (3) the medical care content stage, (4) the dependent–patient role, and (5) the recovery or rehabilitation stage (Suchman, 1965). The major

shortcoming of the model is that it assumes that health-seeking behaviour tends to follow certain stages, which may not be the case for every individual or for all illness conditions.

Igun, (1979) identified 11 steps that could characterize change in health behaviour after experience in Nigeria and with perspectives from other models. These stages are; the symptoms-experience stage; self-treatment stage; communication to significant others stage; assessment of symptoms stage; assumption of the sick-role stage; expression of concern stage; assessment of the appropriateness of sources of treatment stage; selection of treatment plan stage; treatment stage; assessment of the effects of treatment on symptoms stage; and recovery and rehabilitation stage (Igun, 1979). The main weakness of the model is that it describes these stages but does not describe the factors that influence the movement from one stage to another (Mackian *et al.,* 2004).

In summary, health-seeking behaviour theories and healthcare utilization models help us to understand the factors influencing health seeking behavior and the steps people take from illness recognition to the choice of therapy. However, these theories suffer from several weaknesses. Health-seeking behaviour models focus on individual characteristics to explain reasons for the delay in seeking treatment, non-compliance with treatment or non-utilization of health services. Few of them have taken provider-related factors into consideration or the context in which these individual factors operate.

The result of emphasizing individual factors is to blame the victim for inadequate health-seeking behavior. These models do not give due recognition to the structural factors, which shape and constrain the operation of individual factors and mediate health-seeking behavior. It should be

noted that power relations and political discourses can significantly influence health-seeking behaviour (Hausmann-Muela *et al.,* 2003).

3.6 Conceptual Framework

This review of the literature shows that factors associated with the utilization of PAC services can be put into three main categories. The categories are individual factors, community factors, and health system factors. Individual-related factors comprise age, education, marital status, occupation, religion, severity of the complications, awareness of the availability of the services, decision-making and resources control at the household level. Community-related factors comprise the community's perception and alternative sources of care, while the health system-related factors include quality of care, type of health facility and providers' attitude and competency as shown on Figure 3.1 below.

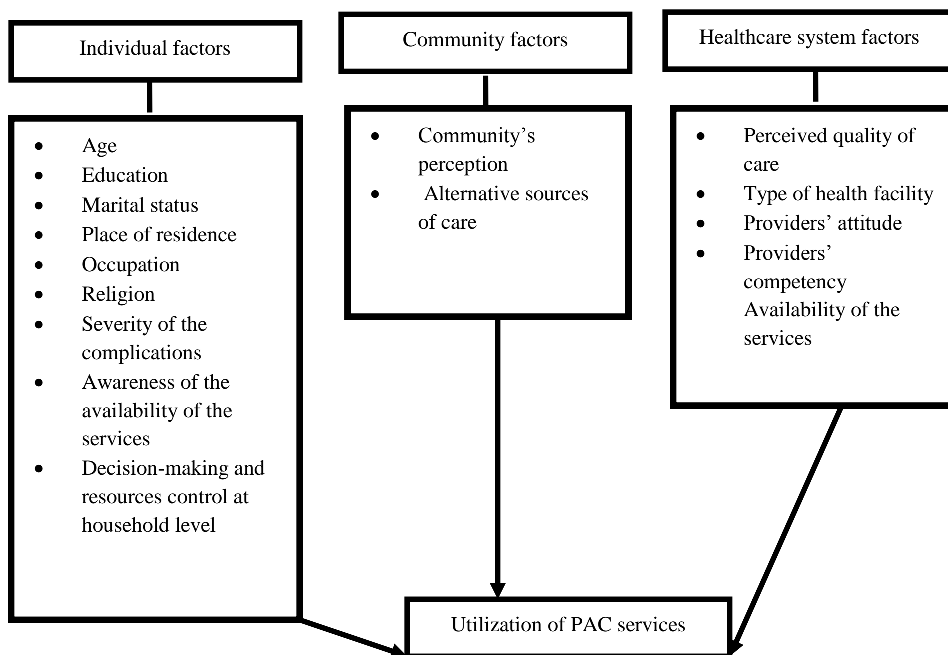


Figure 3.1 A Conceptual Framework for Factors Influencing Utilization of PAC Services
Source: Author's Modification of the Andersen's Model

3.7 Operational Framework

Andersen's model for healthcare utilization has been widely used to study factors associated with the utilization of healthcare services (Phillips *et al.,* 1998). As explained earlier, Andersen's model classifies the determinants into three main categories as predisposing, enabling and need factors. It also considers provider-related factors and contextual factors. Some scholars have applied the model to test the applicability of its different components in different contexts (Brown *et al.,* 2009) while others have used the model as a framework to identify the variables to be measured in their studies (Phillips *et al.,* 1998).

Andersen's model is widely used in studies applying primary or secondary data (Scheppers *et al.,* 2006). The model focuses on individual-level determinants and contextual factors that influence utilization of care (Andersen, 1995). Andersen's model is a framework of analysis rather than a mathematical model. Therefore, it offers flexibility in choosing variables for analysis. It does not dictate which variables and methods must be used (Phillips *et al.,* 1998).

This study used Andersen's model for healthcare utilization to identify various factors associated with the utilization of PAC services. The model can be looked at from the perspective that some are; **predisposing factors,** notably socio-economic and demographic factors, such as age, education, religion, occupation, marital status and place of residence; while others are **enabling factors** such as the source of PAC, distance to a health facility, providers' availability, sex and attitude, community perceptions, and perceived quality of PAC. Finally, some can be considered as **need factors** such as the expected benefits of treatment, severity of complications and previous use of the services (Fig 3.2).

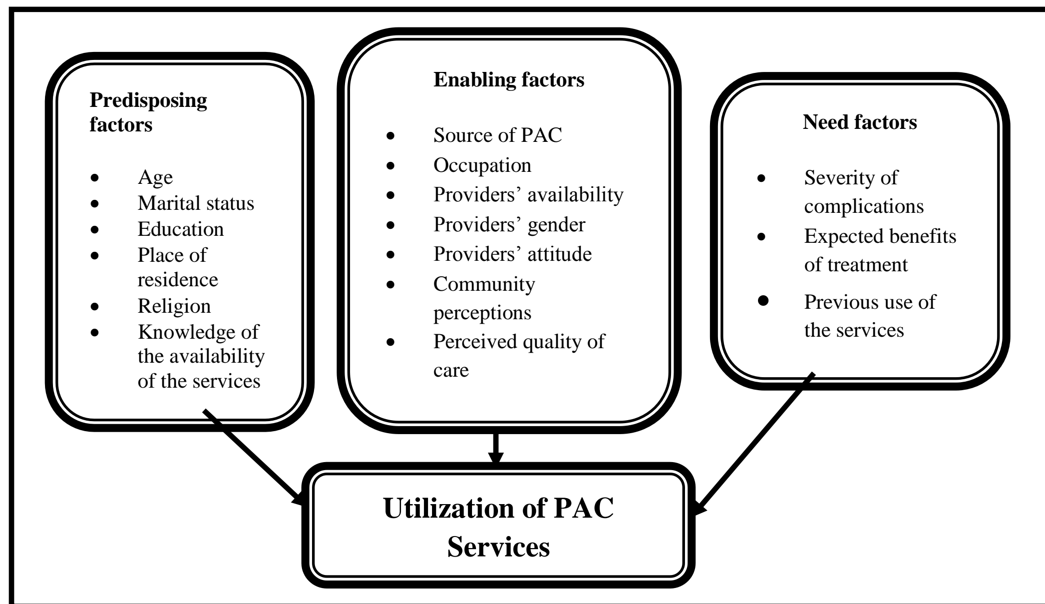


Figure 3.2 A Modified 1995 Andersen's Model of Healthcare Utilization
Source: Andersen (1995)

3.8 Summary of the Literature Review

The review has indicated that unsafe abortion is a major public health problem in developing countries. Low contraceptive uptake, restrictive abortion laws, economic hardship, religious, cultural beliefs and stigmatization are among the factors that lead to induced abortion. In Tanzania estimates show that the rate of induced abortion is 36 abortions per 1,000 women aged 15-49. Most of these abortions are performed unsafely due to legal restrictions. Unsafe abortion has a detrimental impact on a woman's health. It may lead to loss of life. Over 13 percent of maternal mortality in developing countries is due to unsafe abortion. It is estimated that 13-25 percent of maternal mortality in Tanzania is associated with unsafe abortions.

This review shows that the Government of Tanzania has made deliberate efforts to ensure that PAC services are available to women who need them. In addition, there are various policies and

programs in place to ensure that PAC services are available. The government has also made efforts to decentralize PAC services however, the utilization of PAC services remains low. Factors associated with low utilization of PAC services are not well known.

Studies conducted elsewhere show that the utilization of PAC services relates to the individual, the community and the health system factors. All these studies provide useful information on factors associated with the utilization of PAC in developing countries. However, it is not possible to generalize from these studies since they were conducted in countries with different socio-economic and cultural contexts.

Theories of health seeking behaviour provide useful information on factors that may hinder or promote the utilization of healthcare services. The theories have focused on the individual factors that influence utilization of PAC services. It should be noted that other factors such as political, socio-cultural and health system factors influence utilization of health services. The study used Andersen's model of healthcare utilization due to these inadequacies of the behavioural models. Andersen's model considers the individual, community and health system-related factors that influence the utilization of modern healthcare services.

Studies focusing on abortion and PAC clients are available in Tanzania. The available studies provide information on aspects such as the proportion of women admitted in health facilities due to unsafe induced abortion, PAC services and HIV counselling, the incidences of induced abortion, methods used to induce abortion and the consequences of induced abortion. These studies provide useful information regarding abortion and PAC services in Tanzania. On the other hand, studies focusing on the utilization of PAC services are rare. In addition, studies that provide information of the perceptions of the community on abortion and PAC services in

Tanzania are limited. Furthermore, there is lack of information on users and providers' perceptions of quality of PAC services. This study therefore sought to understand factors associated with the utilization of PAC services in Temeke district.

3.9 Definition of Key Terms

Post-abortion Care

PAC is a package of services provided to women who have had an incomplete abortion after a spontaneous or an induced abortion (Adinma, 2012). They include treatment, counselling, family planning, community/provider partnership and reproductive and other health services. A facility was included in the study if it treated abortion-related complications and provided counselling and family planning services.

Users of PAC Services

These were women who experienced abortion complications and sought PAC services from health facilities. Users of PAC services, patients for PAC and clients for PAC services were used interchangeably.

Non-users of PAC

Non-users of PAC were women who had experienced abortion-related complications but did not seek care from a public or a private health facility. A woman was identified as a PAC non-user if she did not seek PAC services from health facilities which are recognized by the government as providers of PAC services. PAC services sought from pharmacies or provided by qualified providers but outside the public or private facilities recognized by the government were considered informal sources of PAC services.

Utilization of PAC services

In this study, utilization of PAC services entailed the process of seeking one or all components of PAC services from a health facility by women experiencing abortion-related complications resulting from induced or spontaneous abortion.

Unsafe Abortion

Unsafe abortion is defined by the World Health Organization (WHO) as a termination of an unintended pregnancy performed by persons lacking the necessary skills, in an environment that does not conform to minimal medical standards, or both (WHO, 2007c). Safe abortion, on the other hand, refers to those performed within a legal framework in properly equipped and regulated health facilities by qualified professionals with specific training in abortion (Singh *et al.,* 2009).

Not all legal abortions are carried out in hygienic conditions by skilled providers. In some instances, abortion may be legally permitted but carried out by an unqualified person in unhygienic conditions. Notably, unsafe is not synonymous with illegal or clandestine. Induced abortion may be legal but carried out in unsafe conditions and vice versa. Illegal abortions are those occurring outside the legal system. In most cases, they are carried out by unskilled and unqualified providers or may be self-induced, and they often take place in unhygienic conditions (WHO, 2007b). In Tanzania, it is highly possible that most induced abortions are unsafe because induced abortion is not legally permitted except in certain circumstances. In this study, the WHO definition of unsafe abortion was adopted.

Abortion Complications

These are health-related problems associated with induced or spontaneous abortion. They include among others bleeding, genital or cervical trauma, injuries, and uterine perforation (Henshaw *et al.,* 2008).

Providers of PAC Services

In this study, providers of PAC services mean health workers that were directly involved with delivery of PAC services.

Health System

A health system is defined as all organizations, people and actions whose primary aim is to promote, restore or maintain health (WHO, 2007a). In this study, health system and healthcare system were used synonymously and interchangeably. In this study a health system includes the health facilities, providers of PAC services and other stakeholders that are involved with PAC services issues.

CHAPTER FOUR

METHODOLOGY

4.1 Introduction

This chapter presents the methodology used in the study. Firstly, it describes the design of the study and the justification of the choice of the design. Secondly, it presents the sources of data for the study (i.e. the study area and population). Thirdly, it highlights the sample size and sampling procedures employed to obtain the sample. The chapter then describes the instruments used to collect data, followed by data quality assurance and ethical considerations. The last section presents the methods used for analysis.

4.2 The Design of the Study

According to Kumar (2005;84) a research design is a procedure that is adopted by the researcher to answer questions validly, objectively accurately and economically. Study designs can be categorized depending on the number of contacts, reference periods or the nature of the investigation (Kumar, 2005). This study sought to understand factors associated with the utilization of PAC services at a specified time. Therefore, a cross-sectional design was the most appropriate. Cross-sectional studies are undertaken to obtain the overall picture of a phenomenon at a given point in time. They are best suited for determining the prevalence of the phenomenon, a situation or attitude by taking a cross-section of the population (Babbie, 1989 cited in Kumar, 2005). In this study both qualitative and quantitative data were gathered using various research tools.

4.2.1 The Study Approach

Basically, there are two main approaches to research. The approaches are quantitative and qualitative. The difference between the two approaches lie on how reality is perceived *(ontology)* (Amaratunga *et al.,* 2002) and the means of generating it *(epistemology)* (Sandelowski, 2000). Qualitative research is grounded on the constructivist ontology which perceives reality as subjective. Per the constructivist school of thought, reality is socially constructed. Constructivists hold that there are multiple realities that are constructed by human being who experience the phenomenon (Krauss, 2005). On the other hand, quantitative research is grounded in the positivist ontology which views reality as independent of the observer (Aliyu *et al.,* 2014).

Social problems are complex. The complexity necessitates the application of a complex research design to understand them (Sandelowski, 2000). The use of either the qualitative or quantitative approach by itself is inadequate for gaining an understanding of complex social problems (Creswell, 2009). Thus, using both methods ensures that complex social problems are understood properly (Creswell, 2002). Mixed methods approach is a research approach applying the elements of both qualitative and quantitative research methods in a single study (Creswell, 2009). The application of both qualitative and quantitative approaches helps to provide insights that could not be gained by one research approach (Bryman, 2007).

Various authors have identified some challenges in applying the mixed-methods approach. Sandelowski (2000) argues that its main problem lies in the when, what and how of the combination (Sandelowski, 2000). Leech and Onwuegbuzie posit that the mixed-methods approach is still in its developmental stage and so there exist various mixed method designs from which to choose. In some instances, the presence of multiple mixed method designs has left

researchers with a challenge of which is the best mixed method to use (Leech and Onwuegbuzie, 2009). Bryman (2007) identified nine barriers to the application of the mixed-method approach which are: difference in audiences; methodological preferences; structure of the research project; role of timelines; skills specialism; nature of the data; bridging the ontological divides; publication issues and problems of exemplars (Bryman, 2007).

Sandelowski (2000) argues that the analysis of where, why, what and when to use mixed methods is done at the technical level. That is at sampling, data collection and analysis levels (Sandelowski, 2000). Application of mixed method approach may be difficult at the paradigm level because each school of thought has a different conception of epistemology and ontology (Bryman, 2007; Sandelowski 2000). Yin (1994) cited in Amaratunga *et al.* (2002) posits that the choice of a research strategy depends on the research situation. Therefore, the mixed-methods approach can be applied at any level of the research, depending on the type of research and the aim of applying mixed methods (Amaratunga *et al.,* 2002).

4.2.1.1 Qualitative Approach

This study was predominantly qualitative however quantitative approach was also applied at data collection and data analysis levels. At data collection level, a semi-structured questionnaire was designed to solicit information on the characteristics of the users of PAC services, factors that facilitated the seeking of PAC services and their perceptions on the quality of PAC services. The questionnaire had both closed and open-ended questions.

At the analysis level, qualitative information generated from the closed questions and qualitative information gathered from the open-ended questions were combined. The application of both qualitative and quantitative methods at this stage was used when the results of the analysis of the

qualitative data were combined with the results of the quantitative analysis at the interpretive level (Sandelowski, 2000). Quotes were generated from the open-ended question to describe the quantitative information generated by the close-ended questions (see chapters five and six). The study also collected information through focus group discussions, in-depth interviews and observation. These methods are common in qualitative research (Boyce and Neale, 2006; Berg, 2004).

4.3 The Study Area and Justification

The study was carried out in Temeke district of Dar es Salaam from June 2014 to February 2015. Temeke district was chosen for three reasons. Firstly, a prior visit to the regional referral hospitals in Temeke and Ilala districts indicated that the number of patients in need of PAC services at the regional referral hospital in Temeke distict ranged between 3 and 7 patients per day. This was approximately 90-210 PAC cases per month. In the regional referral hospital in Ilala distict, the number of PAC patients was estimated to be approximately 40 per month. It was not possible to get information on the number of PAC clients who utilize PAC services from the regional referral hospital for Kinondoni district, for reasons beyond the researcher's control.

Secondly, Temeke is the district where people with high, middle and low socio-economic status co-exist. About 4 percent of people are estimated to be practicing agriculture (URT, 2007). The district has the highest number of people living below basic needs poverty line among the Dar es Salaam districts (NBS and RCO, 2014).

Thirdly, collecting information on abortion-related issues is challenging because of its sensitive nature. Thus, information on the incidences of abortion and seeking PAC services is hard to find in Tanzania in general and in Dar es Salaam. A study in Temeke hospital on abortion and

contraception acceptance found that between January 2001 and July 2002, 532 of 1085 women who were admitted with an incomplete abortion or septicemia had undergone unsafe abortion (Rasch *et al.,* 2004). The study showed that it would be possible to conduct this study in Temeke district because it was difficult to find studies on abortion and PAC in the other two districts of Dar es Salaam.

4.4 The Study Population, Inclusion and Exclusion Criteria

Users of PAC services: Users of PAC services were women who had experienced abortion-related complications and sought PAC services from any of the three study facilities during the study period. They formed the unit of analysis for the study. They provided information on factors that facilitated the utilization of PAC services. They also provided information on and the perceived quality of PAC services they received at the study facilities.

Non-users of PAC services: Non-users of PAC were women who had experienced abortion-related complications but did not seek PAC from private or public health facility. Their inclusion shed light on the factors that may hinder some women from not seeking PAC services in case of abortion complications.

Providers of PAC services: Providers of PAC services were the healthcare providers involved in delivering PAC services in the study facilities. The study intended to interview all the providers who were involved in the delivery of PAC services in the study facilities however, only the providers were available during the study period were interviewed. They provided information on perceived quality of PAC services and perceptions on abortion and PAC services. Healthcare providers’ perceptions on abortion and PAC services may influence the health-seeking behaviour of the users of PAC services (Shaikh, 2005).

Community members: Community members were males and females of reproductive age who participated in the focus group discussions. They were recruited from the community with the help of ward and ten cell leaders. Community members provided information on the perceptions about abortion and PAC services. In this study, focus group discussions were conducted among males aged 15-24 years and 24+ years; and among females aged 15-24 years and 25+ years. The group of young women (15-24 years) were oversampled because available evidence indicates that women of this age are more likely to be at risk of getting pregnant and an induced abortion (WHO, 2013; Rasch *et al.,* 2004). They are more likely to experience difficulties in utilizing PAC services than older women (PCC, 2002). Men were included because as household heads, they may influence the health-seeking behaviour of their wives/partners (Azmat *et al.,* 2012; Mpembeni *et al.,* 2007).

Key informants (KIs): The key informants were community health workers (CHWs) and religious leaders. A community health worker was included in the study if she/he was attached to a study facility as a health worker or was identified by ward and ten cell leaders as an individual involved in health-related issues in their locality. CHWs were included because of their direct involvement with community health-related issues at the grassroots level. CHWs play an important role in connecting the providers and consumers of healthcare services. Additionally, they may facilitate access to healthcare through outreach, disease prevention services and health promotion. The involvement CHWs in community health issues may lead to improved quality of care (Witmer *et al.,* 1995).

Religious leaders were Priests, Fathers, Evangelists or Parish Workers for Christian religion and Imams for Islamic religion. They were included in the study if they were attached to a church or

a mosque and were providing religious services. They were included in the study because religious beliefs and teachings may have an influence on people's attitude on abortion and PAC services (Cochran *et al.,* 1996).

4.5 Sampling Procedures

Information on the incidences of abortions is hard to find (Haddad and Nour, 2009). The magnitude of unsafe abortion and its consequence is one of the least documented reproductive health problem and very difficult to document (Rasch and Kipingili, 2009). Equally, few records are kept of women who utilize PAC services in developing countries which may assist in selecting a sample. In addition, under-reporting and misreporting are obvious because it is sometimes difficult for a woman to admit to having had an induced abortion (Srivastava *et al.,* 2013). Tanzania is no exception in this regard. Therefore, in this study, obtaining a sampling frame from which the sample of the users of PAC services could be drawn was not possible. This led to the adoption of non-probability sampling techniques.

Teddlie and Yu (2007) define purposive sampling as the process of selecting units such as individuals, institutions or groups of individuals to answer the research question. Likewise, Maxwell 1997 cited in Teddlie and Yu (2007) defines purposive sampling as deliberately selecting events, persons or particular settings to provide information which cannot be obtained from other sampling methods (Teddlie and Yu, 2007). Non-probability samples 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).

4.5.1 Criterion Sampling

Criterion sampling is a kind of purposeful sampling where elements of the study are chosen based on a preconceived criterion (Suri, 2011). In this study, criterion sampling was employed to select the study facilities, users of PAC services, providers of PAC services and key informants.

Selection of the Health Facilities

A facility was selected for the study if it provided PAC services, i.e. treatment, counselling and family planning. Facilities which provided only one component of PAC were not included in the study. In Temeke district, PAC is provided in two health centres and two hospitals (all public) and one private facility (MoHSW *et al.,* 2011). In 2013, one of the health centres was upgraded to a district hospital. Two facilities (public) were selected purposefully since they were offering treatment counselling and family planning. The private facility was included automatically since it was the only facility from the private sector. Therefore, three facilities (2 public and 1 private) were selected for the study.

Selection of the Users of PAC Services

A patient was eligible to participate in the study if she was experiencing abortion-related complications and sought care in one of the study facilities. The causes of the abortion complications were not taken in to consideration. Participants were recruited with the help of the healthcare providers. After the treatment, healthcare providers referred a patient to the researcher for an interview. The researcher approached the patient to request her to participate in the study. Patients who were critically ill and patients who were under the age of 18 who did not have an accompanying parent or family member were excluded from the study.

Selection of the Providers of PAC Services and the KIs

A provider of PAC services was included in the study if she/he was providing PAC services in the study facilities during the study period. Community health workers who were attached to a health facility and those identified by ward and ten cell leaders as individuals involved in health-related issues in their locality were included in the study. Religious leaders were contacted by a letter prior to the study. Those who accepted to participate in the study were interviewed. Eight religious leaders were approached for their participation in the study. However, only three (two Christian and one Muslim) agreed to participate in the study.

4.5.2 Snowball Sampling

Snowball sampling was applied to recruit the non-users of PAC services. Some of the FGD participants were among the non-users of PAC services and agreed to share their experience after the discussion. Other non-users of PAC services were recruited with the help of the FGD participants. Contacts of the non-users of PAC services were taken and later approached to request them to be interviewed. Interviews were arranged with the participants who were willing to be involved.

4.6 The Sample Size

A total 159 users of PAC services were recruited for the study. About 64.7 percent (103) of the recruited users of PAC services were interviewed in the three study facilities. Two consecutive months were spent in each facility. In facility A, 40 users of PAC services were recruited in the study. About 67.5 percent (27) of the recruited users of PAC services were interviewed. Over 32.5 percent (13) of the recruited users of PAC services did not agree to participate in the study. In facility B, a total of 67 PAC users of PAC services were recruited in the study. About 70.1

percent (47) agreed to participate in the in reviews. About 29.9 percent (20) did not agree to participate in the interviews. In facility C, 43 users of PAC services were recruited for the study. Over 67.4 percent (29) agreed to participate in the interview. About 32.6 percent (14) did not agree to participate in the study (Table 4.1).

Table 4.1: The Response Rate Among the 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: Primary Analysis of the Survey Data

4.7 Data Collection Instruments

The choice of a data collection tool is determined by the purpose of the research, the resources available and researcher's skills (Kumar, 2005). This study employed a range of data collection instruments. Exit-interviews, in-depth interview guide, focus group discussion guide and observation checklist were the main data collection instruments used in the study. The study instrument can be found in Appendix (ii) page 180-205.

4.7.1 Exit-Interviews

A semi-structured questionnaire was administered to the participants when they were about to leave the facility after receiving PAC services. This instrument collected information on their basic characteristics, factors that facilitated their seeking of PAC services and their perceptions

on the quality of services. Only patients who agreed to participate were interviewed. Patients whose health conditions were not good enough to be interviewed, and those whose parents/guardians refused to give consent were excluded from the study.

The questionnaire consisted of three major parts. The first part collected information on the basic characteristics of the participants. The second part solicited information on factors that enabled them to seek PAC services. The third part gathered information on their perceptions on the quality of PAC services. Aspects of the quality of PAC services covered were the sex of the provider, counselling, privacy, family planning, youth-friendly PAC services, facility location and set-up, waiting time and the cost of PAC services.

Another semi-structured questionnaire was administered to sixteen (16) providers of PAC services. Interviews were carried out after the providers were approached and a convenient time for the interview established. Some interviews were conducted out of the hospital setting due to their busy schedule. The interview consisted of both open-ended and closed questions. It gathered information on the perceptions of the providers about the quality of PAC services and on abortion and PAC services. Aspects of the quality of PAC services covered were the availability and the qualifications of the providers, method and place of uterine evacuation an availability of essential equipment and supply.

4.7.2 In-Depth Interviews

In-depth interview is a qualitative research technique which seeks to solicit information from a small number of respondents. It explores their views on a certain programme, idea or situation. In-depth interviews are mostly used when detailed information is needed on people's thoughts, understanding and behaviour or when exploring new issues in depth (Boyce and Neale, 2006). In

this study, in-depth interviews were carried out with the non-users of PAC services. It was used to collect information on the factors that hindered utilization of PAC services. Six (6) in-depth interviews were carried out. Each interview was treated as a single case. The cases were summarized and relevant information required for the study was extracted. Six cases were narrated by the non-users of PAC services themselves while one case was narrated by a family member.

A second in-depth interview was carried out with CHWs and religious leaders. A total of 4 CHWS and 3 religious leaders were interviewed. The interview focused on their perceptions about abortion and PAC services.

4.7.3 Focus Group Discussions

FGDs were used to collect information about the perceptions of the community on abortion and PAC services. A total of 10 FGDs were conducted with male and female community members of reproductive age (15-45). FGD is among the common methods of data collection used in qualitative research. Discussion groups are typically one method among many that are used to create a complete picture of how a given issue that affects a community of people (Mack *et al.,* 2005). They are frequently used to obtain knowledge and people's perceptions of issues and behaviour that is less easy to obtain in a one-to-one interview (Wong, 2008).

Identification of the Wards and Recruitment of FGD Members

Two wards of Temeke district were selected by a means of a simple random sampling technique. A list of all wards of Temeke district was obtained from Temeke municipality. During the study, the district of Temeke had 24 wards. Thereafter, the names of all wards were listed in separate in pieces of papers. The papers were mixed thoroughly. Two piece of paper was picked randomly.

For each of selected ward, names of all the streets were written on pieces of paper and mixed. Thereafter, five pieces of papers were picked randomly from each ward. A total of 10 streets were identified. Therefore, one FGD was done in one street. The study named the two selected wards as Ward-1 and Ward-2 for confidentiality purposes.

There is no common agreement on the number of FGDs that are ideal for a study. The number of discussion groups may range from 6 to over 50 groups depending on the study aims and available resources. In most cases, the majority of studies involve a few FGDs while others combine them with other methods (Kitzinger, 1995). In this study, 10 FGDs were conducted, that is in each ward, 1 FGD among males (15-24), 1 FGD among males (24+), 1 FGD among female (aged 25+) and 2 FGDs among young women (15-24).

Participants for FGDs were recruited with the assistance of ward and ten cell leaders. For each group discussion, a maximum of 6 participants were recruited considering various socio-economic and demographic backgrounds. After the recruitment, the FGD participants were contacted regarding the date, time and the venue of the discussion. Participants of the same age group for instance 15-25 formed one discussion group, however, the researcher ensured that they were not residing in the same street. Having participants of the same age group in one discussion group ensures homogeneity and encourages participants to talk freely (Krauss, 2005).

Scheduling for the FGDs

The FGDs were conducted on Saturdays to allow participants who were students and those who were employed to participate in the discussion. The participants were given information on the date, time and venue for the discussion. The venue for the FGD was identified with the

assistance of a ten cells leader. The venues were chosen taking into consideration their proximity and privacy during the discussion.

Implementing the FGDs

The FGDs elucidated community perceptions on abortion and PAC services. Specifically, the discussion centred on how the members perceive abortion and PAC services. FGDs were conducted in Swahili, a language which is widely spoken and understood in Tanzania. The informed consent of participants was sought verbally. The aim of the study was clearly explained to the FGD members. They were ensured that neither their pictures nor their names or any other form of identity would appear in any of the text. Each of the FGD participant was given a unique number. The numbers were used as their identities during the discussions. The FGDs lasted between one and two hours. The discussions were tape recorded and transcribed verbatim at the end of each discussion.

4.7.4 Direct Observation

Direct observation was another method of data collection used in this study. It enriched the information collected by the other research instruments. A checklist of elements to be observed was prepared. It consisted of aspects such as how easy to identify the facility, the condition of the treatment room, availability of family planning and counselling services, privacy, availability of electricity and running water and provider-client interactions. Any other issues relevant to the study that emerged which were not in the checklist were recorded. All observations were recorded in field notes instantly to avoid forgetting the information which was then followed by a detailed description.

4.8 Data Quality Assurance

The instruments for data collection were pre-tested to check for the quality, clarity and completeness. The research assistants (who assisted in conducting the FGDs) were trained before data collection to familiarize them with the objective of the study, the kind of information needed for the study and how to conduct the discussions. Necessary adjustments were done before the actual field work. For example, a questionnaire item on the causes of complication was omitted because only one respondent among ten responded to it during the pre-test. Data from the FGDS and in-depth interviews were transcribed and shared among peers (fellow PhD students, who were knowledgeable about qualitative research and the use of NVivo program) for coding (developing nodes). The nodes from the peers were compared with those of the researcher for consistency before the actual analysis was done. Quantitative data was coded and entered in Statistical Package for the Social Sciences (20.0). Data cleaning was undertaken to check for the missing data and incomplete information.

4.9 Ethical Considerations and Approval

Observance of good ethics are of paramount importance in any research project that involves human subjects. The World Medical Association has established international guidelines for research that combines clinical care and non-therapeutic aspects in health research since the Declaration of Helsinki in 1965 (WHO, 2001). The people to be studied by social researchers should be informed about the research in a comprehensive and accurate way and should give their unconstrained consent (Hammersley and Atkinson, 1995).

The approval for this research was granted by the Tanzania National Institute for Medical Research (NIMR). Information was collected with informed consent. Consent to participate in

the study was sought verbally from the participants. The result of the pre-testing of the research instruments indicated that the users of PAC services were not ready to sign the consent forms. This might have been contributed by the fact that abortion is not legal in tanzania thus signing of the form could have exposed their identities. Therefore, the oral consent was sought instead of the signed consent.

The consent form was prepared and red verbatim to the participants. Participants were asked some questions regarding the consent to assess whether they understood their involvement in the study. The questions also sought to assess whether the participants understood what was expected of them during the interview. Clarification was provided in areas where the participants did not understand. All participants were informed that their participation in the study was voluntary. They were informed that non-participation did not have any consequence for their further treatment. They were further informed that they were free to withdraw from the study at any point.

A participant was approached for an interview after the providers had been satisfied that her condition had improved to able to respond to interview questions. The accompanying individuals of the participants under 18 years were approached to give approval for the patient to be interviewed. Participants who were under the age of 18 who did not have accompanying individuals were excluded from the interviews. Participants who were critically ill were excluded from the study. A special place in the facility premises was identified for conducting the interviews. This was to ensure privacy and freedom during the interview.

Issues related to abortion are sensitive and so during the interview with the users of PAC services some became emotionally distressed. A PAC services provider was contacted immediately to

counsel the distressed participant. The interview was stopped to wait for the participants' condition to stabilize. Thereafter a participant was asked if she was comfortable to proceed with the interview. Participants who were comfortable continued with the interviews while those who were not did not continue.

Non-users of PAC services were recruited outside the health facility setting. Thus, a participant was asked to choose allocation that ensured privacy. In other words, the researcher did not dictate the meeting place for the interview but made sure that the chosen place was appropriate for the interview given the sensitive nature of the topic. Interviews were tape recorded with the permission of the participant. A participant was given a pseudonym to maintain confidentiality. The recorded information was kept by the researcher and transcribed as soon as the interview ended. The transcribed information was checked thoroughly and proof reading was done. Thereafter, all the audio recorded information was deleted. The researcher ensured that the data was stored safely and the identities of the participants were not revealed in any of the transcriptions.

4.10 Methods of Data Analysis

The study employed both qualitative and quantitative approaches to organize and analyse the data. The intent of the analysis was not to treat the qualitative and quantitative data separately. The aim was to integrate qualitative and qualitative information to gain a comprehensive understanding of the topic under investigation.

4.10.1 Analysing Qualitative Information

The first stage of the analysis involved transcribing the information collected from the FGDs and from in-depth interviews. The transcriptions and analysis were done in English. The transcription

started soon after data collection. Immediate transcription helped to avoid stockpiling and forgetting some valuable information. The next step involved going through the transcribed texts repeatedly and coding with the aid of NVivo 9.0. The NVivo 9.0 is a software program that helps organize similar qualitative information into the same category called nodes.

Descriptive thematic analysis both the inductive and deductive approaches were employed. The inductive approach means allowing research themes to emerge from the data (Thomas, 2006). The deductive approach involved checking the transcriptions from the in-depth interviews and FGDs transcriptions and code 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 to provide more meaning of the themes that emerged.

4.10.2 Analysing Quantitative Information

Analysis of the quantitative data involved analysing the first and third objectives of the study. The first objective required information on the socio-economic and demographic characteristics of users of PAC services. The third objective explored their perceptions on the quality of PAC services. The analysis was mainly descriptive due to the small sample size. Quantitative data was analysed using Statistical Package for the Social Sciences (SPSS) version 20. 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 variables.

CHAPTER FIVE

FACTORS FACILITATING AND THOSE HINDERING UTILIZATION OF PAC SERVICES

5.1 Introduction

This chapter presents the findings on the socio-economic and demographic characteristics of the users of PAC services, factors which facilitated the seeking of PAC services and factors which hindered utilization of PAC services. It is divided into four sections. The first section presents the socio-economic and demographic characteristics of the participants. The second section focuses on the factors that facilitated the seeking PAC services from health facilities. The third section provides results on the factors that hindered utilization of PAC services from health facilities.

The study was conducted among 103 users of PAC services in the three health facilities in Temeke district. A semi-structured questionnaire was administered to the participants when they were about to exit the facility. It solicited information on their basic characteristics, the factors that facilitated their utilization of PAC services and their perceptions on the quality of PAC services. Table 5.1 provides the distribution of the participants by facility.

Table 5.1: Distribution of the Users of PAC Services by Facility

Facility code	Frequency (n)	Percent (%)
A	27	26.2
B	47	45.6
C	29	28.2
Total	**103**	**100.0**

Source: Primary Analysis of the Survey Data

To obtain information about the factors that hindered potential PAC clients from seeking care, the study recruited non-users of PAC services. However, only six non-users of PAC services were recruited and interviewed.

5.2 Characteristics of the Users of PAC Services

The study collected information on the socio-economic and demographic characteristics of the users of PAC services. The basic characteristics were age, education, marital status, religion, occupation and place of residence. Table 5.2 summaries the basic characteristics of the clients for PAC services who participated in the study.

Table 5.2: Percent Distribution of the Users of PAC Services According to Their Socioeconomic and Demographic Characteristics

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: Primary Analysis of the Survey Data

5.2.1 Age

The mean age of the users of PAC services was 26.2 years while the median age was 25. More than quarter (29.1 percent) were aged 20-24 years while 16.5 percent were aged 15-19 years. In other words, close to half (44.6 percent) of women who utilized PAC services from the study facilities were below 25 years. Age groups 15-19 and 20-24 represent adolescents and young women respectively. This finding confirms the earlier studies in Tanzania that most of the users of PAC services are likely to be under 24 years (Rasch *et al.,* 2004; Rasch *et al.,* 2009). They also corroborate findings in Ethiopia, Nigeria and Zambia that users of PAC services are more likely to be under 25 years (Kumbi *et al.,* 2008; Henshaw *et al.,* 2005; Likwa and Whittaker 1996), respectively. Having a high proportion of younger women seeking PAC services may be associated with an improvement in their care-seeking behaviour (Sathar *et al.,* 2013).

Some studies have documented that older women are more likely to use PAC services compared to younger women (Kumar *et al.,* 2009; Melkamu *et al.,* 2010). Other studies have found that younger women are at a greater risk of suffering from abortion complications than older women (WHO, 2013), but they are more likely to delay seeking PAC services (Bruyn and Packer, 2004; Kumar *et al.,* 2009). Studies show that factors that may hinder younger women from utilizing PAC services are lack of transport, lack of knowledge of the availability of PAC services, lack of money to pay for PAC services and stigma (Kumar *et al.,* 2009; Okonofua, 2006; Grimes *et al.,* 2006; Bruyn and Packer, 2004).

5.2.2 Marital Status

This study found that more than half (64.4 percent) of the users of PAC services were not married. Only 36.9 percent were married. This finding is similar to findings by studies in

Ethiopia (Demtsu *et al.,* 2014), Nigeria (Henshaw *et al.,* 2005) and Zambia (Likwa and 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). From this finding, both married and unmarried women may seek PAC services in the case of the abortion complications.

5.2.3 Education

About half (50.5 percent) of the users of PAC services had primary education. Over 43.7 percent had secondary education. Only 5.8 percent were educated beyond secondary school. Having formal education may be one of the facilitating factors for their seeking of PAC services from the study facilities. Formal education attainment among women may have a positive impact on utilization of PAC services. A study in Pakistan found that education contributed to high acceptance of PAC services (Azmat *et al.,* 2012). Formal education attainment among women may lead to formal employment and therefore increasing their ability to pay for PAC services (Wariki *et al.,* 2015; Svanemyr and Sundby, 2007). It should be noted that, women may have formal education but lack of information about PAC services may hinder their utilization of PAC services (Okonofua, 2006).

Five out of the six users of PAC services who had tertiary education sought care in facility C. Four of them indicated that good providers' attitude was the reason for choosing the facility for PAC services. This finding agrees with a study in Pakistan that educated women are more likely to seek care from private facilities. The study highlighted that educated women preferred private facilities because of their belief in good quality of care, providers' positive attitude and their ability to pay for PAC services (Wariki *et al.,* 2015).

5.2.4 Occupation

The results show that most of the users of PAC services were not formally employed (61.3 percent). About 12.6 percent were still attending secondary school at the time of the study. This study did not ask about the causes of the complication. Therefore, it is not known whether the complications were due to induced or spontaneous abortion. A study in Côte d'Ivoire found that younger women who got pregnant while in school opted for abortion because they wanted to complete their studies. They believed that having education would make them economically independent and therefore enable them to support their families (Svanemyr and Sundby, 2007).

5.2.5 Religious Affiliation

Two dominant religious affiliations were found in the study area. Half (50.5 percent) of the uses of PAC services were Muslims while the rest were Christians. Those who were Christians were not asked about their denomination. This finding suggests that women from various religious background need PAC services in the case of complications. As indicated in the literature review, almost all religious teachings condemn abortion. However, the way in which women from different religious affiliation would act on issues related to abortion and PAC services may differ.

5.2.6 Place of Residence

Almost all the patients for PAC interviewed were from within the district. Only 4.9 percent were from outside Temeke district. Having most of the patients from the same district utilizing PAC services from facilities within the same district may reflect the availability and acceptance of PAC services but may not necessarily reflect the adequacy and quality of the services.

The presence of patients for PAC services who were from outside Temeke district suggests that patients are free to choose a health facility in the case of an illness. Users of PAC services were not asked why they did not seek PAC services from the facilities within their districts. This study was done in an urban district where PAC services may be available compared to rural areas where facilities offering PAC services are limited. Some studies have documented that women who live in rural areas are less likely to access PAC services because of the unavailability of PAC services in their locality (Azmat *et al.,* 2012; Singh, 2006). Literature indicate that the choice of a facility for PAC services may be influenced by factors relating to stigma, providers' attitude, the quality of care, the cost of the services and privacy (Wariki *et al.,* 2015; Payne *et al.,* 2013; Melkamu *et al.,* 2010; Webb, 2000).

5.3 Factors that Facilitated the Seeking of PAC Services

The study found that there were some variations in time regarding the seeking care after the onset of the complications. The majority (54.4 percent) sought care one to two days after the start of the complications. About 33.3 percent sought care the same day the complications started. Few (12.3 percent) sought care more than two days after the complications had started. Users of PAC services who sought care more than two days after the start of the complications indicated lack of money to pay for the services and fear of the evacuation procedure and fear of being asked about the partner as the main factors for not seeking care promptly. A married woman reported having delayed seeking care because of lack of money to pay for PAC services. She narrated tat:

> *I did not have money…as you know these services are not free. I had to wait until my husband borrowed money from his friend [User, 34 Years, Married].*

Another user of PAC services reported that she was afraid to seek PAC services because of fear of being asked about her partner. She said that:

> *I didn't know if they would give me services as I am not married. So, I was afraid of being asked about my partner…My boyfriend ran away after I told him I was pregnant [User, 22 Years, Not Married].*

Fear of seeking PAC because of pre-marital pregnancy has also been documented in other studies (Melkamu *et al.,* 2010; Bennett, 2001).

Another use of PAC services reported that she had to wait for a few days before seeking care because she was afraid of the evacuation procedure. She narrated that:

> *I was afraid...my friend told me that 'kusafishwa' (evacuation) is painful because she once had complications, and so I was afraid and decided to buy some pain killers. As time went by, it was too painful to bear. Then I decided to come to the hospital [User, 27 Years, Married].*

5.3.1 Sharing of Information About One's Health Status

The study found that parents, significant others and partners influenced the seeking of care after complications. Most of the participants (52.4 percent) informed their partners about their health condition while others informed their close friends, relatives or parents. Participants who were not married were more likely to communicate their health problem to their relatives, friends and parents than to their partners. On the other hand, those who were married shared information on their health condition with their partners rather than with their relatives and friends (Table 5.3).

Table 5.3: A Cross Tabulation of Whom the Users of PAC Services Shared Information About their Health Status by their Socioeconomic Characteristics

Characteristic	To whom the information was shared				Total
	Partner %	Friend %	Relative %	Parent %	%
Age					
15-19	48.7	18.9	21.6	10.8	100
20-24	30.1	33.3	23.3	13.3	100
25-29	54.5	18.3	22.7	4.5	100
30-34	70.0	5.0	20.0	5.0	100
35-39	78.6	7.1	14.3	0	100
Marital Status					
Single	29.4	23.5	29.4	17.8	100
Married	81.4	13.3	5.3	0	100
Cohabiting	57.2	21.4	21.4	0	100
Religion					
Christian	51.1	23.5	17.6	7.8	100
Muslim	53.8	15.4	21.2	9.6	100
Education					
Primary	53.8	15.4	21.2	9.6	100
Secondary	46.7	24.4	20.0	8.9	100
Tertiary	83.3	16.7	0	0	100
Occupation					
Employed	44.4	16.7	27.8	11.1	100
House wife	48.7	18.9	21.6	10.8	100
Self employed	60.0	20.0	17.1	2.9	100
Students	53.8	23.1	7.7	15.4	100
N= 103					

Source: Primary Analysis of the Survey Data

Table 5.3 above shows that majority of the users of PAC services informed their partners about their health status, although there were some minor variations across their basic characteristics. For example, those who were married were more likely to share information to their partners than those who were not married. A recent study in Indonesia indicates that almost all women who sought PAC services discussed their health status with their partners. Their partners even recommended the type of facility to seek care from (Wariki *et al.,* 2015). The study does not indicate whether the partners paid for the services. A similar finding is reported by studies in Ethiopia and Nigeria whereby approval to seek PAC services was sought from the partner or

family member (Melkamu *et al.,* 2010). A study in Pakistan documented that married women who can pay for PAC services have high chances of making their own independent decision to seek care, despite informing their partners about their health status (Sathar *et al.,* 2013).

This study also found that some of the users of PAC services made their own independent decision to seek care although they shared the information with someone. For example, those who were not married, those with tertiary education and those who were employed were more likely to make their own independent decision to seek care (Table 5.3). A study in Côte d'Ivoire study showed that some users of PAC services admitted that they made their own decision to terminate a pregnancy even though their partners were prepared to take care of the child. Partners offered support to their partners when they were contacted for the support of PAC following abortion complications (Svanemyr and Sundby, 2007).

Table 5.4: A Cross Tabulation of the Users of PAC Services Decision to Seek Care by Their Socioeconomic Characteristics

Characteristic	Who Made Decision to Seek Care					Total %
	Self %	Partner %	Parents %	Both %	Relative/friend %	
Age						
15-19	29.4	23.5	17.6	29.5	0	100
20-24	46.7	20.0	13.3	13.3	6.7	100
25-29	54.5	22.8	4.5	13.7	4.5	100
30-34	55.0	30.0	0	15.0	0	100
35-39	42.9	42.9	0	14.2	0	100
Marital status						
Single	56.8	15.7	15.7	5.9	5.9	100
Married	36.8	42.1	0	21.1	0	100
Cohabiting	78.6	21.4	0	0	0	100
Religion						
Christian	49.0	29.4	5.9	13.7	2.0	100
Muslim	55.8	23.1	9.6	7.7	3.8	100
Education						
Primary	49.0	29.4	5.9	13.7	2.0	100
Secondary	55.7	33.3	4.4	4.4	2.2	100
Tertiary	66.7	33.3	0	0	0	100
Occupation						
Employed	55.5	22.2	5.6	5.6	11.1	100
Housewife	50.0	26.3	10.5	10.5	2.7	100
Self-employed	57.1	22.9	2.9	17.1	0	100
Students	0	38.5	15.3	46.2	0	100
N= 103						

Source: Primary Analysis of the Survey Data

Sharing of information about health status influenced the seeking PAC services. The study found that some users of PAC services became aware of the availability PAC services and facilities offering PAC services after sharing of information about their health status. In other instances, friends advised them of the specific health facility to seek care from. Generally, the study shows that the knowledge of PAC services among the users of PAC services was poor. Only a few (34 percent) stated that they had ever heard about PAC services before. Those who knew about PAC services indicated that the main sources of information were healthcare providers (43 percent)

and friends (54 percent). The following excerpts illustrate how sharing of the information helped some of the users of PAC services to seek care.

> *I called my friend and told her about my condition because I know that last year she experienced the same. She advised me to look for treatment here because she was treated here. I have heard people talking about "kusafishwa'' (evacuation) but today I have experienced it [User, 31 Years, Married].*

> *I decided to inform my sister about my problem; she advised me that I should go to the hospital because the painkillers I was using might not help. She advised me to come here to receive proper treatment [User, 20 Years, Not Married].*

> *You know these services are not advertised like family planning and so it is difficult to know about them. I didn't know if PAC services were available until I told my friend about my health problem [User, 20 Years, Not Married].*

> *After I told my mother about my condition, she was angry with me. Later, she informed a nurse who was our neighbour. The nurse advised my mother to take me to this facility because the bleeding was too much [User, 17 Years, Not Married].*

One user of PAC services admitted that although she did not know about PAC services, she felt that visiting a health facility would solve her health condition. She said that:

> *I did not know about PAC services, but I believed that a hospital is where I can be helped, and so I decided to come here for treatment [User, 28 Years, Married].*

The above narrations imply that having knowledge of PAC services is likely to facilitate their utilization. A study in Ethiopia found that women who knew about the components of PAC services were seven times more likely to utilize PAC services than women who did not have knowledge about PAC services (Zemene *et al.,* 2014). Similarly, a study in Pakistan found that women who knew about the availability of PAC services utilized the services. The study further noted that, women who did not know about PAC services sought care from local *Dias* (traditional birth attendants) (Azmat *et al.,* 2012). Poor information about the availability of PAC services may hinder women from receiving quality PAC services (Okonofua, 2006).

5.3.2 Financial Support

The results of this study show that some of the users of PAC services sought care from a health facility because they received financial support to meet transport cost and treatment cost. The financial assistance was obtained from a partner, parent, relative or friends. The support for transport the participants obtained from a relative, parent, partner or friend facilitated their seeking of care. Majority of the participants who were housewives and those who were students had their transport costs met by their partners (51.4 percent and 58.3 percent) respectively.

Almost all users of PAC services who were interviewed paid for the PAC services. Treatment cost was covered by the partner (45.6 percent), a parent (3.9 percent), a friend relative (10.7 percent), a facility (6.8 percent) or by the client herself (33 percent). Those who were not married, and shared information about their health status were more likely to get financial support for treatment cost from their partners and parents. Most of those who were married and those who were cohabiting had their treatment cost met by their partners (Table 5.5). Being married does not necessarily guarantee the partner's support in seeking PAC services. Some studies have documented partner's objection as a barrier to accessing PAC services (Vlassoff *et al.,* 2012; Azmat *et al.,* 2012).

Table 5.5: A Cross Tabulation of the Characteristics of the Users of PAC Services by Who Paid for their Treatment Costs

Characteristics	Who Paid for The Treatment Cost					
	Self	Partner	Parents	Relative/friend	Facility	Total
Age						
15-19	17.6	47.1	17.6	11.8	5.9	100
20-24	40.0	30.0	16.6	6.7	6.7	100
25-29	18.3	54.5	4.5	13.6	9.1	100
30-34	20.0	55.0	5.0	10.0	10.0	100
35-39	28.6	71.4	0	0	0	100
Marital status						
Single	37.3	27.5	15.7	13.6	5.9	100
Married	34.2	57.9	0	5.3	2.6	100
Cohabiting	28.6	50.0	0	0	21.4	100
Religion						
Christian	35.3	49.0	3.9	9.8	2.0	100
Muslim	26.9	42.4	11.5	7.7	11.5	100
Education						
Primary	38.5	44.2	1.9	9.6	5.8	100
Secondary	26.7	46.7	4.4	13.3	8.9	100
Tertiary	50.0	50.0	0	0		100
0ccupation						
Employed	55.5	38.9	0	5.6	0	100
House wife	31.6	44.7	5.3	10.5	7.9	100
Self employed	35.3	44.1	0	8.8	11.8	100
Student	0	61.5	15.4	23.1	0	
N= 103						

Source: Primary Analysis of the Survey Data

One user of PAC services who came from outside Dar es Salaam stated that she decided to travel to Dar es Salaam for PAC services because she could not afford PAC services. She said that:

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

Another user of PAC services indicated how sharing the information about her health status helped her utilize PAC services. She narrated that:

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

5.3.3 Availability of PAC Services

About 32 percent of the users of PAC services indicated that they sought care elsewhere before visiting the study facilities. For those who sought care elsewhere, 30.3 percent sought help from a pharmacy, 27.3 percent from a public health centre, 24.2 percent from a public dispensary, and 18.2 percent from a private dispensary. Those who visited a pharmacy reported that they bought some painkillers and decided to seek care from the studied facilities when they found that they would not recover after taking the drugs. The following extracts provide more details.

I visited a pharmacy to obtain some medication for pain relief but I decided to come here (Facility B,) for thorough treatment [User of PAC Services, 23 Years, Not Married].
My problem started four days ago and I went to the pharmacy to buy some medicine, I used it for three days but the problem was still there. I had to tell my mother about my condition and she brought me to this hospital (Facility A) [User, 20 Years, Not Married].

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

Some users of PAC services who visited other facilities were referred to the study facilities because the facilities they had visited did not have equipment for uterine evacuation or their cases were too complicated to be handled at the lower-level facilities. Some of them had the following to say:

I visited a public health centre but they told me that they couldn't manage my condition because they did not have the equipment. They told me to come here (Facility A) [User, 29 Years, Married].

I went to a government dispensary but they referred me here (Facility B) because they told me that my condition needed a specialist [User, 37 Years, Married].

The study also found that lack of specialist in the lower level facility made some of the users of PAC services to seek PAC services from the study facilities. The following quotes provide more details.

> *I visited a public dispensary and was told that they do not have a specialist to help me with my problem. My friend who escorted me advised me to come here (Facility C) [User, 26 Years, Not Married].*

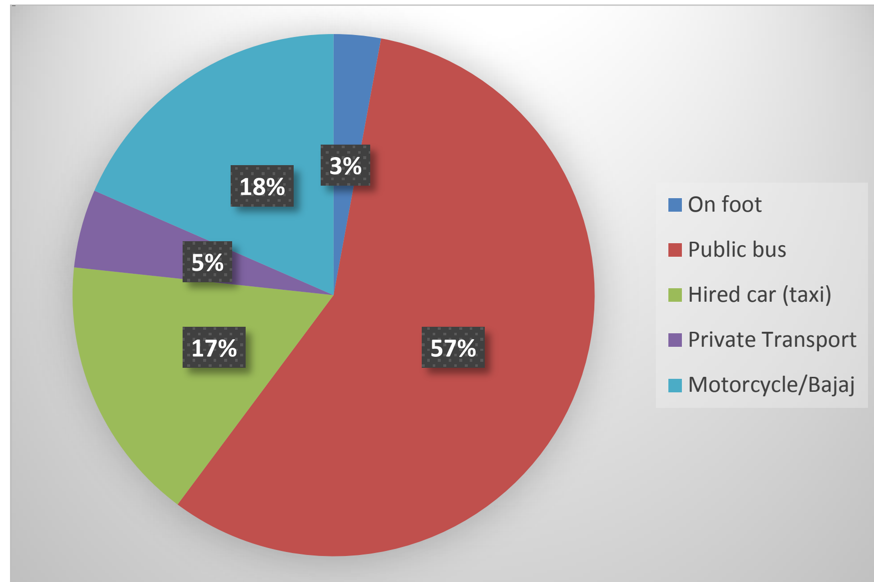
> *I went to a private dispensary the doctor informed me that I was supposed to be hospitalized but they had no specialist to help me. They advised me to come here (Facility B) [User, 24 Years, Not Married].*

This study has shown that the users of PAC services sought care from the study facilities because PAC services were available. However, a proportion of them sought care elsewhere before going to the study facilities. The facilities they visited were either private or public, mostly lower-level facilities, an indication of the lack of some or all the components of PAC. The extracts above indicate that lack of the providers and lack of equipment were the main factors which hindered the utilization of PAC services in the facilities they had visited before. This finding is consistent with findings of other studies in Ethiopia which found that the lack of equipment and experts in PAC services as some the inadequacies of lower-level facilities (Melkamu *et al.,* 2010; Kumbi 2008 *et al.,* 2008). Women who need PAC services maybe at increased risk of maternal mortality when they move from facility to facility for PAC services (Melkamu *et al.,* 2010).

5.3.4 Availability of Transport

The majority of the users of PAC services were from within Temeke district as noted earlier. It took less than an hour for majority of them (61.2 percent) to reach a facility for PAC services. The most common used mode of transport was public transport i.e. buses (57 percent), motorcycle/bajaj (18 percent) and hired a taxi (17 percent) (Fig. 5.1).

Figure: 5.1: Mode of Transport Used by the Users of PAC Services to Reach to a Health Facility



(N=103): Source: Primary Analysis of the Survey Data

This study was done in an urban setting where transport to the health facilities was available. In addition, most of the users of PAC services were from within Temeke district, an indication that they did not live far from the study facilities. Therefore, the availability of transport facilitated their seeking of care. Studies in other places show that women who are poor and those who live in rural areas are more likely to face transport problems in accessing PAC services (Vlassoff *et al.,* 2012). Women in need of PAC services are more likely to reach a facility earlier if the facilities are 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 care if the services are far away and there is no reliable transport (Melkamu *et al.,* 2010).

5.3.5 Privacy and Waiting Time

Some users of PAC services who were not the residents of Temeke district but sought care from facility C indicated that privacy and having a short waiting time were the reasons for seeking care from the facility. Some of them had the following to say.

> *I came here because I have been here before and like their services. The environment is clean and you do not have to wait long to be served [User, 26 Years, Married].*

> *A friend of mine advised me to come here because there is more privacy and it is less crowded, as you can see by yourself, people do not spend a long time at the reception [User, 32 Years, Not Married].*

> *You know what, sometimes you may go to facility and spend the whole day for treatment but there are fewer people here. For me it is better I spend more money and get the services quickly [User, 34 Years, Married].*

Privacy was also mentioned as a reason for seeking care from facility B by one user of PAC services who was a resident of Kinondoni district. She said that:

> *I decided to come here because I thought I would be more comfortable. You know what, sometimes you may meet people at the hospital…they will ask you what is your problem…I don't like that [User, 28 Years, Married].*

Privacy is one of the key factors of quality PAC (Webb, 2000). Some participants from other districts of Dar es Salaam sought PAC from the study facilities because of privacy. Although the study did not inquire about the cause of the complications, it is likely that participants who came from other districts sought care in Temeke for fear of being stigmatized. One of them avoided meeting people she knew at the facility in her usual residence. Women in need of PAC services would prefer facilities that can guarantee their privacy in setting where abortion is stigmatized and criminalized (Payne *et al.,* 2013).

Public facilities have been characterised by long queues and long waiting hours (Wariki *et al.,* 2015). Long waiting time may hinder utilization of PAC services. On the other hand, private

facilities are characterised by high quality services and providers' good attitude, although they are more expensive than public facilities (Wariki *et al.,* 2015; Sathar *et al.,* 2013).

5.4 Factors that Hindered the Utilization of PAC Services

Obtaining information where abortion is restricted is challenging (Haddad and Nour, 2009; Rasch and Kipingili, 2009). Thus, it was difficult to recruit a considerable number of non-users of PAC services. The study managed to recruit six non-users of PAC services. This study acknowledges that the six cases may not be a representative of women who have not used PAC. However, they provided information which shed light on possible factors which may hinder utilization of PAC services.

The study found that factors which hindered the non-use of PAC services among the non-users of PAC services were fear of ill treatment by the providers of PAC services, fear of being arrested by the policy for having an illegal induced abortion and lack of money to carter for transport and treatment costs. The following cases provide an illustration on the factors that hindered utilization of PAC services from health facilities. The identities of the interviewees (names and place of residence) are not provided for ethical reasons. The cases are indicated together with the year the abortion was carried out.

CASE Number 1: 2014

22-Years-Old, Not Married

This was a case of a 22-year-old single girl, out of school, who was made pregnant by her boyfriend after being in a relationship for a few months. She informed her boyfriend when the pregnancy was one month old. Her boyfriend promised to take care of her and the pregnancy. Two months later, the boyfriend decided to travel to another region. He informed the girl that he would not return and would not be responsible for the child. This made the girl confused.

She informed one of her friends about the issue and they advised her against procuring an abortion. She could not stand the expectation of having a child out of wedlock, let alone the pregnancy. She finally decided to go for an abortion. She went to a pharmacy where she bought pills after being assured by the pharmacist that they were abortion pills. Two days after taking the pills, she started bleeding and experiencing severe abdominal pains. She went back to the pharmacist who advised to go to the hospital for treatment.

She did not have money to pay for the services and so she asked her friend who assisted her with 50,000[2] *Tanzanian shillings (Tsh) (30$). However, she did not go to the hospital because she was afraid that the providers would shout at her for inducing the abortion. Finally, she went to a doctor who provided abortion services privately at his home after being told about him by her friend. She paid him 50,000Tsh for the services.*

CASE Number 2: 2014
32-Years-Old, Married

This is the case of a woman who was married but the husband was living in another region. The woman remained with their children. The woman had an affair with another man and got pregnant. She was afraid that her husband might leave her because of the pregnancy. She went to a pharmacy and abortion was procured by machuma[3] *at the cost of 20, 000 Tsh (12$). She thought that the induced abortion had been done properly, which is why she experienced no complications. She was afraid of going to the hospital because she thought she would not be given services because she had had an induced abortion. She became very sick, and four (4) days after the abortion, her relatives decided to take her to the hospital after she had revealed to them but unfortunately she passed away on the way to the hospital.*

CASE Number 3:2013
17-Years-Old, Not Married

This was a student who was made pregnant by a fellow student (not from the same school). They agreed to keep it secret for fear of being expelled from school. As time passed, they agreed that the girl should tell her mother. Three months later the girl told her mother and the parents became angry and chased her from the home. Her parents told her to go to her boyfriend's home. The boyfriend's parents took her to a pharmacy for an induced abortion but after three days she experienced complications. She was taken back to the pharmacy but they were told that the individual who performed the

[2] The exchange rate at that time (2014) was 1$ per 1670 Tsh.
[3]According to the narrator, *machuma* meant that some metallic equipment was inserted in the vagina. Since the narrator could not describe it, the researcher associated the equipment with a curette which is used in the dilation and curettage procedure.

abortion had travelled. They were afraid to go to the hospital for fear of being arrested since induced abortion is illegal. They thought that the heavy bleeding would have made the providers discover that it was an induced abortion. They went to another pharmacy and managed to get services. They were charged Tsh 250,000[4] Tsh (155$) because the pharmacist insisted that the procedure was too risky and illegal.

CASE Number 4: 2014

24-Years-Old, Not Married

She got a boyfriend, a fellow student, after joining the university. They initially used contraceptives but after a few months they stopped. Later she became pregnant and agreed with her boyfriend to terminate the pregnancy because they were still students. Besides, her school fees were being paid by one of her relatives and so she was afraid that the relative might get angry and stop paying her fees if he learns about the pregnancy. She was also afraid of her friends, colleagues and parents as she thought that they would think they had become a laughingstock. Another factor that made her procure an abortion was her family's reputation and religious background. In her family, no-one has ever had child outside wedlock hence she was afraid of bring shame on the family.

Because of fear, she pretended that someone else (her friend) was seeking an induced abortion. Therefore, she asked one of her friends where a friend of hers could obtain an induced abortion. Her friend informed her of a certain woman who has helped many women have an induced abortion. She met the abortion provider and the abortion was done at the cost of 35,000Tsh (21$) using traditional medicine. After few days, she felt some pain and was bleeding. She took painkillers but they didn't help anything. She told her boyfriend about it, and decided to go back to the woman who carried out the induced abortion. She was given some herbs, which she used for three days. After a week, her condition improved.

They did not seek care from a modern health facility because she was afraid that the providers might stigmatize her. She believed that by going to a hospital her friends or relatives would find out about her pregnancy. She indicated that if she was to go to a hospital, she would have preferred to travel outside Dar es Salaam, but that was costly.

CASE Number 5:2013

19-Years-Old, Not Married

She became pregnant while still at secondary school but the boyfriend was not a student. She was terrified about the fact that she was pregnant because she was still a student. She thought she was a bad example to her younger sister by falling pregnant while at school. She was also concerned about taking care of the child because her parents were not well off economically.

[4] The exchange rate at that time (2013) was 1$ per 1614Tsh.

Her boyfriend had a friend who was a medical doctor who prescribed and brought her pills which she could not describe. She started bleeding two days after taking the drugs. The bleeding continued for two days and she was worried because the doctor had told her it would not take long. Later, after informing him, the doctor conducted the evacuation process at his house. She was not given any painkiller but she was given an anti-biotic after the procedure. She did not seek further care from a formal health facility because the provider had advised them to call him in case of any complications. The doctor told her and her partner that his job would be in danger if it was discovered that he was providing abortion services.

CASE Number 6:2013
25-Years-Old, Not Married

She tried to have an induced abortion for her three-month-old pregnancy using tea leaves. She bought four packets of tea leaves at 500 Tsh (less than 1$) and made a strong black tea and took in. After a few days, she started experiencing pain as the sign of abortion. Her friend advised her to go to the hospital for treatment but she refused for fear of being arrested for having an induced abortion.

Later, she went with her friend to a woman in the neighbourhood who had been helping women with induced abortion. She was given a glass of a concoction of herbs and told to rest. Three hours later she started bleeding heavily. She could not go to the hospital although advised to by her friend because she did not have money to pay for the services. She went back to the woman and was given a different medicine. She took it for three days and finally got better. She supplemented the traditional medicine with painkillers she bought from the pharmacy.

5.4.1 Discussion of the Case Studies

From the cases, the providers of induced abortion services were pharmacies, herbalists (case number four and case number six) and a clinician or doctor (case number five). PAC services were mostly sought from the provider of the induced abortion after the complications. The study found that fear of being arrested by the police, fear of the negative reactions by the providers, fear of been seen by a relative or a friend at a health facility and lack of money to pay for PAC services were the main reasons for not seeking PAC services from health facilities.

Fear of ill treatment and harassment by the providers of PAC services was a factor that prevented

some participants from seeking PAC services. Cases number one and case number four showed that the participants did not seek PAC services because of fear of harassment by the providers of PAC services. Studies have found that the attitudes of the providers of PAC services on abortion and PAC services may have an influence on utilization of PAC services (Melkamu *et al.,* 2010; Likwa *et al.,* 2009; Iqbal and Åhman, 2004; Webb, 2000). A provider of PAC services who is not willing to provide PAC services due to moral or religious belief (Harries *et al.,* 2009) may judge a PAC client negatively, which may affect the utilization of PAC services. In Ethiopia, a study found that some providers of PAC services were uncomfortable to provide PAC services to adolescents and unmarried women (Kumbi *et al.,* 2008). In Pakistan, a study found that the users of PAC services opted for PAC services in the private sector due to the provider's positive attitude (Sathar *et al.,* 2013).

Case number six indicated that the participant did not seek care from a health facility for fear of being arrested by the police because induced abortion is illegal in Tanzania. She understood that the law does not allow induced abortion. Thus, going to a facility for PAC services might have exposed her to an arrest by the police. Similarly, case number three indicated that the parents of her boyfriend were not prepared to seek PAC services from a health facility because of fear of being arrested by the police.

The fear of being arrested was not only felt by the non-users of PAC services but also by the providers of induced abortion services. For example, in case number five, the healthcare personnel who performed the procedure at his house insisted that the client should call him in case of any problem following the induced abortion. The doctor was afraid that if they went to the hospital, he might be arrested and his job put at risk. He had to provide the PAC service at

home, but it is not known whether the equipment used was privately owned or owned by the facility the doctor was working at. Similarly, in cases number one and six, PAC services were provided informally by health personnel. In case five, the provider of PAC services informed the client that his/her job would be in danger if it was discovered that she/he provided abortion and PAC services at home.

Studies indicate that fear of legal prosecution may affect the willingness of providers of PAC services to treat unsafe abortion complications (Rahman *et al.,* 1998). Furthermore, providers of PAC services might refuse to provide PAC services to women with abortion complications for reasons of conscience or may even fail to refer them to other facilities even where abortion services are legal (Singh *et al.,* 2009).

Case number four showed that the participant was unwilling to seek care from a health facility because she thought she would meet relatives and friends at the hospital who might talk and spread information about her abortion. She preferred the PAC services from informal provider for the sake of privacy. She was afraid of setting a bad example to her sister and ruining the reputation of the family. The fear of family members and friends knowing about the pregnancy may be connected to the community's attitude on pre-marital sex and children born out of wedlock. Younger women who had had an abortion before marriage may have low self-esteem and may sometimes feel powerless. They are more likely to enter an abusive relationship if their abortion is discovered. They are less likely to have information about appropriate care, in case of complications. Furthermore, they may opt to seek care from informal sources to avoid the stigma. Seeking care from informal sources may lead to chronic morbidity, which may remain unrecognized and untreated for a long time (Bennett, 2001).

Case number one shows that the participant was unemployed and so she had to ask for financial assistance from friends to pay for PAC services. Similarly, in case four, the participant indicated that she could have sought care outside Dar es Salaam if she was to go to the hospital for PAC. However, lack of money to meet the cost made her decide go back to the same traditional healer who provided her with an induced abortion at low cost. Financial constraints have been indicated as one of the challenges women face in accessing PAC services (Sathar *et al.,* 2013). Research in Pakistan found that utilization of PAC services was hindered by lack of finance to pay for PAC services (Azmat *et al.,* 2012).

5.5 Conclusion

The study found that most of the users of PAC services were below 25 years, had formal education, were not married and did not have formal employment. They were either Muslims or Christians and were from within Temeke district. Having the majority of younger women utilizing PAC services may be linked to improvement in seeking behaviour among this group (Sathar, *et al.,* 2013). Reserch evidence suggest that younger and unmarried women are less likely to seek PAC services due to poor knowledge of the availability of PAC services, fear of providers' reaction and lack of money to pay for PAC services (Grimes *at al.,* 2006; Okonofua 2006; Kumar *et al.,* 2009; Bruyn and Packer, 2004).

Several factors facilitated the seeking of PAC service from the study facilities. Sharing of information about one's health status, availability of public transport, having received financial support to cater for treatment and transport costs, privacy, short waiting time and availability of PAC services were factors that facilitated utilization of PAC services. Therefore, this implies that utilization of PAC services can be facilitated if the services are available, affordable, well known

to the users and there is available and affordable transport to reach to the health facility. On the other hand, some women did not seek PAC services because of fear of being arrested by police because of an induced abortion, fear of the negative reactions of the providers of PAC services, fear of being seen by friend or relative at a facility and lack of money to pay for the treatment cost. Thus, criminalization and stigmatization of abortion affect negatively the utilization of PAC services.

CHAPTER SIX

PERCEPTIONS OF THE PROVIDERS AND THE USERS ABOUT THE QUALITY OF PAC SERVICES

6.1 Introduction

This chapter presents information on perceptions of the providers and the users about the quality of PAC services. It is organized in four sections. The first section provides the introduction of the chapter. The second section presents information on the perceptions of the providers on the quality of PAC services. The third section focuses on the perceptions of the users on the quality of PAC services while the fourth section presents the conclusion of the chapter.

The study was carried out among 16 providers and 103 users of PAC services. Semi-structured questionnaires were used to collect information from the providers and users of PAC services. Descriptive statistics, that is, frequency tables, percentage tables and cross-tabulations were used in the analysis. The three study facilities offered treatment of abortion-related complications, counselling, family planning services and the provider-community link. The community-provider link component of PAC services was not investigated.

6.2 Perceptions of the Providers on the Quality of PAC Services

The study focused the aspects of quality PAC services such as the availability of the staff, method and place of uterine evacuation and the availability of essential equipment and supplies.

6.2.1 Availability of the Staff

The study found that PAC services in the study facilities were provided by Medical Doctors (MD), Medical Officers (MO), Assistant Medical Officers (AMO), Nurse Midwives (NM), Nurses (N) and Auxiliary Nurses (AN). The study found that there were inadequate health

providers to offer PAC services in the study facilities. The 2006 WHO Report on Health established a ratio of 2.28 doctors, nurses and midwives per 1,000 persons as the minimum threshold required to cover adequately the population with essential health services. Tanzania is among the 57 countries which did not meet that threshold (WHO, 2006). Available information for Temeke district indicates that the doctor population ratio in Temeke district is estimated to be 1 doctor per 4504.1 persons. Temeke has the smallest number of health personnel compared to the other districts of Dar es Salaam (NBS and RCO, 2014). This is an indication of inadequate healthcare providers in the district.

The study found that the providers attended to PAC patients and other patients with gynaecological problems. For example, one of the facilities received PAC patients referred from health centres and dispensaries because not all dispensaries and health centres offer PAC services. Some health centres and dispensaries offer some components of PAC, such as treatment only, while others do not offer any of the components of PAC services.

The staff in the study facilities admitted that the inadequate number of providers posed a challenge to the provision of PAC services, as well as compromising quality of the PAC services provided. This finding corresponds to a study in Pakistan which indicated that inadequate supply of PAC providers is one of the challenges in delivering PAC services (Sathar *et al.,* 2013). In other situations, providers may be available but stigma, religious beliefs and inadequate training may limit the provision of PAC services (Schuster, 2005).

The study also found that on-the-job training was not regularly offered in facilities A and B. This affected the functioning of some of the providers to some extent. For example, in one facility not

all providers were aware of the use of MVA. Some of the providers of PAC services narrated that:

> *I have a training on how to use D&C method of uterine evacuation. Now there is this new technology of using MVA. I never attended any training on how to use MVA so I prefer using D&C method because I am comfortable using it. Providers who use MVA say that it is simple to use and they have showed me how to use it but I would prefer more training [Provider, Facility B].*

> *When there is a new thing or technology in our field it is important to make sure that all providers are aware of it. Regular and short course training make us aware of what is new in the field. Trainings help to improve the delivery of PAC services and other healthcare services in general [Provider, Facility A].*

This findings agrees with the 2014-2015 Tanzania Service Provision Assessment Survey which indicates that only 3 providers in Dar es Salaam received in-service training for PAC services 24 months preceding the survey (MoHSW *et al.,* 2015). Research evidence has shown that providers' experience and training have an impact on the delivery of PAC services and impact on changing their attitude to PAC services (Paul *et al.,* 2014). Thus, regular training to PAC providers not only makes them aware of changes in technology but it also shapes their attitude on abortion, PAC services and on the users of PAC services.

6.2.2 Method and Place of Uterine Evacuation

MVA was the method used to perform uterine evacuation in the study facilities. In one facility, MVA was used along with D & C. The providers in all facilities admitted that the use of MVA is one step towards enhancing the provision of quality PAC services. The MVA is recommended in the management of abortion complications because it is less painful and easy to use where there is no electricity (Sathar *et al.,* 2013; Graff and Amoyaw, 2009).

The study facilities varied in the areas where uterine evacuation was performed. In one facility, uterine evacuation was performed in a ward, in a special place covered by screens. The facility had no designated MVA room because of limited facility space. This ward served both the patients for PAC services and post-natal mothers. Therefore, this affected the privacy of the users of PAC to some extent. It was easy for the post-natal mothers to hear providers' conversation and patients' screams (if any) during the uterine procedure. Some of the users of PAC services who were treated in this facility felt that the post-natal mothers overheard the providers' conversation during uterine evacuation. Some of them stated their concerns that:

> *The space for this facility is limited, and that is why you see we (PAC clients) and those with babies use this room. Everyone here can hear what the doctor is saying [User, 27 Years, Married).*

> *Although their services are good, what I do not like about the facility is that the space is very small. That is why you see we are treated behind these curtains. Everyone hears everything the nurses and the doctors are saying. You do not feel good after treatment because everyone looks at you because they know everything [User, 22 Years, Married).*

Some of the users of PAC services were of the opinion of having a separate room for the MVA procedure for more privacy. A participant made this recommendation:

> *My recommendation is, if possible, to have a separate room for treatment only, which would be good because they (post-natal mothers) hear everything the doctor is saying…others cry because of the procedure…so you do not feel good after the treatment because you rest here and they see you [User, 21 Years, Not Married).*

Another user of PAC services said:

> *I think this room is meant for people with health problems like ours. I think the small space has made them mix us with other patients. I recommend that if possible, the facility could find a place for postnatal mothers. It pains when you see your neighbor holding a baby while you have lost yours [User, 33 Years, Married).*

In the other two facilities, uterine evacuation was performed in the MVA room, so other people could not see or hear any conversation in the MVA room. None of the patients treated in these facilities reported any dissatisfaction during uterine evacuation. This observation implies that

privacy is very important during the evacuation procedure. Having a separate room for MVA ensures privacy as found in the two health facilities.

6.2.3 Availability of Essential Equipment and Supplies

Essential equipment such as MVA which is used in uterine evacuation and medication especially painkillers for PAC clients were available in all three study facilities. All the study facilities had one MVA set. The providers in facilities A and B reported that the available equipment for PAC were insufficient for the number of the users of PAC services the facilities served. The study found that it was a challenge to replace a damaged equipment. It was found that it may take a long time to replace damaged MVA because of government procurement procedures which require more time to order the equipment. This finding is consistent with a finding by a study in Ghana that there have been challenges in procuring MVA in low income, low-volume providers (Graff and Amoyaw, 2009).

In facility C, equipment may be ordered from another facility in their network in case of a damage. The availability of essential equipment, such as MVA and medication for pain relief and for treating infections, is very important in any facility to ensure quality PAC services (PCC, 2014). The availability of essential equipment ensures prompt provision of PAC services and may reduce delays in receiving care (Kumbi and Melkamu, 2008).

The study revealed that painkillers were available always except when there was a shortage because the Medical Stores Department (MSD) had not supplied them. Patients were advised to purchase painkillers and antibiotics from the nearest pharmacy if there was a shortage. This study found that over 92.2 percent of the patients reported to have felt pain during the evacuation

procedure. Of these, 88.4 percent were administered pain relief either by swallowing a pain relief tablet or by injection.

The shortage of blood was indicated as a challenge in the provision of PAC services in the study facilities. Some patients are admitted with severe bleeding, thereby needing blood transfusion. The facilities referred the patients to other health facilities for blood transfusion when there was a shortage of blood. Providers pointed out that:

> *Some patients come here with severe bleeding (you saw one yesterday). The facility does not have enough blood because blood transfusion is needed by many patients for example people who are injured during accidents. We usually refer a client to another facility if we do not have enough blood in our blood bank. We call the facility before we refer them to make sure they have blood for transfusion. If it happens the facility, we have called does not have blood for transfusion we communicate with another facility to make sure that we refer a patient to a facility where she can get blood transfusion [Provider, Facility A].*
>
> *Our facility receives patients who are critically ill, some of whom may need blood transfusion. When that happens, we refer them to a nearest health facility after communicating to the facility. If they have shortage of blood, we refer the patient to a facility within our network [Provider, Facility C].*

Availability of blood in the health facilities can help to save the lives of women requiring PAC services. It may also reduce number to cases referred to other facilities for blood transfusion therefore reducing the chances of maternal mortality as well as the chances of congestion in the referred facility.

6.2.4 Water and Electricity Supply

The study facilities had an adequate water supply. One facility had a well which supplied water to the facility and to the community around. Each facility used a power generator when there was a power cut. However, providers admitted that there were some challenges running the generator for long periods when there was a long-term power supply crisis. It was very expensive for

facilities to run the generator because the facilities had to purchase fuel to sustain the generators during a long-term power crisis. As a solution to this, the staff turn off the lights in some departments of the facility, such as the PAC section, leading to challenges regarding the provision of PAC services, especially for clients who seek care at night. Some providers had the following to say.

> *This facility has a power generator which is used during power rationing. The major challenge is that it is very expensive to run a power generator especially during acute power crisis. Alternatively, the facility turns off the lights in some departments including this dealing with the users of PAC services. I remember previous years, patients used to come with their own lamps because it was dark here, and to run a power generator was very expensive [Provider, Facility A].*
>
> *Electricity is not a problem in this facility. Our facility does not operate during the night so the problem comes when there is power cut during the day. We use a generator when there is no electricity [Provider, Facility C].*
>
> *We use electricity to run this facility. We also have a power generator which we use in the time of power cut. I must admit that it is not easy to run a power generator for example when there is no power the whole day. This facility is big and you need more than one power generator to have enough power supply. There are some departments that cannot function without power. Other sections may function without power during the day but at night it becomes very difficult [Provider, Facility B].*

Water and electricity supply are very important in the delivery of PAC services. Inadequate supply of water and electricity can affect negatively the delivery and the quality of PAC services.

6.3 Perceptions of the Users on the Quality of PAC Services

The perceptions of the users on the quality of PAC services focused on the provider's sex, counselling, family planning, waiting time, cost of PAC services, privacy and facility location and set up.

6.3.1 Providers' Sex

Half the providers were male and the other half female. All Nurses and Auxiliary Nurses were female while Medical Doctors and Medical Officers were male (Table 6.1).

Table 6.1: Providers' Sex by Health Facility

Facility code	Providers' Sex				
	Male		**Female**		**Total**
	n	%	n	%	
A	3	18.8	4	25.0	7
B	3	18.7	2	12.5	5
C	2	12.5	2	12.5	4
Total	8	50.0	8	50.0	16

Source: Primary Analysis of the Survey Data

The patients for PAC services were attended to by either a male provider (27.2 percent), a female provider (20.4 percent) or both (52.4 percent), depending on who was on shift when she was admitted. About 34.0 percent of the patients were comfortable being attended to by a male provider, 18.4 percent were comfortable being attended to by a female and 47.6 percent were comfortable being attended by both. Patients who preferred a female provider had the following to say:

> *I prefer a female provider because as a woman she will better understand my problems and so it will be easier for her to help me [User, 30 Years, Married).*

> *If you are attended by a female provider she will feel it because she is a woman and so she will do it better [User, 24 Years, Not Married).*

> *I prefer a female provider because she knows about women's issues and as a woman she will understand my problems better so it will be easier to help me [User, 29 Years, Married).*

Some of the patients who preferred a male provider indicated that;

> *When I compare them, male providers will not stigmatize you, they do not yell at you sometimes as female providers do [User, 19 Years, Not Married).*

> *It is easy for a male provider to keep a secret and they do not use abusive language with clients [User, 27 Years, Married).*

I like them because they are more competent than women and they are serious about their work [User, 36 Years, Married).

Patients who indicated that they would prefer both a male or a female provider believed that when you are sick you do not have a choice. Some of them had the following to say:

You know when you are sick you don't choose who will treat you. I am comfortable being attended by any [User, 22 Years, Not Married).

They both listen to clients and they are competent in what they are doing [User, 17 Years, Not Married).

What I look at is the service not the person who gives the service if I get the service, sex is not a problem to me [User, 34 Years, Married).

This study has shown that providers sex was not a concern to most of the users of PAC services. Studies elsewhere have documented that the provider's sex is a concern to some the users of PAC services. In settings where people have strong religious or cultural beliefs, some users of PAC services may not accept being attended by a male provider (Kruk *et al.,* 2010). In India, a study found in one community societal taboos prohibit men from conducting a physical examination or invasive and diagnostic and therapeutic procedures on women. Therefore, trained male providers offered pills and injections to women requiring PAC services. On the other hand, female providers offered PAC services although they lacked appropriate training (Johnston *et al.,* 2003).

6.3.2 Post-Abortion Care Counselling

All the study facilities provided on-site counselling for the users of PAC services. The counselling was provided either by doctors or nurses before or after the client had been treated for abortion complications. About 69.9 percent of the users received counselling. None of the

users of PAC services who missed counselling at the study facilities were referred to another facility for counselling.

Users of PAC services who were in the age group 25-29 were more likely to receive PAC counselling compared to the users in the other age groups. On the other hand, those who were in the age group 20-24 were more likely to miss PAC counselling compared to others. Users of PAC services who had secondary and tertiary education were more likely to receive counselling compared to those who had primary education. Table 6.2 displays the percentage of the patients who received counselling per their socioeconomic and demographic characteristics.

Table 6.2: Proportion of the Patients Who Received Counselling After Treatment Per Their Characteristics

Characteristic	Counselling		Total
	Offered %	Not offered %	%
Age			
15-19	76.5	23.5	100
20-24	60.0	40.0	100
25-29	81.8	18.2	100
20-34	80.0	20.0	100
35+	50.0	50.0	100
Marital status			
Single	72.5	27.5	100
Married	71. 1	28.9	100
Cohabiting	57.1	49.2	100
Religion			
Christian	68.6	31.4	100
Muslim	57.1	48.9	100
Education			
Primary	57.7	42.3	100
Secondary	82.2	17.8	100
Tertiary	83.3	16.7	100
Occupation			
Employed	83.3	16.7	100
Housewife	60.5	39.5	100
Self-employed	73.5	26.5	100
Student	69.2	30.8	100
N=103			

Source: Primary Analysis of the Survey Data

This study found that some of the users of PAC services were not introduced to counselling. Thus, they missed an important component to PAC services. Counselling to women requiring PAC services may lead to increased contraceptive uptake. A study in Turkey showed that counselling to the users of PAC services led to an increase in contraceptive uptake, which resulted to decreased post-abortion pregnancy rates (Ceylan *et al.,* 2009).

6.3.2.1 Privacy During Counselling

The study found some variations regarding where counselling was provided in the study facilities. Two facilities had special counselling rooms, while one facility had no counselling room. More than 90 percent of the clients who received counselling in the facilities with a counselling room stated that the privacy of the counselling place was satisfactory. Counselling was provided in the MVA room or the ward (while a patient was lying on a bed) in the facility which had no counselling room. In the facility, which had no counselling room, providers used a screen when there was more than one patient in a bed. More than half of the users perceived the privacy of the counselling place to be unsatisfactory in that facility.

Privacy especially during counselling is very important in the delivery of PAC services. Having a separate room for PAC counselling may help to ensure privacy but it may not be possible in most cases. Alternatively, the providers may use curtains and sit beside clients' bed and speak softly (Tabbutt-Henry and Graff, 2003). This is practical where a bed is occupied by one patient, and some of the providers in one of the study facilities applied it. The challenge encountered by the providers was the difficulty to provide counselling to a PAC services user when a bed was shared.

6.3.3 Post-Abortion Care Family Planning

The study found that the study facilities offered a range of family planning methods such as injection, norplant, condom, diaphragm, the pill and intrauterine device (IUD or coil). They also emphasized the use of natural methods, such as withdrawal and the calendar method. About 62.1 percent of the users of PAC services were offered a family planning method. More than a quarter were not offered a family planning method. Close to half (43.3 percent) of the patients who missed family planning were between 20 and 24 years (Table 6.3).

Table 6.3: Proportion of the Users of PAC Services Offered a Family Planning Method According to Their Characteristics

Characteristic	Family Planning After Treatment		
	Offered (%)	Not offered (%)	Total (%)
Age			
15-19	64.7	35.3	100
20-24	56.7	43.3	100
25-29	72.7	27.3	100
30-34	55.0	45.0	100
35+	64.7	35.3	100
Marital status			
Single	64.7	35.3	100
Married	63.2	36.8	100
Cohabiting	50.0	50.0	100
Religion			
Christian	64.7	35.3	100
Muslim	59.6	40.4	100
Education			
Primary	59.6	40.4	100
Secondary	62.2	37.8	100
Tertiary	83.3	16.7	100
Occupation			
Employed	72.2	27.8	100
Housewife	52.6	47.4	100
Self-employed	67.6	32.4	100
Student	61.5	38.5	100
N=103			

Source: Primary Analysis of the Survey Data

Women with abortion complications need family planning regardless of the cause of complications (Demtsu *et al.,* 2014). The fertility of a woman who has had abortion complications may recover as early as two weeks after an induced or spontaneous abortion (Curtis *et al.,* 2010). The WHO recommends that a woman who has experienced abortion-related complications should wait for at least six months before the next pregnancy (WHO, 2007b). Therefore, family planning is very important to prevent any pregnancy before the recommended period.

Some of the patients who were not offered a family planning method reported that they were not given any information about family planning, as illustrated by the following excerpts.

> *After I was treated, I was told to go home and come back if a problem arises. I was not told about family planning methods [User, 25 Years, Not Married).*

> *I have never used a family planning method. I hear about condoms and pills but I am afraid of the side effects. No-one told me about a family planning method in this facility. …Yes I would have used one because you know these are words of people (about side effects), and so if you hear about it from a nurse or doctor you are comfortable using them (family planning) [User, 20 Years, Not Married).*

Efforts were made by the researcher to refer some patients back to the providers for family planning however, none of them accepted. On the other hand, the providers indicated that some of the patients left a facility without a family planning method because some of them could not accept a method without discussing it with a partner. Others left a facility after treatment for fear of being arrested by the police for having an illegal induced abortion. One provider said:

> *You know because of legal issues and stigma, some women run away after treatment, they do not wait until they are discharged, and you know family planning is usually the last thing to be given to them. So, if she runs away she misses this important part of care [Provider, Facility B].*

Another provider expressed that:

> *Others will tell you that they do not want a family planning method until they discuss it with their partner. That is why there is a need to encourage the partner's involvement in post-abortion care [Provider, Facility B].*

Having some users of PAC services leaving a facility before being discharged may suggest clients' fear of legal reprisals for an induced abortion. A study in Uganda found that some users of PAC services left the facility before being discharged, which meant that they left a facility without a contraceptive (Paul *et al.,* 2014). The fact that some of the users of PAC services left the facilities without a family planning method may imply that the availability of family planning methods does not always guarantee the uptake. Studies elsewhere show that factors which may hinder the uptake of PAC family planning among the users of PAC services include: stigma, lack of knowledge on family planning, lack of integrated family planning services, need for partner's approval, lack family planning at the facility, lack of the desired method, inadequate counselling services and fear of side effects (Paul *et al.,* 2014; Curtis *et al.,* 2010).

6.3.4 Youth-Friendly Post-Abortion Care Services

The study found that none of the patients who were under 18 years reported to have been mistreated by the providers. The study facilities did not have a special counselling room for the under-age. However, the under-age had the priority of being attended promptly to avoid spending long time at the facilities. The main concern of the under 18 users of PAC services was sharing the recovery room with the adult patients for those who needed extra check-up and close monitoring. The three facilities did not have a special post-procedure recovery room for young clients (under 18 years). All patients who were under 18 years indicated that they were not comfortable being placed in the same recovery room as adult women. In the facilities, efforts were made to give priority to younger users of PAC services to avoid them having to spend long time at the facility. The following extracts present some of their concerns.

It was hard for me to be in that room for 24 hours. Older women were looking at me and sometimes I saw them talking to each other. I thought they were discussing about me. I did not sleep; I was waiting for the time to be discharged. I thank God that the doctor who came this morning discharged me [User, 17 Years, Not Married].

I was not comfortable because most of them in the room were older than me. There were times I thought of running away but I feared that the provider would have caught me. I had to persevere [User, 16 Years, Not Married].

Do you think it was easy? I felt that I was placed in a prison although none of the adult clients asked me about anything. Some of them were discussing about their health conditions… I had to turn to the other side of the bed and pretend that I was asleep. I didn't want them to ask me about anything [User, 16 Years, Not Married].

One of the adult client felt sorry for me because she overheard when I was screaming. When the provider was not at the room, the older woman told me that I should concentrate on my studies and not to focus on men. I felt bad although what she was telling me was true [User, 17 Years, Not Married].

The reproductive health needs of the younger women need to be taken in to consideration because they are fearful and sometimes lack an understanding of their own needs. Therefore, it is difficult for them to seek guidance and they sometimes avoid seeking care in case of a health problem (Senderowitz, 1999).

6.3.5 Facility Location and Set-Up

In facility A, PAC services were offered in the Obstetrics and Gynaecology Department. Specifically, the patients were admitted to the labour ward. The room for the patients for PAC services were located near the maternity ward. It was designated for women with abortion complications but room was shared with post-natal mothers due to limited facility space. The structure of the facility made it easier for the patients to identify the ward from the outpatients' department.

In facility B, users of PAC services were admitted in the Obstetrics and Gynaecology Department. The ward was on the ground level, making it easier for the patients to reach it. In

facility C, there were no departments since it is a dispensary, which offers reproductive health services alongside other health services. All services were provided in the same building, therefore, the patients moved from one room to the next. In general, users of PAC services did not have a difficulty locating the services in the study facilities. A study in Ethiopia found that the inability of users of PAC services to locate PAC services was a source of their dissatisfaction with the care (Demtsu *et al.,* 2014).

Although the location and set-up of the facilities were not a challenge to the users of PAC services, some of them found it challenging to share a hospital bed in facilities A and B. In facility A, the bed was shared either with a fellow user of PAC services or with a post-partum mother. In facility B, the bed was shared amongst the users of PAC services. One of the patients expressed her concern about sharing a bed, especially with a post-natal mother. She was of the view that sharing a bed may lead to infections. The following extract shows her concern.

> *As you have seen yourself, I was sharing the bed with a woman who had just delivered. This may lead to infection in the baby since I was bleeding, you cannot stretch yourself, hygienically it is not good, we had to sleep that way because we had no option, and the space is very limited [User, 27 Yeras, Married].*

Available data show that Temeke distict has the worst ratio of population per hospital bed (1:4,924), compared to the other the districts of Dar es Salaam (NBS and RCO, 2014).

6.3.6 Waiting Time

The time a patient had to wait before receiving care depended on the volume of the patients the facility received, the time the the patient reached the facility and the severity of the complications. The majority, (71.8 percent) of the users of PAC services reported that the time they waited to receive care was satisfactory. About 13.6 percent perceived that the time was too long. Patients who indicated that the time was too long were those who had to stay at the facility

for more than a day for further treatment. Mondays and Tuesdays were always the peak days in the study facilities. Therefore, patients who sought care on those two days were likely to spend more waiting time than those who sought care during the rest days of the week.

Most of the users of PAC services in the study facilities were discharged the same day except for those whose conditions required close monitoring. In facilities A and B, patients who required close monitoring were admitted for at least 24 hours. In facility C, patients who required close monitoring were referred to a facility in their network providing 24-hour services or to nearest public facility that provided a 24-hours services. As noted previously, some of the users of PAC services indicated that they had to seek care from a private facility because of short waiting time, although the costs were higher than in public facilities. This may suggest that clients may not seek care or may opt to seek care from informal sources if they wait for a long time to receive care. A study in Ethiopia indicated that long waiting time was one of the causes of dissatisfaction reported by the users of PAC services (Kumbi *et al.,* 2008).

6.3.7 Cost of PAC Services

The cost of PAC services varied from facility to facility. In facility C, the cost of PAC services was the same for all patients (45,000Tshs (27$)[5]. In one of the public facilities there was a billboard indicating the type of services offered and the cost of each service. The cost of PAC services indicated was 20,000 Tshs (12$). However, patients in this facility were charged between 20,000 Tshs (12$) and 50,000 Tshs (30$). Providers stated that patients who paid more had to go for an extra check-up, such as x-ray and ultrasound. In the other public facility, the cost of PAC services ranged from 20,000 Tshs -100,000 Tshs (12 -60).

[5] The exchange rate at that time (2014) was 1$ per 1670 Tsh.

Generally, 58.3 percent of the users perceived the services to be affordable. Close to half (41.7 percent) thought the services were expensive. The perceptions of the users on the cost of PAC services differed from facility to facility as shown on Table 6.4.

Table 6.4: Perceived Affordability of PAC Services Per Study Facility

Facility	**Affordability**			
	Affordable		**Unaffordable**	
	N	%	n	%
A	25	92.6	02	7.4
B	19	40.4	28	59.6
C	16	55.2	13	44.8
Total	**60**		**43**	

Source: Primary Analysis of the Survey Data

The study found that the three facilities had programmes to help patients who were unable to pay for healthcare services. Unfortunately, in Facility A and B, none of the users of PAC services were treated under *daftari la msamaha*[6] during the study period. Seven users were treated under a special program in facility C.

This study found that facilities A and B were public facilities in the same district but charging different fees for PAC services. This may have an impact on the utilization of PAC. The study has shown that there is a possibility that the users of PAC services may share information about their health status. Furthermore, they may even recommend the type of facility from which to seek care. Thus, if there are huge differences in the cost within the same district, some facilities may be congested because of low cost of PAC services. High congestion in the health facilities may lead to poor quality services, therefore affecting the utilization of PAC services.

The variation in the cost from provider to provider was also observed by other studies elsewhere. The studies show that the cost of PAC services varied from provider to provider depending on

[6] This is a programme where the health facility supports patients (PAC clients included) who are unable to pay for health care services.

the severity of the complications and the qualifications and experience of the provider (Wariki *et al.,* 2015, Azmat *et al.,* 2012). A study in Ethiopia found that users of PAC services were turned away because they did not have enough money to pay for PAC services (Kumbi *et al.,* 2008). Low cost or the absence of charges for PAC services may not necessarily increase utilization. Demtsu and colleagues found that some women did not utilize PAC services (although they were free of charge) because of lack of knowledge of its availability and providers' attitude (Demtsu *et al.,* 2014).

6.3.8 Satisfaction with Care

The users of PAC services in the study facilities were asked if they were satisfied with care they had received. They were also asked if they would recommend the services to a friend. Over 84.4 percent indicated that were satisfied with the care they had received and were ready to recommend the same services to a friend. They pointed out that:

> *I would still recommend the services to a friend although they are expensive, because their services are reliable [User, 24 Years, Not Married].*
>
> *I will recommend her to come here because the services I have obtained here are good. They look after the client, although their job is very difficult [User, 32 Years, Married].*
>
> *Their services are good and that's why you see many people here, and so I will recommend her to come here to get services, but I will tell her that she should be patient [User, 26 Years, Not Married].*

A few (15.5 percent) indicated that they were dissatisfied with the care they had received. The main reasons for their dissatisfaction were having to wait for a long time to be served, high charges of PAC services and sharing a hospital bed. They indicated that they would not recommend the service to a friend. Some of them narrated that:

I cannot recommend a friend to this facility because their services are too expensive here. Most people living in this community are not well off, and cannot afford these services [User, 28 Years, Married].

Some medicines are unavailable and they told me to go and buy them outside. Sometimes you go outside but do not find them, and if you do not have someone to send to buy them for you, you will suffer, you have seen yourself my condition, I am weak, I cannot go outside [User, 30 Years, Married].

Although they provide better services, I can't recommend them to a friend because there are so many clients in this hospital. That is why you have seen that we are sharing beds here, two patients occupy almost every bed here, so it takes time to get a service [User, 25 Years, Not Married].

Clients' dissatisfaction with care can affect an impact on the utilization of PAC services (Demtsu *et al.,* 2014).

6.4 Conclusion

The study found that the perceived quality of PAC services offered in the three study facilities was good. On the other hand, the study found there were inadequate staff as well as inadequate equipment and supplies. In addition, some users of PAC services were not satisfied with the privacy during delivery of care. Lack of privacy, inadequate providers of PAC services and inadequate essential equipment and supplies can affect the quality and the utilization of PAC services. MVA was used as the main method of uterine evacuation except in one facility where it was used alongside D&C method. The use of MVA is a step towards enhancing quality of PAC. MVA is recommended in the management of abortion complications because it is less painful, easy to use and can be used in places where there is no electricity (Sathar *et., al* 2013; Graff and Amoyaw, 2009).

All the study facilities offered on-site PAC counselling and family planning services. However, some of the users of PAC services left a facility without being counselled or without a family planning method. That means they missed out the important components of care. It should be noted that each component of PAC services is very important to women experiencing abortion-related complications. Patients were satisfied with the time they waited before receiving care but close to half of them perceived the charges of PAC services to be high. High charges on PAC services is likely to lead to delays in seeking care following abortion complications therefore increasing the likelihood of negative health impacts.

CHAPTER SEVEN

PERCEPTIONS OF THE COMMUNITY ON ABORTION AND PAC SERVICES

7.1 Introduction

This chapter looks at the perceptions of the community and the providers on abortion and PAC services in two wards of Temeke district. It is divided in four sections. The first section provides the definition of abortion, that is how the community members define abortion and whether they could distinguish between spontaneous and induced abortion. The second section focuses on the perceptions of the community members on abortion while the third section focuses on the providers' perceptions. The fourth section provides information on how healthcare providers and community members perceived PAC services and last section presents the conclusion of the chapter. FGDs were used to collect information from female and male community members of members of reproductive age (15-45).

7.2 Defining Induced and Spontaneous Abortion

The discussion started by defining induced and spontaneous abortion by the community members. The aim was to understand how they defined these terms and whether they could differentiate them. Induced abortion was defined as a deliberate act of ending the life of a *kiumbe*[7], which can be done by the woman herself without informing her partner or by agreement between a woman and her partner as illustrated by the following quotes.

> *...induced abortion means a woman was pregnant but she has decided to end the pregnancy deliberately [Female, Student, Ward-1].*

> *Induced abortion is killing a kiumbe that was supposed to be born [Male, – Ward-2].*

---

[7]Kiumbe was used to refer to the pregnancy because it is difficult to call it a baby or a child in the early stages of the pregnancy. A *kiumbe* is a creature in English.

...induced abortion is when a woman intends to end the pregnancy deliberately [Female, Ward-1].

…induced abortion is when it is done deliberately when a man and woman agree to end the pregnancy [Male, Student, Ward-2].

Spontaneous abortion was defined as the abortion that occurs by itself because of various factors, such as diseases or inability of the uterus to carry the pregnancy to term. The main emphasis was that spontaneous abortion occurs unintentionally. They defined spontaneous abortion as:

…spontaneous abortion occurs accidently without woman's intention [Female, Ward-2].

Spontaneous abortion happens by itself for different reasons, although a woman wanted the pregnancy [Female, Student, Ward-1].

...spontaneous abortion occurs naturally that the kiumbe comes out without human involvement. It occurs accidentally… not planned [Male, Ward-2].

From these definitions, the community understood the difference between induced and spontaneous abortion. They indicated that the former is performed deliberately while the latter occurs unintentionally. Some community members were aware of induced abortion which is performed on medical grounds when it is confirmed that the life of the mother will be in danger if she continues with the pregnancy.

Both men and women FGD participants agreed that abortion (spontaneous and induced) is a problem in their community. Community members pointed out that:

Induced abortion is a health problem in our community because we know some women who have lost their lives because of it [Female, Ward-1].

Induced abortion exists and many women are dying because of it and its impact is very big [Male, Ward-2].

Induced abortion is a problem in our society because many women, especially students, are involved in having abortion and they lose a lot of blood…we have seen them at school [Male Student, Ward-2].

7.3 Community's Perceptions About Induced Abortion

The participants were asked about their own perceptions about abortion (both induced and spontaneous abortion). Perception to induced abortion was considered negative if the indicated that it was undesired, immoral or contrary to normative behaviour.

7.3.1 Negative Perceptions on Induced Abortion

Two major impressions of induced abortion emerged from the discussion. Induced abortion was perceived as either murder or a sin.

7.3.1.1 Induced Abortion as Murder

Induced abortion was perceived by the community as murder because the life of a *kiumbe,* which was supposed to be born, has been ended deliberately. The participants expressed that:

> *Induced abortion is killing an innocent kiumbe that was supposed to be born [Male, Ward-1].*
>
> *Induced abortion is murder and there is no religion which allows induced abortion [CHW].*

It emerged from the discussion that neither Christianity nor Islam support induced abortion. Followers of Islam believed that those who have had an induced abortion have killed a sinless *kiumbe*. Therefore, they will die like a *kafir*[8] as a punishment for killing the *kiumbe*. Likewise, for Christians, induced abortion was considered as an act that was not supported by their religion since it is considered murder. The extracts from the religious leaders and community members below provide more details.

> *... God will punish you for committing murder because when you perform an abortion you kill a kiumbe of God, which is free from sin [Religious Leader, Islam].*

[8]In Islamic Religion, kafir is a person who is not a Muslim.

... for the church, abortion is a bad thing because it is murder. The church does not allow it by any means...it is something that the church cannot accept [Religious Leader, Christian-2].

According to the Islamic religion, someone who has performed an induced abortion will die like a kafir[9] *because Allah (God) does not allow murder [CHW].*

I consider performing an induced abortion as something that is very bad as we all know that no religion advocates for it [Female, Ward-1].

7.3.1.2 Induced Abortion as a Sin

Induced abortion was viewed as a sin. This feeling was rooted in both Christian and Islamic beliefs, which were dominant in the study community. Muslims and Christians believed that if a woman had had an induced abortion she had committed the sin of murder. They pointed out that:

Religion does not allow induced abortion even if it is a safe abortion. It is a sin …if anyone had had an induced abortion, has committed the sin of murder [Religious Leader, Islam].

I think most women who seek an abortion know that the government does not allow induced abortion and religion prohibits it, and even they know that what they are doing is a sin, to have an induced abortion [CHW].

Abortion is not good even before God. It is considered a sin by all religious dominations and it is unacceptable [Religious Leader, Cristian-1].

A Christian religious leader emphatically said that the followers are aware that induced abortion is a sin. The leader acknowledged having attended to some followers who came to church to confess after having an induced abortion. A Christian religious leader narrated that:

I would like to insist that, according to the religious teachings, they [believers] know that it [induced abortion] is not right. That is why they come themselves to confess to us. This year (2014) I attended to two who came to confess that they have had an induced abortion. In most cases women are the ones who come but men who are responsible for the pregnancy do not usually come [Religious Leader, Christian-2].

The negative perception on induced abortion was not only attributed to the act itself but also to a woman who had had an induced abortion. A woman who had had an induced abortion was perceived either as a murderer, a useless person, a woman who does not want to give birth or a cruel person. They expressed that:

> *She (a woman who had had an induced abortion) is a murderer and the one who helped her have an induced abortion is also a murderer [Female Student, Ward-2].*
>
> *I perceive that a woman who had had an induced abortion does not want to give birth because she does not know what kind of help she would get from that child [Female, Ward-2]*
>
> *I consider her (a woman who had had an induced abortion) like a bad person in society [Male Student, Ward-2].*
>
> *Society regards her as someone cruel who does not fit into the community [Female, Ward-1].*
>
> *They [community members] consider her a bad person and in some cases if they discover someone has done it [induced abortion] they take her to the police. Some people may decide to keep quiet but those who are knowledgeable may send the provider to the court [CHW].*

Giving names to women who had had an induced abortion is also observed in other settings. In Zambia, a girl who had had an induced abortion is called *kaponya mafumo*, 'the terminator of pregnancy', while others call them 'DCM' 'direct communication' to the mortuary' because they believe that an individual may fall sick if he had sex with a girl who had had an induced abortion (Webb, 2000). Abortion stigma may lead to seeking abortion services from unqualified providers. In addition, it may prohibit some patients from seeking PAC services from health facilities (Okonofua, 2006).

In other places names are not only given to women who had had an induced abortion but also to the providers of PAC services. In Ghana, a study indicates that obstetricians and gynaecologists are labeled abortionists, which makes them not want to be associated with induced abortion,

although they have the qualifications to do so. In other instances, when they acquire new cars or houses they are labelled abortion houses or abortion cars. Stigmatization of the providers has impacted their willingness to obtain training on abortion and PAC services (Payne *et al.,* 2013). In Pakistan, the clergy view the providers of PAC services as murderers and are always harassed (Azmat *et al.,* 2012).

At some point, the participants who had a negative perception of induced abortion agreed that there are circumstances where induced abortion was unavoidable. It was argued that in the case of rape, for example, a woman might opt for an induced abortion since she was forced into a sexual activity. Some of the participants narrated that:

> *I consider the carrying out of an abortion as something very bad as we all know that no religion advocates it. However, you may find that someone has done it willingly, for example, when someone has been raped. In that case, you may find that she does not have an option but to perform an induced abortion [Female, Ward-1].*

> *I agree that when a woman is raped, induced abortion may be acceptable because it will be difficult for her to raise a child when she doesn't know the father ... take the example of a woman being raped by a gang [Male, Ward-2].*

A recent study in Uganda found that healthcare providers accepted that there are certain circumstances when induced abortion may be acceptable despite their strong negative attitude to it. They agreed that rape is one of the reasons that may justify an induced abortion (Paul *et al.,* 2014).

The fact that some of the FGD participants recognized the provision of induced abortion in the case of rape may signal the acceptability of the provisions of the Maputo Protocol. Tanzania ratified the Maputo Protocol to the African Charter on the Rights of Women in Africa. Article 14 (2a) calls for states to provide adequate, affordable and accessible health services to women.

Article 14 (2b) calls for states to protect the rights of women by authorizing medical abortion due to sexual assault, rape, incest and in circumstances where the life of the pregnant mother is in danger (AU, 2003). However, the law in Tanzania has not changed to accommodate the provisions of the Maputo Protocol (Woog and Pembe, 2013).

Participants in the group discussions reported that in most cases women have an induced abortion covertly to avoid shame, because induced abortion was regarded as unacceptable. They narrated that:

> *They do it in secret because that is murder… Because of that they can't do it openly and that is why they go to these secret places because it is unacceptable in the community [Female, Ward-1].*
>
> *There are two main reasons for performing an induced abortion secretly. The first is because of religious belief, in that most religions consider a woman who has had an abortion a killer, someone who has sinned against God. The second reason is the law, which prohibits someone from carrying it out except in certain circumstances, otherwise you will be charged with murder [Male, Ward-1].*

Women keep abortion secret in both developed and developing countries. In Cameroon, the public shaming of women who had had an induced abortion is common. Therefore, women make sure that induced abortion remains a secret. If a woman who had had an induced abortion showed up in a public place, songs indicating her name were sung to shame her. Young women may be expelled from the village for having an induced abortion (Schuster, 2005). In the United Kingdom where abortion is legally permitted, a study found that women who had had an induced abortion were fearful of being disapproved if friends and healthcare providers knew their induced abortion. Therefore, women kept the abortion as secret as possible (Astbury-Ward *et al.,* 2012). Keeping abortion secret may lead to a delay in seeking care, to providing inaccurate information when seeking PAC services and sometimes to death (Okonofua, 2006; Schuster, 2005). With reference to case number two in chapter five, a woman who had an induced abortion

passed away because she kept the abortion secret. She sought care when the complications were at an advanced stage.

A community health worker stated that women may seek induced abortion secretly because these services are provided secretly. She added that the providers of induced abortion understand that it is illegal to provide them, which is why they do it secretly to avoid being arrested. This proves the finding in chapter five. Some of the non-users of PAC services indicated that they obtained an abortion and PAC services at the provider's residence because the providers were fearful of being arrested by the police for carrying out an illegal induced abortion.

7.3.2 The Perceptions of the Providers About Induced Abortion

The perceptions of the providers about induced abortion were mixed, as found in the community. However, their perceptions were not as harsh as that of the community members. The common expression of the providers was that they do not judge a woman who had had an induced abortion because they believed that there are circumstances behind induced abortion. Some of the providers felt that an illegally induced abortion is not good. They expressed that:

> *To me, induced abortion is not a good thing ...but we should distinguish between illegally induced abortions and legal ones. If a woman has ectopic pregnancy and abortion is done that is ok, but personally I consider that illegally induced abortion is not good [Provider, Facility B].*
>
> *Induced abortion (illegal) in our communities is not considered good, and neither do I because of my religion (Christian)…if it is legalized for example, I will not do it…thank God I am about to retire [Provider, Facility B].*
>
> *I cannot judge a woman who has had an induced abortion because as a professional, I understand the reasons for induced abortion, but in our community, induced abortion is not acceptable [Provider, Facility A].*
>
> *If you put the profession aside, everyone has his/her own attitude to induced abortion, which is influenced by either religion or culture. Remember, we providers are influenced by community norms and religion, and so as individuals we have our own perceptions of*

> *it. I feel sorry for a woman who has had an induced abortion because there must be the reason for her decision, we need to understand why she decided to do so [Provider, Facility C].*

Some providers in this study disapproved of induced abortion, but felt sorry for the women who came to the facility with induced abortion-related complications. A study in Uganda found that healthcare providers rarely approved of induced abortion and sometimes considered it immoral or murder, although they felt sad when they saw a young woman suffering from abortion-related complications. The study further noted that that sometimes the providers treated clients harshly because they did not provide correct information on the cause of the complications (Paul *et al.,* 2014). The analysis of thirty-six studies on abortion in sub-Saharan Africa and South East Asia indicates that healthcare providers' attitude to induced abortion is influenced (positively or negatively) by six factors, which are human rights, unpreparedness of religion, quality of care, quality of life, stigma and victimization (Loi *et al.,* 2015).

Several studies have documented that the provider's attitude to abortion and PAC clients tends to be positive when providers are asked directly (Demtsu *et al.,* 2014; Gebreselassie *et al.,* 2010; Kumbi *et al.,* 2008). On the other hand, clients' dissatisfaction with the provider's attitude has been identified as one of the hindrances to using PAC services (Sathar *et al.,* 2013; Webb, 2000). The judgmental or negative attitude of the providers on induced abortion may lead to women receiving poor quality services, women not being referred to other facilities for PAC services, and women delaying or not seeking care in case of complications (Melkamu *et al.,* 2010; Likwa *et al.,* 2009; Sing et *al.,* 2009). All these factors may put women at risk of maternal mortality.

The study found that religion came out as an important factor that influenced community's perception on induced abortion. This was also evident from both the healthcare providers and

community health workers. Healthcare providers indicated that, besides their profession they are individuals who live in the community and are shaped by religion and society's norms and culture. Some community members were aware that culture is a determining factor, but it did not come out as strong as religion. In Ghana, stigma due to induced abortion is influenced by religion and the attitude of society to premarital sex (Payne *et al.,* 2013). In Ethiopia, a study found that in Amhara and Oromiya regions, induced abortion is considered a sin and the community believed that it is sought when the child is considered illegitimate (Kumbi *et al.,* 2008).

Research evidence has shown that women may resort to abortion despite their understanding of its immorality. A study in Cameroon found that women who had had an abortion were more concerned about its health impacts, and how to maintain secrecy than its legal restrictions or the immorality of the act (Schuster, 2005). Factors such as the desire to limit family size, the lack of a family planning method, unintended pregnancy due to sexual violence, especially in war zones, may transcend the limits of religious teachings on abortion in Muslim-dominated societies (Hessini, 2008). Therefore, an induced abortion may be carried out even if it is restricted by the laws or suppressed by the religion (Faúndes and Hardy, 1997).

7.3.3 Positive Perceptions About Induced Abortion

Participants who had a positive attitude to induced abortion made it clear that their main argument was taking into consideration factors leading to an induced abortion. They stressed that there is a need to understand what led a woman to have an induced abortion before judging her. Most students, providers, parents whose daughters had had an induced abortion and male participants who were involved in their partner's decision to have an induced abortion expressed

a positive perception of induced abortion. The extracts below provide more details on their perceptions.

> *… may be she didn't plan to become pregnant at that time and so for me it is ok for her to have an induced abortion [Female Student, Ward-1].*
>
> *I don't judge a person who has had an induced abortion because there are reasons that made her do that [Male, Ward-2].*
>
> *You know many factors may influence a woman to opt for an induced abortion. I cannot judge her because we don't know the circumstances which led her to have an induced abortion [Provider, Facility C].*

A male participant who agreed that his girlfriend should have an induced abortion said;

> *To me, I don't judge her negatively because I have been involved and I understand the circumstances which made us decide for an induced abortion [Male, Ward-1].*

Another male participant whose daughter had had an induced abortion had the following to say.

> *I regard an induced abortion as normal ... these are our children and they have their needs. I think we should be true to them that if they get pregnant we encourage them not to have an induced abortion. Some of them do so because of the harsh reactions from their parents [Male, Ward-1].*

Studies have shown that providers who have training on PAC services and who have experiences in delivering PAC services are more likely to have a positive attitude or may change their attitude to induced abortion. A study in Pakistan found that members of the community who are educated are more likely to have positive attitude to induced abortion and PAC (Azmat *et al.,* 2012).

Participants who had a positive attitude to induced abortion added that the community judges negatively a woman who had had an induced abortion but not the other people involved. They insisted that if the community is to judge, it should judge not only the woman but also the partner who was responsible for the pregnancy, particularly when the partner refused to take

responsibility for the pregnancy. Some participants further indicated that if the community is to judge, the providers of abortion, whether formal or informal, should also be labeled killers, since they assisted women in having an induced abortion. Some of them expressed their feelings that:

> *Regarding who to blame more than one person should be blamed. When a man denies the pregnancy, he should be blamed. If we are to make a judgment, then I think both the man and the woman are killers [Female, Ward-1].*
> *In other instances, these abortion providers should be blamed as well because they assist in killing [Female, Ward-2].*
>
> *Society regards her as a cruel person who does not fit into the community. In addition, the girl gets all the blame but she did not commit the act independently. Even in school, you find that the boy goes on with his studies while the girl is expelled. Most young girls do not want to do it, or the parents who are involved, and most of them regret what they have done. What I am insisting on is that they girls should not be the only ones blamed [Female, Ward-1].*

Studies have shown that a woman may decide to have an induced abortion without informing her partner. Sometimes the partner may convince her to have an induced abortion and in other instances, both may agree for her to have an induced abortion (Svanemyr and Sundby, 2007; Rasch and Lyaruu 2005; Bennett, 2005). Therefore, judging a partner may depend on his role in influencing his partner to have an induced abortion.

7.3.3 Perceptions About Spontaneous Abortion

The study found that the participants' perceptions on spontaneous abortion were positive. Spontaneous abortion was less stigmatized than an induced abortion. The study found that owing to the non-stigmatization of abortion, majority of women with abortion-related complications report them as due to spontaneous abortion even when they are due to induced abortion. The providers of PAC services also admitted that women usually report induced abortion-related complications as due to spontaneous abortion because spontaneous abortion is less stigmatized.

Fear of being arrested, stigma and the fear of being charged more by the healthcare providers came out as the main factors which may influence women to report an induced abortion as spontaneous. The extracts below provide more details.

> *Due to stigma and fear of being arrested, most of them do not reveal that it was an induced abortion, they report it as a spontaneous abortion [Provider, Facility A].*
>
> *... they do not tell the doctors that they have had an induced abortion, but most of them lie that it was spontaneous and doctors can't deny them the service [Religious Leader, Christian-2].*
>
> *When she reaches the hospital, she does not state directly that she had an induced abortion ... rather she tells the doctor that it just happened by itself because they fear that they may be charged more money by the doctors [Female, Ward-1].*

This finding corresponds with a study in Uganda, where providers of PAC expressed their positive perception of spontaneous abortion. In that study, providers were asked to rank their readiness to treat a woman who had had a spontaneous abortion and a woman who had had an induced abortion. The providers were more willing to assist a woman with a spontaneous abortion than a woman with an induced abortion. Self-induced abortions were considered to add to the workload of the nurses and midwives, making them frustrated (Paul *et al.,* 2014).

7.4 Perceptions About PAC Services

The study found that both community members and healthcare providers had positive perceptions about PAC services. They were of the view that PAC services should be available and provided to all women who have experienced abortion- related complications. Providers of PAC services and Christian religious leaders had a positive perception about PAC services. They considered them as among the necessary health services. Four major reasons were put forward by the participants for their positive perception about PAC services that: absence of PAC services may lead to more deaths; not all complications are caused by induced abortion; induced

abortion is sometimes reported as spontaneous abortion; and PAC clients have the right to access care. The four reasons are discussed in detail hereafter.

7.4.1 Absence of PAC Services May Lead to Maternal Mortality

The first reason put forward by the participants was that the absence of PAC services might lead to more cases of maternal mortality. They were aware of the health impacts of induced abortion such as excessive bleeding and infections which may lead to deaths if care was not provided. Thus, they insisted that PAC is an important for preventing maternal mortality. The participants supported their points that:

> *I support PAC services because if they were not there more women would die and it would be a loss [Male, Ward-1].*
>
> *I agree that these services should be provided, otherwise most of our young girls will die from bleeding and infection [Female, Ward-1].*
>
> *I can say that these services (PAC) should be there, otherwise if you deny them more women will die [Religious Leader, Christian-1].*
>
> *I think they should be there (PAC services) because if they are not there these women will die. So, it will be homicide [Religious Leader, Christian-2].*

Like the community members, the providers admitted that PAC services are necessary for women to avoid maternal mortality associated with abortion-related complications. They pointed out that:

> *We have experience of treating women with abortion-related complications…I am trying to imagine if PAC was not provided, we would have lost a lot of lives [Provider, Facility B].*
>
> *Post-abortion care is an important service because it saves lives of women, it should be available at all levels of healthcare [Provider, Facility C].*
>
> *To me, PAC is an important service although induced abortion is illegal because if you do not offer PAC, maternal mortality may rise because we receive clients who are in a critical condition. Such patients may die if these services are not available [Provider, Facility A].*

Community members and providers who had negative perceptions on induced abortion supported the provision of PAC services. Their support was due to their understanding of the impact of induced abortion on women's lives. They understood the contribution of induced abortion-related complications to maternal mortality and therefore the need for PAC services. Likewise, the healthcare providers supported PAC services on the same grounds that it is a necessary service to avoid maternal mortality, which corroborates a study in Uganda (Paul *et al.,* 2014). Abortion-related complications contribute to 13-25 percent of maternal mortality in Tanzania (Keogh *et al.,* 2015; MoHSW, 2008; Woog and Pembe, 2013) and over13 percent in the world (Singh *et al.,* 2009). All these deaths could be easily prevented by providing accessible and quality PAC services (Okonofua, 2006; Corbett and Turner, 2003; UNFPA,1995).

7.4.2 Not all Abortion Complications are Due to Induced Abortion

The second reason in the support of PAC services was that not all abortion-related complications are caused by induced abortion. Hence, if PAC services are not provided because induced abortion is illegal in Tanzania, justice will not be done to women who had lost their pregnancy unintentionally. Participants expressed that:

> *These services (PAC) must be there because of spontaneous abortion, which occurs suddenly. When this happens to women they must be given post-abortion care [Female, Ward-2].*
>
> *Post-abortion care must be there because there are some women whose abortion occurred unintentionally ... they should be treated [Female, Student, Ward-2].*
>
> *It is not possible to separate a woman having an induced abortion from a woman having a spontaneous abortion as regards to post-abortion care. As we have said, those having an induced abortion report it as spontaneous, and so PAC services should be provided on these grounds [Male, Ward-1].*

Women who experience spontaneous abortion also need PAC services although their complications may not be as fatal as that of induced abortion. Some of them may have an

emotional concern because they have lost an expected pregnancy. Therefore, counselling is very important. In addition, they need to wait for at least six months for the health subsequent birth and their health as well (Curtis, 2007; WHO, 2007b).

7.4.3 Induced Abortion is Sometimes Reported as Spontaneous Abortion

The third reason put by the participants was that induced abortion is sometimes reported as spontaneous abortion. The providers and the community members pointed out that, in most cases, it is difficult for a client to state directly that the complications were caused by induced abortion. The providers stressed that women who seek PAC services from a health facility are more likely to attribute the complications to spontaneous abortion even if they were caused by an induced abortion. They do so to avoid stigma and being arrested by the police. They added that in other instances, some users of PAC services reach the health facility in an unconscious state and so they cannot provide their history. Therefore, failure to provide PAC services to a woman experiencing abortion-related complications because of induced abortion becomes difficult. On these grounds, the participants maintained that PAC is a necessary service for all women who experience abortion-related complications. Their argument was supported by religious leaders and some participants. The following extracts provide more details:

> *Even though a woman has procured an induced abortion somewhere, she cannot tell you that she did something to end the pregnancy. Most of them report it as a spontaneous abortion although on examination you may notice that something was done to end the pregnancy [Provider, Facility B].*

> *They (women with induced abortion-related complications) should be given the service because when they reach the hospital they do not directly state that the complications were due to an induced abortion but that it has just happened by itself [Female, Ward-1].*

> *It is not easy for them (women with induced abortion-related complications) to tell you directly that the complications she is suffering from are caused by an induced abortion. They usually tell us that the abortion was spontaneous, and so we treat them; after all it is our duty to help them [Provider, Facility A].*

Some of them come to us when they are critically ill, to the extent that they cannot even provide their history. You cannot deny them services in such circumstances [Provider, Facility B].

These women (with induced abortion-related complications) go to the hospital when they have already procured the abortion at home. If that is the case, when they reach the hospital, they cannot be denied services because in the first place they do not tell the doctors they have had induced an abortion, but lie that it was spontaneous and doctors can't deny them the services [Religious Leader, Christian-2].

Users of PAC services reporting induced abortion as spontaneous abortion was found by Paul and colleagues (2014). Providers admitted that when the clients report that an induced abortion was spontaneous, it makes their job very frustrating and may cause them to maltreat the clients (Paul *et al.,* 2014).

7.3.4 The Right to Access Care

The fourth reason for supporting PAC services was that women who experience abortion -related complications have the right to access healthcare services regardless of the cause of the complications. This point was mostly made by the providers of PAC services, who reiterated that the users of PAC services are individuals who have the potential to contribute to the development of the nation. Thus, denying them PAC services means denying them the right to access healthcare and the right to contribute to the development of the nation. They stated clearly that:

These women (women with induced abortion-related complications) need to be provided with the service because it is their right to receive healthcare regardless of their condition [Provider, Facility C].
...PAC services are very important...she (a woman with induced abortion complications) is a citizen and she has something to contribute to the development of her country. If you let her die you have lost a member of the labour force [Male, Ward-1].

...They have equal rights to access healthcare just like other patients. Providing PAC services means you will save her life and that of living children if she has any [Provider, Facility C].

Nowadays, we insist that citizens be given training in their right to access healthcare, including PAC services. Therefore, women have the right to access PAC services when they suffer from abortion-related complications [Provider, Facility B].

The 1994 ICPD stressed on the importance of PAC services as a right for all women experiencing abortion-related complications (UNFPA, 1995). Thus, women who experience abortion-related complications have the right to access PAC services (Billings *et al.,* 2003). The provision of PAC services is likened to advancing women's rights, i.e. when women are provided with PAC services, especially in places where abortion is illegal, their right to access healthcare is advanced.

Some concerns were raised during the discussion regarding the positive perceptions of PAC services. They argued that though the government of Tanzania ensures/supports the provision of PAC services, it is likely that most women who need PAC services do not know about their availability. A female participant expressed her concern that:

I think these services are available but the problem is knowing about their availability. It seems many people do not know that these services are available and if they do they fear going to hospital because they think that what they have done is not right [Female, Ward-1].

Inadequate knowledge about the availability of PAC was found in this study, as discussed in detail in chapter five. Lack of knowledge of the availability of PAC services and fear of being stigmatized for having an induced abortion may lead to low utilization of PAC even where PAC is widely available (Azmat *et al.,* 2012).

It emerged from the discussion that it is possible that those who know about the availability of PAC know more about evacuation component of PAC services than about counselling and family planning. A participant who previously sought PAC services admitted that she did not know that counselling and family planning were part of PAC services. She was treated for the complications but she was given neither a family planning method nor counselling. She narrated that:

> *I didn't know that family planning and counselling are part of PAC. What I knew was that a woman experience abortion-related complications needs to be given a service, which is kusafishwa (evacuation). They only treated me, I was not told anything about family planning or counselling [Female, Ward-2].*

Some providers reported that lack of resources and low awareness of the availability of PAC and the right to PAC services are among the hindrances to accessing PAC. On the other hand, the providers added that there has been a slight increase in the utilization of PAC, which may be attributed to increased health education, friendly care and the presence of *daftari la msamaha*[10]. Some of the providers indicated that:

> *The government does not have enough resources to make sure that these services are available at all levels of healthcare and so clients move from facility to facility in search of PAC services [Provider, Facility C].*
>
> *What I can say is that many women do not know about PAC services and no efforts are being made to ensure that they come to a facility in the case of the complications…for spontaneous abortion it is different…we usually tell them during the antenatal visit that they should come to a facility as soon as they experience something different [Provider, Facility A].*
>
> *We must admit that it is possible that PAC services are not widely known. In addition to that, most women do not know that it is their right to access PAC in the case of complications. This is contributed to by stigma and the fear of being arrested, which is why they come to us when sometimes it is too late, and when they come they can hardly tell you that it was an induced abortion although you can see that it was [Provider, Facility B].*

[10] This is a programme in public health facilities to support patients who are unable to pay for health services.

Another concern raised by the community members was on the cost of PAC services. The concern was that some providers of PAC services may charge the users too much by taking the advantage of their poor knowledge of their right to PAC services. A participant shared the story of a relative who passed away at a certain facility (not among the study facilities) because she did not have money to pay for PAC services. In addition, she could not be offered PAC services after the providers of PAC discovered that the complications were caused by an induced abortion. A female participant shared a story that:

> *My younger brother had a relationship with a woman who became pregnant... Therefore, he decided to help her to get an induced abortion. They went to X (a pharmacy), where they inserted some drugs into her vagina and she was told to go back later. She did not notice any changes for three days. She started swelling and had stomach pains. So, she was sent to (Y) hospital but the providers did not help her when they discovered she had had an induced abortion. They did not have enough money to pay the doctors to help them and so she was not given any service. She stayed in the hospital for one day without receiving any treatment until her condition got worse. She was referred to Muhimbili National Hospital for treatment but she passed away before reaching the hospital [Female, Ward-2].*

High cost of PAC as a factor affecting its use has been documented as one of the challenges facing women in utilizing PAC services (Sathar *et al.,* 2013; Melkamu *et al.,* 2010; Kumbi *et al.,* 2008), which is consistent with the finding of this study. It should be noted that poor women living in rural areas are more disproportionately affected by the high cost of PAC services compared with women living in urban areas (Okonofua, 2006).

7.4.5 Negative Perceptions on PAC Services

A few participants had a negative perception on PAC services. They were mostly students and a Muslim religious leader. None of the providers and the older participants indicated negative perceptions on PAC services. The major argument of the participants not supporting PAC was that if PAC services were not provided/available, women would have to be more careful and

make sure that they use contraceptives or any other means to make sure that they do not fall pregnant. They argued that:

The second argument related to the legal status of abortion in Tanzania. The participants who had a negative perception on PAC services argued that since induced abortion is not permitted except in certain circumstances, there is no need to provide PAC services. If PAC services are provided, abortion should be legalized as well. They pointed out that:

> *I see is not proper to provide this services (PAC) to her because the government does not allow induced abortion [Female, Ward-1].*
> *If it is possible these services should not be provided… it is a sin to kill and the one who commits murder should also be killed according to religious teachings. I don't see the need to help her by providing PAC services when abortion is against the law… [Religious Leader, Islam].*

7.5 Conclusion

The study found that the perceptions of the community on induced abortion were negative. Induced abortion was perceived as a sin, murder, and a bad thing. A woman who had had an induced abortion was perceived as a murderer, cruel person and someone who does not want to give birth. Religion and state laws rather than culture of the community influenced the negative perceptions of the community on induced abortion. This implies that religion and laws on abortion have an influence on how community perceives induced abortion.

The perceptions of the community on PAC services was positive despite their negative perceptions on induced abortion. They agreed that the absence of PAC services is likely to lead to more deaths. Access to PAC services was viewed as a right to all women who experience abortion-related complications. PAC services were considered as among the necessary health service because not all abortion-related complications are caused by induced abortion. The

community members noted that PAC services are not widely known and the cost of PAC services is likely to be high, hence majority of women who need them may not afford them. This finding suggest that PAC services can be accepted in setting where abortion is stigmatized and criminalized. However, its acceptability will largely depend on the extent to which they are known and affordable to the community. In addition, that fact that the community understands the impact of induced abortion and the right to care regardless of the causes of the complications further signals the acceptability of PAC services.

CHAPTER EIGHT

SUMMARY, CONCLUSION AND RECOMMENDATIONS

8.1 Introduction

This study investigated the factors associated with utilization of PAC services in Temeke district of Dar es Salaam. The study identified the characteristics of the users of PAC services, factors that facilitated and those that hindered utilization of PAC services. It also explored the perceptions of the providers and the users about the quality of PAC services. Furthermore, the study sought to identify and document community's perceptions on abortion and PAC services.

The study was cross-sectional and conducted in three health facilities between June 2014 and February 2015. The study was mainly qualitative. However, quantitative information was collected on the basic characteristics of the users of PAC services. It used purposive sampling to recruit the study participants. A total of 103 users of PAC services, 16 providers of PAC services, 6 non-users of PAC services and 7 key informants (4 CHWs and 3 Religious leaders) participated in the study. In addition, a total of 10 FGDs were carried among the community members. The study used exit-interviews, in-depth interviews, FGDs and direct observation to collect information. Descriptive analysis was the main approach used in data analysis. For the quantitative information, frequency and percentage tables, mean, median and cross tabulation were performed. For the qualitative information, descriptive thematic analysis was used. Inductive and deductive approaches were used to generate themes from the qualitative information.

8.2 Summary of the Results

The study found that more than 45 percent of the users of PAC services were below 25 years. More than half (64.1 percent) were not married. About half (50.5 percent) had primary education, 43.7 percent had secondary education and 5.8 percent had tertiary education. More than half (61.3 percent) did not have formal employment while 12.6 percent were still attending to school. Almost all the users of PAC services came from within Temeke distict. Only 4.9 percent were from outside Temeke. Having a high proportion of younger women (below 24) utilizing PAC services from health facilities may be associated with improvement in health seeking behaviour among this group.

The study found that factors that facilitated the use of PAC services in the study facilities were: sharing of information about one's health status, receiving financial support to carter for transport and treatment cost, availability of PAC services, availability of transport, privacy and short waiting time. The study found that very few (34 percent) users of PAC services were aware about PAC services before they had shared information about their health status. This finding is an indication of low awareness of the availability of PAC services.

The study found that factors that hindered the utilization of PAC services among the non-users of PAC services were: fear of being arrested by the police because of an illegal induced abortion, fear of the negative reactions by the providers of PAC services, fear of been seen at a health facility by relatives and friends and lack of money to meet the treatment cost. The study recognizes that six cases of the non-users of PAC services may not be sufficient to generalize on the factors that may hinder utilization of PAC services. However, they have helped add information on possible factors that may hinder utilization of PAC services.

The study found that most users of PAC services rated the quality of services as satisfactory. However, there were some concerns raised by the providers and the users. The main concerns raised by the providers were the shortage of staff, lack of on-the-job training and inadequate essential equipment and supplies. It was found that inadequate essential equipment was contributed by difficulties in ordering equipment because of current procurement procedures. The users were concerned about the lack of privacy due to limited facility space and high cost of PAC services. The study also found that the two public facilities charged different fees for PAC services while the cost of PAC services at the private facility was fixed and sometimes less than what was charged in the public facilities.

The study found that MVA was used as a method of uterine evacuation in the study facilities. This is a credit to the study facilities. The use of MVA is recommended in the management of abortion complications because it is less painful, easy to use and can be used in places where there is no electricity. Another important finding was the presence of special programs in the three facilities to help users of PAC services who were not able to pay for the services. This is considered a factor which can facilitate utilization of PAC services.

The study found that all the facilities provided PAC counselling and family planning services onsite. However, some of the users left the facility without being counselled and without a family planning method. The study also found that in some facilities, PAC services were not offered in the same location where the treatment was done. One of the facilities did not offer family planning and counselling on the same day of treatment. Some providers indicted that some of the users left the facility before they were offered a family planning or counselling perhaps because of fear of being arrested by a police for having an illegal induced abortion. On

the other hand, some of the users who did not receive contraceptives or counselling reported that they were not informed about counselling and family planning services.

The study found that the community perceived induced abortion as a sin or murder. Women who had had an induced abortion were perceived as murderers, cruel, heartless and women who do not want to give birth. Religion came out as the main factor that influenced community's perceptions on induced abortion. The community members and the providers had positive perceptions on PAC services. PAC services were considered necessary services because their absence may lead to more maternal mortality. The study further noted that, PAC services were considered a right to all women who need them despite the causes of the complications. Community members indicated that despite the government's commitment to provide PAC services, these services are not known to most of the community members. They further noted that the cost of PAC services is high thus majority of women who need PAC are not able to afford them.

8.3 Conclusion

This study concludes that women with abortion complications can utilize PAC services regardless of their age, marital status or their socioeconomic backgrounds. Their utilization of PAC services is facilitated if PAC services are available, well known, affordable and there is a reliable and affordable transport to reach to the health facility. On the other hand, stigma and criminalization of abortion can hinder utilization of PAC services. Women who need PAC services may not seek proper care following abortion complications for fear of being arrested by the police for having an illegal induced abortion. It should be noted that failure to seek PAC

services following abortion complications can increase the risks of negative health impacts as well as the increased costs for treating the complications.

Provision of quality PAC services can facilitate their utilization. The quality of PAC services is enhanced when the providers are available and adequate, and the equipment and essential supplies necessary to deliver PAC services are available at health facilities. Availability of the providers, equipment and essential supplies can lead to timely provision of PAC services thereby reducing the chances of congestion at health facilities. It also helps to ensure that none of the users of PAC misses any of the components of PAC service since each component is important to patients requiring them. Ensuring privacy during the delivery of PAC services is very important for continued use of the services. Privacy can help to minimize the number of patients leaving the facility before completing care because of fear of being arrested by the police or because of stigma.

Induced abortion may be perceived negatively in settings where abortion is illegal or where it is condemned by religion. On the other hand, PAC services may be perceived positively in such settings. The positive perception on PAC services in such settings suggest the acceptability of the services. Nonetheless, the acceptability of PAC services in such settings will depend on the extent to which the services are known to the community and the extent to which they are affordable.

This study was guided by the 1995 Andersen's model of healthcare utilization. Even though the model is criticized for not paying attention to societal interaction and culture, Andersen argues that the culture and social interaction are included in the predisposing factors (Guendelman,

1991, Portes *et al.,* 1992). Certain variables may play a dual role in the utilization of health services (Andersen and Davidson, 2001). The 1995

The Andersen model was used in this study because it takes into consideration individual, community and healthcare system factors can influence utilization of healthcare (Bradley *et al.,* 2002). Being a framework of analysis and a model that can be used in qualitative or quantitative study, the model guided in the selection of the aspects of utilization of care to be included in the study. The study found that the users of the PAC services in the study facilities were young and unmarried. Age and marital status are the predisposing factor in utilization of health services as suggested by Andersen's the model. Knowledge of the availability of PAC services was a predisposing factor for utilization of PAC services. Ability to pay for PAC services, providers' attitudes were some of the enabling factors for the utilization of PAC services.

8.4 Recommendations

The results of this study have several implications for policy programming (action) and for further research.

8.4.1 Recommendations for Action

The study found that majority of the users of PAC services were below 24 years. This study recommends that for continued use of care among this group, increasing the levels of awareness about PAC services is important. In addition, issues of privacy and affordability of the services should be taken in to consideration to enhance utilization.

The study found that the knowledge of PAC services was low among the users before they had shared information about their health status. This study recommends that concerted efforts

should be made to create awareness about the PAC and the availability of PAC services in the country. Raising awareness about the services may help to reduce fear and stigma thus enhancing prompt seeking of care following abortion complications.

The study found that there was shortage of providers in the study facilities. The shortage of providers is likely to affect the delivery and quality of PAC services. The study recommends that efforts should be made to ensure that providers are adequate. Adequate providers will help to ensure that users of PAC services do not spend much time at health facilities. It will also help to reduce congestion at the facilities therefore reducing the chances of clients sharing hospital beds. In addition, adequate providers will help to minimize the number of patients leaving the facilities without completing care. The availability of the providers should go hand in hand with regular on-the-job training to make them aware of changes in the delivery of PAC services. This study recommends also recommends that efforts should be made to enable health facilities to have necessary equipment and supplies at the right time.

The study found that some of the users of PAC services missed counselling and family planning services. Most of the users who missed counselling services were those who utilized PAC services in the facility where family planning services were being offered at a separate section from the treatment place and those who sought care from the facility where counselling and family planning services were not offered at the same time as the treatment. This study recommends that family planning and counselling services should be offered in the same place/section to avoid clients moving from one location to another therefore missing some components of care. The study also recommends that there should be a regulation on when

counselling and family planning are offered to users of PAC services at the same day of treatment to avoid the low turn up among the clients.

The study also found that lack of privacy during the delivery of PAC services and during counselling was a concern to some of the users. Therefore, concerted efforts should be made to ensure that privacy is maintained throughout the care to enhance utilization of PAC services.

The study found that the charges of PAC services ranged from to 20,00Tsh-100,000Tsh (12-60). Close to half of the users indicated that the charges were high. This study recommends that MoHSW should ensure that the cost of PAC services in the public and private health facilities should be fair. The MoHSW should make it mandatory to the private and public facilities to have visible billboards indicating the prices of PAC services to help the public aware of the services and the cost.

The study found that the non-users did not seek of PAC services from health facilities because of fear of providers' negative reactions for having an induced abortion and fear of being arrested by the policy for having an illegal induced abortion. This study recommends that efforts should be made to educate the community about PAC issues to raise the levels of awareness about the availability of the services to reduce the fear of legal reprisals fear of being stigmatized by the providers.

The study revealed that the community's perceptions about PAC services were positive despite their negative perceptions about induced abortion. This suggest an acceptability of PAC services in legally restricted and stigmatized settings. This study acknowledges the efforts of the government to provide PAC services despite abortion being legally restricted in Tanzania.

Therefore, the study recommends that the government should make efforts to rise the levels of awareness about PAC services and the importance of seeking care immediately following abortion complications.

8.4.2 Recommendations for Further Research

This study found that some women experienced abortion complications but did not seek care from health facilities. The main factors that hindered their utilization of PAC services were fear of being arrested by the police, fear of the provider's negative reactions about their induced abortion and lack of money to pay for the services. These factors cannot be generalizable given the limited sample size which was contributed by difficulties in recruiting many non-users of PAC services. This study recommends for more research at community level which can recruit a considerable number of the non-users of PAC services. Such studies will provide more insights on factors that hinder utilization of PAC services.

The study found that the perceptions of the community about induced abortion was negative but their perceptions about PAC services were positive. This study did not establish how the community's perceptions about abortion and PAC services can influence the use of PAC services. This study recommends further research on how the perceptions of the community about abortion and PAC can influence utilization of PAC services.

REFERENCES

ACQUIRE 2007. Community Postabortion Care Project (COMMPAC) in Nakuru District, Kenya: Summary Report, Phase I—July 2005–September 2006. New York: The ACQUIRE Project/ EngenderHealth.

Aday, L. A. & Andersen, R. 1974. "A Framework for the Study of Access to Medical Care". *Health Services Research,* 9**,** 208–220.

Adinma, E. D. 2012. Post Abortion Care Services in Nigeria. *In:* Sifakis, S. & Vrachnis, N. (eds.) *From Preconception to Postpartum.* InTech. Available from: http://www.intechopen.com/books/from-preconception-to-postpartum/post-abortion-care-services.

Ahmed, S., Adams, A., Chowdhury, M. & Bhuiya, A. 2000. Gender, Socioeconomic Development and Health-Seeking Behaviour in Bangladesh. *Soc Sci Med,* 51(3)**,** 361-71.

Aliyu, A. A., Bello, M. U., Kasim, R. & Martin, D. 2014. Positivist and Non-Positivist Paradigm in Social Science Research: Conflicting Paradigms or Perfect Partners. *Journal of Management and Sustainability,* 4(3)**,** 79-95.

Amaratunga, D., Baldry, D., Sarshar, M. & Newton, R. 2002. Quantitative and Qualitative Research in the Built Environment: Application of "Mixed" Research Approach. *Work Study,* 51(1)**,** 17-31.

Andersen, R. & Davidson, P. 2001. Improving Access to Care in America: Individual and Contextual Indicators. *In:* Andersen, R., Rice, T. & Kominski, E. (eds.) *Changing the U.S. Health Care System: Key Issues in Health Services, Policy, and Management.* San Francisco, CA: Jossey-Bass.

Andersen, R. & Newman, J. F. 1973. Societal and Individual Determinants of Medical Care Utilization in the United States. *Health and Society,* 51(1)**,** 95-124.

Andersen, R. M. 1995. Revisiting the Behavioral Model and Access to Medical Care: Does It Matter? *Journal of Health and Social Behavior,* 36 (1)**,** 1-10.

Anderson, J. G. 1973. Health Services Utilization:Framework and Review. *Health Service Research***,** 184-199.

Anderson, R. 1968. A Behavioral Model of Families' Use of Health Services.Research Series No. 25. Chicago: University of Chicago Press.

Astbury-Ward, E., Parry, O. & Carnwell, R. 2012. Stigma, Abortion, and Disclosure—Findings from a Qualitative Study. *J Sex Med* 9**,** 137-3147.

AU 2003. Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa. African Union.

Awoyemi, T. T., Obayelu, O. A. & Opaluwa, H. I. 2011. Effect of Distance on Utilization of Health Care Services in Rural Kogi State, Nigeria. *J Hum Ecol,* 35(1)**,** 1-9.

Azmat, S. K., Shaikh, B. T., Mustafa, G., Hameed, W. & Bilgrami, M. 2012. Delivering Post-Abortion Care Through A Community-Based Reproductive Health Volunteer Programme in Pakistan. *J. Biosoc. Sci,* 00**,** 1-13.

Babalola, S. & Fatusi, A. 2006. Determinants of Use of Maternal Health Services in Nigeria - Looking Beyond Individual and Household Factors. *BMC Pregnancy and Childbirth,* 9:43.

Baltussen, R. & Ye, Y. 2006. Quality of Care of Modern Health Services as Perceived by Users and Non-Users in Burkina Faso. *International Journal for Quality in Health Care,* 18(1)**,** 30–34.

Bankole, A., Singh, S. & Haas, T. 1999. Characteristics of Women Who Obtain Induced Abortion: A Worldwide Review. *International Family Planning Perspectives,* 25(2)**,** 68-77.

Bègue, L. 2001. Social Judgment of Abortion: A Black-Sheep Effect in A Catholic Sheepfold. *J Soc Psychol,* 141(5)**,** 640-9.

Bennett, L. R. 2001. Single Women's Experiences of Premarital Pregnancy and Induced Abortion in Lombok, Eastern Indonesia. *Reproductive Health Matters,* 9(17)**,** 37-43.

Bennett, L. R. 2005. Patterns of Resistance and Transgression in Eastern Indonesia: Single Women's Practices of Clandestine Courtship and Cohabitation. *Culture, Health & Sexuality,* 7(2)**,** 101-112.

Berg, B. L. 2004. *Qualitative Reserch for Social Sciences*, Pearson Education.

Betron, M. 2008. Gender-Based Violence in Tanzania: An Assessment of Policies, Services, and Promising Interventions. *USAID Health Policy Initiative, Task Order 1*.

Billings, D. L., Veldsquez, J. F. & Cuevas, R. P. R.-. 2003. Comparing the Quality of Three Models of Postabortion Care in Public Hospitals in Mexico City. *International Family Planning Perspectives,* 29(3)**,** 112-120.

Birungi, H., Mugisha, F., Nsabagasani, X., Okuomi, S. & Jeppsson, A. 2001. The Policy on Public–Private Mix in the Ugandan Health Sector: Catching up with Reality. *Health Policy and Planning,* 16(2)**,** 80-87.

Boyce, C. & Neale, P. 2006. Conducting In-Depth Interviews: A Guide for Designing and Conducting In-Depth Interviews for Evaluation Input. Pathfinder International.

Braam, T. & Hessini, L. 2004. The Power Dynamics Perpetuating Unsafe Abortion in Africa: A Feminist Perspective. *AfrJ Reprod Health,* 8(1)**,** 43-51.

Bradley, E. H., Mcgraw, S. A., Curry, L., Alison Buckser, King, K. L., Kasl, S. V. & Andersen, R. 2002. Expanding the Andersen Model: The Role of Psychosocial Factors in Long-Term Care Use. *Health Services Research,* 37:5**,** 1221-1242.

Brown, C., Barner, J., Bohman, T. & Richards, K. 2009. A Multivariate Test of an Expanded Andersen Health Care Utilization Model for Complementary and Alternative Medicine (CAM) Use in African Americans. *The Journal of Alternative and Complementary Medicine,* 15(8)**,** 911-919.

Bruyn, M. & Packer, S. 2004. Adolescents, Unwanted Pregnancy and Abortion. Policies, Counseling and Clinical Care. Chapel Hill, North Carolina: Ipas.

Bryman, A. 2007. Barriers to Integrating Quantitative and Qualitative Research. *Journal of Mixed Methods Research,* 1(1)**,** 8-22.

Caldwell, J. C. 1986. Routes to Low Mortality in Poor Countries. *Population and Development Review,* 12(2)**,** 171-220.

Ceylan, A., Ertem, M., Saka, G. & Akdeniz, N. 2009. Post Abortion Family Planning Counseling as A Tool to Increase Contraception Use. *BMC Public Health,* 9:20.

Chakraborty, N., Islam, M. A., Chowdhury, R. I., Bari, W. & Akhter, H. H. 2003. Determinants of the Use of Maternal Health Services in Rural Bangladesh. *Health Promotion International,* 18(4)**,** 327-337.

Cochran, J. K., Chamlin, M. B., Beeghley, L., Hamden, A. & Blackwell, B. S. 1996. Religious Stability, Endogamy, and the Effects of Personal Religiosity on Attitudes Toward Abortion. *Sociology of Religion,* 57:3**,** 291-309.

Corbett, M. R. & Turner, K. L. 2003. Essential Elements of Postabortion Care: Origins, Evolution and Future Directions. *International Family Planning Perspectives,* 29**,** 106-111.

Creswell, J. 2002. *Educational Research: Planning, Conducting, and Evaluating Quantitative and Qualitative Research,* Saddle River, NJ, Prentice Hall.

Creswell, J. 2009. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, Sage Publications.

Curtis, C. 2007. Meeting Health Care Needs of Women Experiencing Complications of Miscarriage and Unsafe Abortion: USAID's Postabortion Care Program. *J. Midwifery Women's Health,* 52(4).

Curtis, C., Huber, D. & Moss-Knight, T. 2010. Postabortion Family Planning: Addressing the Cycle of Repeat Unintended Pregnancy and Abortion. *International Perspectives on Sexual and Reproductive Health,* 36(1)**,** 44-48.

Czachesz, I. 2011. Women, Charity and Mobility in Early Christianity Weak: Links and the Historical Transformation of Religions. *In:* CZACHESZ, I. & BIRÓ, T. (eds.) *Religion and Cognition Through the Ages.* Leuven - Paris - Walpole: Peeters.

Demtsu, B., Bugssa, G. & Alemu, A. 2014. Assessment of Quality and Determinant Factors of Post-Abortion Care in Governmental Hospitals of Tigray, Ethiopia, 2013. *Fam Med Med Sci Res,* 3(4).

Ejano, N. E. 2011. Unsafe Abortion: The Preventable Pandemic That Consumes Thousands of Women's Lives. Available at: prochoicenetwork.wordpress.com/2011/06/28/tanzania-unsafe-abortion-the-preventable-pandemic-that-consumes-thousands-of-women's-lives/ 30/8/2011.

Fairhurst, L., Rowswell, P. & Nhleko, L. 2012. ICLEI – Local Governments for Sustainability – Africa Dar es Salaam Baseline Study. ICLEI – Local Governments for Sustainability - Africa.

Faúndes, A. & Hardy, E. 1997. Illegal Abortion: Consequences for Women's Health and The Health Care System. *Int J Gynaecol Obstet,* 58(1)**,** 77-83.

Ferreira, A. L. C. G., Boa-Viagem, M. M. & Souza, A. I. 2015. Contraceptive Continuation, Pregnancy and Abortion Rate Two Years after Post Abortion Counselling. *Open Journal of Obstetrics and Gynecology,* 5**,** 135-141.

Fetters, T., Akiode, A. & Oji, E. 2004. *Putting Quality First: An assessment of postabortion care services at Murtala Muhammad Specialist Hospital in Kano, Nigeria,* Chapel Hill, NC, Ipas.

Fitsum, G., Jira, C. & Girma, B. 2011. Health Services Utilization and Associated Factors in Jimma Zone, South West Ethiopia. *Ethiop J Health Sci,* 21**,** 91-100.

Fitzpatrick, R. 1991. Surveys of Patient Satisfaction: Important General Considerations. *BMJ,* 302**,** 887-9.

Fomba, S., Yang, Y., Zhou, H., Liu, Q. & Xiao, P. M. 2010. Patient's Utilization and Perception of the Quality of Curative Care in Community Health Centers of the Fifth Commune of Bsamako. *Indian J Community Med,* 35(2)**,** 256–261.

Geary, C. W., Gebreselassie, H., Awah, P. & Pearson, E. 2012. Attitudes Toward Abortion in Zambia. *International Journal of Gynecology and Obstetrics,* 118(2)**,** S148–S151.

Gebreselassie, H., Fetters, T., Singh, S., Abdella, A., Gebrehiwot, Y., Tesfaye, S., Geressu, T. & Kumbi, S. 2010. Caring for Women with Abortion Complications In Ethiopia: National Estimates and Future Implications. *International Perspectives on Sexual and Reproductive Health,* 36(1)**,** 6-15.

Graff, M. & Amoyaw, D. A. 2009. Barriers to Sustainable MVA Supply in Ghana: Challenges for the Low-Volume, Low-Income Providers. *Afr J Reprod Health,* 13(4)**,** 73-80.

Grimes, D. A., Benson, J., Singh, S., Romero, M., Ganatra, B., Okonofua, F. E. & Shah, I. H. 2006. Unsafe Abortion: The Preventable Pandemic. *Lancet,* 368**,** 1908-19.

Guendelman, S. 1991. Health Care Users Residing on the Mexican Border What Factors Determine Choice of the U.S. or Mexican Health System? *Medical Care, Vol. 29, No. 5 (May, 1991), pp. 419-429,* 29(5)**,** 419-429.

GUTTMACHER 2012. Facts on Abortion in Africa, Issues In Brief. Guttmacher Institute.

Haddad, L. B. & Nour, N. M. 2009. Unsafe Abortion: Unnecessary Maternal Mortality. *Rev Obstet Gynecol,* 2(2)**,** 122-126.

Hammersley, M. & Atkinson, P. 1995. *Ethnography: Principles in Practice,* London, Routledge.

Harries, J., Stinson, K. & Orner, P. 2009. Health Care Providers' Attitudes Towards Termination of Pregnancy: A Qualitative Study in South Africa. *BMC Public Health,* 9:296.

Hausmann-Muela, S., Ribera, J. M. & Nyamongo, I. 2003. Health-Seeking Behaviour and The Health System Response. DCPP Working Paper No. 14.

Henshaw, S., Adewole, I., Singh, S., Bankole, A., Oye-Adeniran, B., Hussain, R. & Sedgh, G. 2005. Characteristics of Women Seeking Abortion Services and Post-Abortion Care in

Nigerian Hospitals. *The International Union for the Scientific Study of Population,General Conference, July 2005.* Tours, France.

Henshaw, S. K., Adewole, I., Singh, S., Bankole, A., Oye-Adeniran, B. & Hussain, R. 2008. Severity and Cost of Unsafe Abortion Complications Treated in Nigerian Hospitals. *International Family Planning Perspectives,* 34**,** 40–50.

Hessini, L. 2008. Islam and Abortion: The Diversity of Discourses and Practices. *IDS Bulletin,* 39(3)**,** 18-27.

Hyman, A. G. & Castleman, L. 2005. Woman-Centered Abortion Care: Reference Manual. Chapel Hill, NC Ipas.

Igun, U. A. 1979. Stages in Health-Seeking: A Descriptive Model. *Social Science & Medicine. Part A: Medical Psychology & Medical Sociology,* 13**,** 445-456.

Jain, A., Makawia, A., Searing, H., Schlecht, J., Pile, J. M., Lusiola, G., Wickstrom, J., Ntabaye, M., Kanama, J. & Manongi, L. 2006. Tanzania Baseline Survey 2004–2005:Technical Report. E&R Study #4. New York: EngenderHealth/The ACQUIRE Project.

Janz, N. K. & Becker, M. H. 1984. The Health Belief Model: A Decade Later. *Health Eucation Quartley,* 11(1)**,** 1-47.

Jejeebhoy, S. J. 1995. *Women's Education, Autonomy, and Reproductive Behaviour: Experience From Developing Countries,* Oxford, Clarendon Press.

Jejeebhoy, S. J. & Sathar, Z. A. 2001. Women's Autonomy in India and Pakistan: The Influence of Religion and Region. *Population and Development Review,* 27(4)**,** 687-712.

Jerant, A., Bertakis, K. D., Fenton, J. J. & Franks, P. 2013. Gender of Physician as the Usual Source of Care and Patient Health Care Utilization and Mortality. *J Am Board Fam Med,* 26(2)**,** 138 –148.

Johnston, H. B., Ved, R., Lyall, N. & Agarwal, K. 2003. Where do Rural Women Obtain Postabortion Care? The Case of Uttar Pradesh, India. *International Family Planning Perspectives,* 29(4).

Jones, R. K. & Dreweke, J. 2011. Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use. New York: Guttmacher Institute.

Katterl, R. 2011. Socioeconomic Status and Accessibility to Health Care Services in Australia. *PHCRI RESEARCH ROUNDup,* 22.

Keogh, S. C., Kimaro, G., Muganyizi, P., Philbin, J., Kahwa, A., Ngadaya, E. & Bankole, A. 2015. Incidence of Induced Abortion and Post-Abortion Care in Tanzania. *PLoS ONE,* 10(9).

Kevany, S., Murima, O., Singh, B., Hlubinka, D., Kulich, M., Morin, S. F. & Sweat, M. 2012. Socio-Economic Status and Health Care Utilization in Rural Zimbabwe: Findings from Project Accept (HPTN 043). *J Public Health Africa,* 7(3)**,** 46-51.

Khan, K. S., Wojdyla, D., Say, L., Gülmezoglu, A. M. & Look, P. F. A. V. 2006. WHO Analysis of Causes of Maternal Death: A Systematic Review. *Lancet,* 367**,** 1066–74.

Kida, T. 2012. Provision and Access of Health Care Services in the Urban Health Care Market in Tanzania: ESRF Discussion Paper No. 42. The Economic and Social Foundation (ESRF).

Kidder, E., Sonneveldt, E. & Hardee, K. 2004. Who Receives PAC Services? Evidence from 14 Countries. The Futures Group POLICY Project.

Kitzinger, J. 1995. Introducing Focus Groups. *BMJ,* 311**,** 299-302.

Krauss, S. E. 2005. Research Paradigms and Meaning Making: A Primer. *The Qualitative Report,* 10(4)**,** 758-770.

Kruk, M. E., Rockers, P. C., Mbaruku, G., Paczkowski, M. M. & Galea, S. 2010. Community and Health System Factors Associated with Facility Delivery in Rural Tanzania: A Multilevel Analysis. *Health Policy,* 97**,** 209-216.

Kumar, A., Hessini, L. & Mitchell, E. M. H. 2009. Conceptualising Abortion Stigma. *Culture, Health & Sexuality,* 11(6)**,** 625–639.

Kumar, R. R. 2005. *Research Methodology a Step-By-Step Guide for Beginners,* India, SAGE Publication.

Kumbi, S., Melkamu, Y. & Yeneneh, H. 2008. Quality of Post-Abortion Care in Public Health Facilities in Ethiopia. *Ethiop.J.Health Dev,* 22(1)**,** 26-33.

Kwesigabo, G., Mwangu, M. A., Kakoko, D. C., Warriner, I., Mkony, C. A., Killewo, J., Macfarlane, S. B., Kaaya, E. E. & Freeman, P. 2012. Tanzania's Health System and Workforce Crisis. *Journal of Public Health Policy,* 33, S35-S44.

Lauro, D. 2011. Abortion and Contraceptive Use in Sub-Saharan Africa: How Women Plan Their Families. *Afr J Reprod Health,* 15(1)**,** 13-23.

Leech, N. L. & Onwuegbuzie, A. J. 2009. A Typology of Mixed Methods Research Designs. *Qual Quant,* 43**,** 265–275.

León, R. G. P. D., Billings, D. L. & Barrionuevo, K. 2006. Woman-Centered Post-Abortion Care in Public Hospitals in Tucumán, Argentina: Assessing Quality of Care and Its Link to Human Rights. *Health and Human Rights,* 9(1)**,** 174-201.

Likwa, R., Biddlecom, A. & Ball, H. 2009. Unsafe Abortion in Zambia. *Issues in Brief (Alan Guttmacher Institute),* 3**,** 1-4.

Likwa, R. & Whittaker, M. 1996. The Characteristics of Women Presenting for Abortion and Complications of Illegal Abortions at the University Teaching Hospital, Lusaka, Zambia: An Explorative Study. *Afr J Fertil Sexual Reprod Heal,* 1(1)**,** 42-9.

Littenberg, B., Strauss, K., Maclean, C. D. & Troy, A. R. 2006. The Use of Insulin Declines as Patients Live Farther from Their Source of Care: Results of A Survey of Adults with Type 2 Diabetes. *BMC Public Health,* 6:198.

Loi, U. R., Gemzell-Danielsson, K., Faxelid, E. & Klingberg-Allvin, M. 2015. Health Care Providers' Perceptions of and Attitudes Towards Induced Abortions in Sub-Saharan Africa and Southeast Asia: A Systematic Literature Review of Qualitative and Quantitative Data. *BMC Public Health,* 15:139.

López-Cevallos, D. F. & Chi, C. 2010. Assessing the Context of Health Care Utilization in Ecuador: A Spatial and Multilevel Analysis. *BMC Health Services Research,* 10:64.

Lwelamira, J. & Safari, J. 2012. Choice of Place for Childbirth: Prevalence and Determinants of Health Facility Delivery Among Women in Bahi District, Central Tannzania *Asian Journal of Medical Science,* 4(3)**,** 105-112.

Mack, N., Woodsong, C., Queen, K. M. M., Guest, G. & Namey, E. 2005. Qualitative Research Methods: A Data Collector's Field Guide. Family Health International.

Mackian, S., Bedri, N. & Lovel, H. 2004. Up The Garden Path and Over the Edge: Where Might Health-Seeking Behaviour Take Us? *Health Policy and Planning,* 19(3)**,** 137-146.

Mashindano, O. & Maro, F. 2011. Growth Without Poverty Reduction in Tanzania: Reasons for the Mismatch. *Chronic Poverty Research Centre: Working Paper No. 207*.

Melkamu, Y., Betre, M. & Tesfaye, S. 2010. Utilization of Post-Abortion Care Services in Three Regional States of Ethiopia. *Ethiop. J. Health Dev,* 24(1)**,** 23-129.

MoH 2000a. National Package of Essential Health Interventions. Dar es Salaam, Tanzania: Mninstry of Health.

MoH 2000b. National Package of Essential Reproductive and Child Health Interventions. Dar es Salaam, Tanzania: Ministry of Health.

MoH 2002. Postabortion Care Clinical Skill Curiculum: Trainer's Guide Vol.1. Ministry of Health, Tanzania.

MoH 2003a. National Health Policy. Monistry of Health,United Republic of Tanzania.

MoH 2003b. National Policy Guidelines for Reproductive and Child Health Services. Dar es Salaam, Tanzania: Ministry of Health.

MoHSW 2007. Standard Treatment Guidelines (STG) and The National Essential Medicines List (NEMLIT) for Mainland Tanzania. Dar es Salaam, Tanzania: Ministry of Health and Social Welfare.

MoHSW 2008. The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008 – 2015. Dar es Salaam, Tanzania: Ministry of Health and Social Welfare.

MoHSW, MOH, NBS, OCGS & ICF 2015. Tanzania Service Provision Assessment Survey (TSPA) 2014-15. Dar es Salaam, Tanzania, and Rockville, Maryland, USA: Ministry of Health and Social Welfare (MoHSW) [Tanzania Mainland], Ministry of Health (MoH) [Zanzibar], National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF International.

MoHSW, UNFPA & WHO 2011. Survey of All Public and Faith Based Organization Health Facilities to Establish the Availability of Emergrncy Obstretric Care Equipment. Ministry of Health and Social Welfare, United Nations Population Fund, World Health Organization.

Msiska, R., Mangawe, E., Mulenga, D., Sichone, M., Kamanga, J. & Kwapa, P. 1997. Understanding Lay Perspectives: Care Options for STD Treatment in Lusaka, Zambia. *Health Policy and Planning,* 12(3)**,** 248-252.

Mundingo, A. I. 2006. Determinants of Unsafe Induced Abortion in Developing Countries. *In:* Warriner, I. K. & Shah, I. H. (Eds.) *Preventing Unsafe Abortion and its Consequences Priorities for Research and Action.* New York: Guttmacher Institute.

Mwanga, F., Rimoy, M., Killian, R., Kanama, J., Ishengoma, J. & Kikumbih, N. 2013. Increasing Access to and Use of Comprehensive Post-Abortion Care (cPAC) Services:

Evidence from Tanzania. *2013 National Family Planning Conference, October 9 –11, 2013.* Dar es Salaam, Tanzania.

NBS 2009. Household Budget Survey 2007 – Tanzania Mainland. National Bureau of Statistics.

NBS & ICF 2011. 2010 Tanzania Demographic and Health Survey: Key Findings. Calverton, Maryland, USA: NBS and ICF Macro.

NBS, MOF & OCGS 2013. 2012 Population and Housing Census: Population Distribution by Administrative Areas. National Bureau of Statistics, Ministry of Finance Dar es Salaam and Office of Chief Government Statistician President's Office, Finance, Economy and Development Planning Zanzibar.

NBS, MOF & OCGS 2014. Basic Demographic and Socio-Economic Profile Report Tanzania Mainland. National Bureau of Statistics, Ministry of Finance -Dar es Salaam and Office of Chief Government Statistician Ministry of State -Zanzibar.

NBS & OCGS 2013. Population Distribution by Age and Sex. National Bureau of Statistics and Ministry of Finance, Dar es Salaam & Office of Chief Government Statistician President's Office, Finance, Economy and Development Planning, Zanzibar.

NBS & RCO 2014. Dar es Salaam Region Socio-Economic Profile, 2014. National Bureau of Statistics and Dar es Salaam Regional Commissioner's Office.

NBS & SRCO 2007. Shinyanga Regional Socio-Economic Profile. Dar es Salaam: National Bureau of Staistics and Sinyanga Regional Commissioner's Office.

Nielsen, K. K., Lusiola, G., Kanama, J., Bantambya, J., Kikumbih, N. & Rasch, V. 2009. Expanding Comprehensive Postabortion Care to Primary Health Facilities in Geita District,Tanzania. *Afr J Reprod Health,* 13(2)**,** 129-138.

Noh, S., Gagne, J.-P. & Kasper, V. 1994. Models of Health Behaviours Compliance:Application to Audiological Rehabilitation Research *In:* GAUGNE, J. P. & TYE-MURRAY, N. (eds.) *Research in audilogical rehabilitation: Current trends and future directions (Monograph)* Journal of the Academy of Rehabilitative Audiology.

O'hara, B. & Caswell, K. 2012. Health Status, Health Insurance, and Medical Services Utilization: 2010. *Current Population Reports***,** 70-133.

Okonofua, F. 2006. Abortion and Maternal Mortality in the Developing World. *J Obstet Gynaecol Can,* 28(1)**,** 974-979.

Paul, M., Gemzell-Danielsson, K., Kiggundu, C., Namugenyi, R. & Klingberg-Allvin, M. 2014. Barriers and Facilitators in The Provision of Post-Abortion Care at District Level in Central Uganda – A Qualitative Study Focusing on Task Sharing Between Physicians and Midwives. *BMC Health Services Research,* 14:28.

Payne, C. M., Debbink, M. P., Steele, E. A., Buck, C. T., Martin, L. A., Hassinger, J. A. & Harris, L. H. 2013. Why Women are Dying From Unsafe Abortion: Narratives of Ghanaian Abortion Providers. *Afr J Reprod Health,* 17(2)**,** 118-128.

PCC 2002. Essential Elements of Postabortion Care: An Expanded and Updated Model. Postabortion Care Consortium.

PCC 2014. Fact Sheet: Essential Supplies for Postabortion Care. Postabortion Care Consortium.

Peters, D. H., Yazbeck, A. S., Sharma, R. R., Ramana, G. N. V., Pritchett, L., H & Wagstaff, A. 2002. Better Health Systems for India's Poor: Findings, Analysis, and Options. Washington, DC: World Bank.

Phillips, K. A., Morrison, K. R., Andersen, R. & Aday, L. A. 1998. Understanding the Context of Healthcare Utilization: Assessing Environmental and Provider-Related Variables in the Behavioral Model of Utilization. *Health Services Research,* 33(3)**,** 571-596.

Plummer, M. L., Wamoyi, J., Nyalali, K., Mshana, G., Shigongo, Z. S., Ross, D. A. & Wight, D. 2008. Abortion and Supsending Pregnancy in Rural Tanzania: An Ethnoghraphy of Young people's Beliefs and Pactices. *Studies in Family Planning,* 39(4)**,** 281-292.

Portes, A., Kyle, D. & Eaton, W. W. 1992. Mental Illness and Help-seeking Behavior Among Mariel Cuban and Haitian Refugees in South Florida. *Journal of Health and Social Behavior,* 33(4)**,** 283-298.

PRB 2010. Gender-Based Violence: Impediment to Reproductive Health. Population Reference Bureau.

Price, N. 2004. Addressing the Reproductive Health Needs and Rights of Young People since ICPD: The contribution of UNFPA and IPPF. UNFPA and IPPF Evaluation: Synthesis Report.

Rahman, A., Katzive, L. & Henshaw, S. K. 1998. A Global Review of Laws on Induced Abortion, 1985-1997. *International Family Planning Perspectives,* 24(2)**,** 56-64.

Rasch, V. & Kipingili, R. 2009. Unsafe Abortion in Urban and Rural Tanzania: Method, Provider and Consequences. *Tropical Medicine and International Health,* 14(9)**,** 1128–1133.

Rasch, V. & Lyaruu, M. A. 2005. Unsafe Abortion in Tanzania and the Need for Involving Men in Postabortion Contraceptive Counseling. *Studies In Family Planning,* 36(4)**,** 301-310.

Rasch, V., Massawe, S., Yambesi, F. & Bergstrom, S. 2004. Acceptance of Contraceptives Among Women Who Had an Unsafe Abortion in Dar Es Salaam. *Tropical Medicine and International Health,* 9(3)**,** 399–405.

Rasch, V., Silberschmidt, M., Mchumvu, Y. & Mmary, V. 2000. Adolescent Girls with Illegally Induced Abortion in Dar es Salaam: The Discrepancybetween Sexual Behaviour and Lack of Access to Contraception. *Reproductive Health Matters,* 8(15)**,** 52-62.

Rasch, V., Yambesi, F. & Massawe, S. 2006. Post-Abortion Care and Voluntary HIV Counselling and Testing –An Example of Integrating HIV Prevention into Reproductive Health Services. *Tropical Medicine and International Health,* 11(5)**,** 697–704.

Rasch, V., Yambesi, F. & Massawe, S. 2008. Medium and Long-Term Adherence to Postabortion Contraception Among Women Having Experienced Unsafe Abortion in Dar es Salaam, Tanzania. *BMC Pregnancy and Childbirth,* 8:32.

Rasheed, N., Arya, S., Acharya, A. & Khandekar, J. 2012. Client Satisfaction and Perception About Quality of Health Care at A Primary Health Centre of Delhi, India. *Indian Journal of Community Health,* 24(3)**,** 237-242.

Rawlins, B., Brechin, S. J. G. & Giri, K. 2001. An Assessment of the Quality of Postabortion Care Services in Nepal:Training and Service Delivery Perspectives. United States Agency for International Development.

Rehan, N. 2003. Attitudes of Health Care Providers to Induced Abortion in Pakistan. *JPMA,* 53:293.

Saksena, P., Xu, K., Elovainio, R. & Perrot, J. 2012. Utilization and Expenditure at Public and Private Facilities in 39 Low-Income Countries. *Tropical Medicine & International Health,* 17(1)**,** 23-35.

Sandelowski, M. 2000. Focus on Research Methods Combining Qualitative and Quantitative Sampling, Data Collection, and Analysis Techniques in Mixed-Method Studies. *Research in Nursing & Health,* 23(3)**,** 246-255.

Sathar, Z., Singh, S., Shah, Z. H., Rashida, G., Kamran, I. & Eshal, K. 2013. Post-Abortion Care in Pakistan: A National Study. The Population Council.

Scheppers, E., Van Dongen, E., Dekker, J., Geertzen, J. & Dekker, J. 2006. Potential Barriers to The Use of Health Services Among Ethnic Minorities: A Review. *Family Practice,* 23(3)**,** 325-348.

Schuster, S. 2005. Abortion in the Moral World of the Cameroon Grassfields. *Reproductive Health Matters,* 13(26)**,** 130-138.

Sedgh, G., Singh, S. & Shah, I. 2012. Induced Abortion: Incidence and Trends Worldwide From 1995 to 2008. New York, NY,USA: Guttmacher Institute.

Senderowitz, J. 1999. Making Reproductive Health Services Youth Friendly, Research, Program and Policy Series. FOCUS on Young Adults.

Shah, I. & Ahman, E. 2004. Age Patterns of Unsafe Abortion in Developing Country Regions. *Reprod Health Matters,* 12(24)**,** 9–17.

Shah, I. & Ahman, E. 2009. Unsafe Abortion: Global and Regional Incidence, Trends, Consequences, and Challenges. *J Obstet Gynaecol Can,* 31(12)**,** 1149-58.

Shaikh, B. T. 2005. Quality of Health Care: An Absolute Necessity for Patient Satisfaction. *J Pak Med Assoc,* 55(11)**,** 515-516.

Shaikh, B. T. & Hatcher, J. 2004. Health Seeking Behaviour and Health Service Utilization in Pakistan: Challenging The Policy Makers. *Journal of Public Health,* 27(1)**,** 49-54.

Sharan, M., Ahmed, S. & Strobino, D. 2005. Influence of Women's Autonomy and Access to Health Services on Maternal Health Care Utilization in Rural India. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health.

Silberschmidt, M. & Rasch, V. 2001. Adolescent Girls, Illegal Abortions and ''Sugar-Daddies'' In Dar Es Salaam: Vulnerable Victims and Active Social Agents. *Social Science & Medicine,* 52**,** 1815–1826.

Singh, M. K., Singh, J. V., Ahmad, N., Kumari, R. & Khanna, A. 2010a. Factors Influencing Utilization of ASHA Services Under NRHM in Relation to Maternal Health in Rural Lucknow. *Indian J Community,* 35:4**,** 414-9.

Singh, S. 2006. Hospital Admissions Resulting from Unsafe Abortion: Estimates from 13 Developing Countries. *Lancet,* 368(9550)**,** 1887-92.

Singh, S., Fetters, T., Gebreselassie, H., Abdella, A., Gebrehiwot, Y., Kumbi, S. & Audam, S. 2010b. The Estimated Incidence of Induced Abortion In Ethiopia, 2008. *International Perspectives on Sexual and Reproductive Health,* 36(1)**,** 16-25.

Singh, S., Wulf, D., Hussain, R., Bankole, A. & Sedgh, G. 2009. *Abortion Worldwide: A Decade of Uneven Progress,* New York, Guttmacher Institute.

Srivastava, C., Kumar, R. R., Shikha, S., Roy, C. S. K. & Singh, H. K. 2013. Unsafe Abortion: A Study in a Tertiary Care Hospital. *Journal of Indian Academy of Forensic Medicine,* 35**,** 2011-2015.

Stöckl, H., Filippi, V., Watts, C. & Mbwambo, J. K. 2012. Induced Abortion, Pregnancy Loss and Intimate Partner Violence in Tanzania: A Population Based Study. *BMC Pregnancy and Childbirth,* 12:2.

Strecher, V. J. & Rosenstock, I. M. 1997. The Health Belief Model. *In:* Baum, A., Newman, S., Weinman, J., West, R. & Mcmanus, C. (eds.) *Cabridge Handbook of Psychology,Health and Medicine.* United Kingdom: Press Syndicate of the University of Cambridge.

Suchman, E. A. 1965. Stages of Illness and Medical Care. *Journal of Health and Human Behavior,* 6(3)**,** 114-128.

Suri, H. 2011. Purposeful Sampling in Qualitative Research Synthesis. *Qualitative Research Journal,* 11(2)**,** 64-75.

Svanemyr, J. & Sundby, J. 2007. The Social Context of Induced Abortions Among Young Couples in Côte d'Ivoire. *Afr J Reprod Health,* 11(2)**,** 14-23.

Tabbutt-Henry, J. & Graff, K. 2003. Client-Provider Communication in Postabortion Care. *International Family Planning Perspectives,* 29(3)**,** 126-129.

Teddlie, C. & Yu, F. 2007. Mixed Methods Sampling A Typology With Examples. *Journal of Mixed Methods Research,* 1(1)**,** 77-100.

Thiam, F. T. 2006. Scaling Up Postabortion Care Services: Results from Senegal. *Management Sciences for Health (Occasional Papers),* NO. 5

Thomas, D. R. 2006. A General Inductive Approach for Analyzing Qualitative Evaluation Data. *American Journal of Evaluation,* 27**,** 237-246.

Tomlinson, L. M. 2003. Patient and Practitioner Literacy and Women's Health: A Global View from the Closing Decade 1990-2000. *Ethnicity & Disease,* 13**,** 248-258.

Tong, W. T., Low, W. Y., Wong, Y. L., Choong, S. P. & Jegasothy, R. 2012. Exploring Pregnancy Termination Experiences and Needs Among Malaysian Women: A Qualitative Study. *BMC Public Health,* 12:743.

UN 2012. The Millennium Development Goals Report 2012. New York: United Nations.

UN 2015. Sustainable Development Goals: 17 Goals to Transform Our World. United Nations.

UNFPA 1995. International Conference on Population and Development - ICPD - Programme of Action. UNFPA.

URT 1981. Penal Code:Chapter 16 of the Laws (Revised) (Principal Legislation). Dares Salaam: United Republic of Tanzania

URT 2006. Support To Maternal Mortality Reduction Project: Appraisal Report. Human Development Department Health Division.

URT 2007. Welfare Indicators Temeke Municipal Council. Prime Minister's Office, Regional Administration and Local Government.

URT 2011. A Performance Audit On the Monitoring, Evaluations and Budget Allocation for Maternal Health Care Activities in Tanzania. Dar es Salaam,Tanzania: Naational Audit Office.

URT 2013. Summary and Analysis of the Comprehensive Council Health Plans 2013/2014. Ministry of Health and Social Welfare and Prime Minister's Office Regional Administration and Local Government.

URT Undated. Tanzania Mainland National Health Accounts 2009/10. Ministry of Health and Social Welfare

Vlassoff, M., Altaf Hossain, Maddow-Zimet, I., Singh, S. & Bhuiyan, H. U. 2012. Menstrual Regulation and Postabortion Care in Bangladesh: Factors Associated with Access to and Quality of Services. New York: Guttmacher Institute, <http://www.guttmacher.org/pubs/.

VSI 2011. Tanzania Fights Maternal Mortality, Registers Misoprostol for Post-abortion Care Services. http://www.medicalabortionconsortium.org/news/tanzania-fights-maternal-mortality-registers-misoprostol-for-postabortion-care-services-1330.html. Accessed 25.4.2013.

Wanjiru, M., Askew, I., Munguti, N., Ramarao, S., Homan, R., Kahando, R. & Pile, J. M. 2007. Assessing The Feasibility, Acceptability and Cost of Introducing Postabortion Care in Health Centres and Dispensaries in Rural Tanzania. Wshington, DC: Population Council.

Wariki, W. M. V., Ali, M., Mori, R., Wantania, J. J., Kuroiwa, C. & Shibuya, K. 2015. Post-Abortion Care in North Sulawesi, Indonesia: Patients Determinants in Selection of Health Facility. *Quality in Primary Care,* 23(3)**,** 181-188.

Webb, D. 2000. Attitudes to 'Kaponya Mafumo': The Terminators of Pregnancy in Urban Zambia. *Health Policy and Planning,* 15(2)**,** 186-193.

WHO 2001. World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. Declaration of Helsinki. Bulletin of the World Health Organization.

WHO 2002. World Report on Violnce and Health: Summary. Geneva: World Health Organization.

WHO 2005. WHO Multi-Country Study on Women's Health and Domestic Violence Against Women: Initial Results on Prevalence, Health Outcomes and Women's Responses. World Health Organization.

WHO 2006. The World Health Report 2006: Working Together for Health. Geneva, Switzerland: World Health Organization.

WHO 2007a. Everybody Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework For Action. Geneva, Switzerland: World Health Organization.

WHO 2007b. Report of a WHO Technical Consultation on Birth Spacing. Geneva, Switzerland: Department of Making Pregnacy Safer & Depatment of Reproductive Health and Research.

WHO 2007c. Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003, 5th Edition. World Health Organization.

WHO 2010. Gender, Women and Primary Health Care Renewal. A Discussion Paper. World Health Organization.

WHO 2011. Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008. 6th ed. Geneva: World Health Organization.

WHO 2012. Unsafe Abortion Incidence and Mortality Global and Regional Levels in 2008 and Trends During 1990 –2008. World Health Organization.

WHO 2013. Maternal, Newborn, Child and Adolescent Health. World Health Organzation. http://www.who.int/maternal_child_adolescent/en/. Accessed on 26/04/2014.

Witmer, A., Seifer, S. D., Finocchio, L., Leslie, J. & Edward H. O'neil 1995. Community Health Workers: Integral Members of the Health Care Work Force. *American Journal of Public Health,* 85(8)**,** 1055-1058.

Wong, L. P. 2008. Focus Group Discussion: A Tool for Health and Medical Research. *Singapore Med J,* 49(3)**,** 256-261.

Woog, V. & Pembe, A. 2013. Unsafe Abortion in Tanzania: A Review of the Evidence. *Issues Brief (Alan Guttmacher Inst),* 1**,** 1-4.

Zemene, A., Feleke, A., Alemu, A., Yitayih, G. & Fantahun, A. 2014. Factors Influencing Utilization of Post Abortion Care in Selected Governmental Health Institutions, Addis Ababa, Ethiopia. *Family Medicine & Medical Science Research,* 3:1.

APPENDICES

Appendix I: Research Permit and Consent Forms

(i)

UNIVERSITY OF NAIROBI
POPULATION STUDIES AND RESEARCH INSTITUTE

Phone (02) 318262 Ext. 28029
Telex Fax (254) 02-2245566
Telex: 23095 Varsity Nairobi, Kenya

P.O. Box 30197
00100 Nairobi, Kenya
Telegrams Varsity

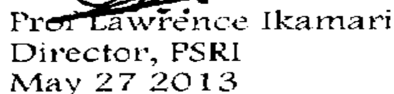
TO WHOM IT MAY CONCERN

RE: MS EVALINE GABRIEL MCHARO

Ms Evaline Mcharo is a bonafide PhD student of the University of Nairobi with the registration number Q80/83341/2012. She is doing research for her PhD titled **'Factors Associated with Utilization of Postabortion care (PAC) Services in Tanzania: A Case Study of Temeke District of Dar es Salaam'**. Ms. Mcharo's research proposal has been approved by the University of Nairobi thereafter reviewed by National institute for Medical Research (NIMR) and obtained a certificate attached herewith. She is now at data collection stage. The data will be collected in Temeke municipality in three health facilities. The study will involve interviewing post abortion care patients and healthcare providers in Temeke Hospital, Marie Stops – Temeke and Mbagala Rangi3 Health Centre; Focus group discussion with community members and key informants interviews.

Before data collection in Temeke District, Ms. Mcharo will conduct a few interviews with post abortion care patients and healthcare providers in Amana Hospital in Ilala District to check for clarity and completeness of her research instruments.

It is my greatest hope that you will accord her the necessary support whenever needed.



Prof Lawrence Ikamari
Director, PSRI
May 27 2013

ISO 9001:2008 CERTIFIED

THE UNITED REPUBLIC OF
TANZANIA

National Institute for Medical Research
P.O. Box 9653
Dar es Salaam
Tel: 255 22 2121400/390
Fax: 255 22 2121380/2121360
E-mail: headquarters@nimr.or.tz

Ministry of Health and Social Welfare
P.O. Box 9083
Dar es Salaam
Tel: 255 22 2120262-7
Fax: 255 22 2110986

NIMR/HQ/R.8a/Vol. IX/1724

12th May 2014

Evaline G Mcharo
Faculty of Humanities and Social Sciences
Dar es Salaam University College of Education (DUCE)
P O Box 2329 DAR ES SALAAM

CLEARANCE CERTIFICATE FOR CONDUCTING MEDICAL RESEARCH IN TANZANIA

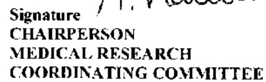
This is to certify that the research entitled: Factors Associated with Utilization of Post abortion Care (PAC) Services in Tanzania: A case study of Temeke District of Dar es Salaam, (Mcharo E G *et al*), has been granted ethical clearance to be conducted in Tanzania.

The Principal Investigator of the study must ensure that the following conditions are fulfilled:

1. Progress report is submitted to the Ministry of Health and the National Institute for Medical Research, Regional and District Medical Officers after every six months.
2. Permission to publish the results is obtained from National Institute for Medical Research.
3. Copies of final publications are made available to the Ministry of Health & Social Welfare and the National Institute for Medical Research.
4. Any researcher, who contravenes or fails to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine. NIMR Act No. 23 of 1979, PART III Section 10(2).
5. Site: Temeke Hospital, Maries Stopes- Temeke and Mbagala Rangi Tatu Health Centre. In Temeke District

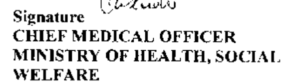
Approval is for one year: 12th May 2014 to 11th May 2015.

Name: Dr Mwelecele N Malecela



Signature
CHAIRPERSON
MEDICAL RESEARCH
COORDINATING COMMITTEE

Name: Dr Donan Mmbando



Signature
CHIEF MEDICAL OFFICER
MINISTRY OF HEALTH, SOCIAL WELFARE

CC: RMO
DED
DMO

TEMEKE MUNICIPAL COUNCIL

ALL COMMUNICATIONS TO BE ADDRESSED TO MUNICIPAL DIRECTOR

P.O.Box. 45232
Tel: 2850142

TEMEKE MUNICIPAL MEDICAL
OFFICE OF HEALTH
DAR ES SALAAM
TANZANIA.

Date 1/05/2014

The Medical Officer I/C
Temeke Referral & Regional Hospital
Rangi Tatu Hospital
Marie Stopes Dispensary

REF; PERMISSION TO CONDUCT HEALTH RESEARCH ACTIVITIES IN TEMEKE MUNICIPALITY.

Please refer to the above heading.
Permission has been granted to Mr. /Mrs/Ms/Prof. /Dr. EVALINE G. MCHARO
From (Institution) UNIVERSITY OF NAIROBI Address BOX 30197, 00100 NAIROBI - KENYA
Tel. No. 0713 668268 to collect data for research work at your institution.

The research title is
FACTORS ASSOCIATED WITH UTILIZATION OF POST ABORTION CARE (PAC) SERVICES IN TANZANIA: A CASE STUDY OF TEMEKE DISTRICT OF DAR ES SALAAM

S/he has submitted a proposal for the mentioned study to the MMOH Office as a pre - condition prior to authorisation.

The researcher has been instructed and agreed to submit the research progress reports and final results to the MMOH prior to any publications.

Data collection will start from 1st JUN/2014/ to 30th/NOV/2014
Sample size 199

This research work is part of academic fulfilment for Diploma/Advanced Diploma/Degree/Master/PhD /its part of the ongoing research in your Institution.

I am kindly requesting you to give him/her the necessary assistance so as to accomplish this task timely.

Yours Sincerely

Dr. M.Mashombo

For; Temeke Municipal Medical Officer of Health

Copy 1. ....
2. ....

TEMEKE MUNICIPAL COUNCIL

[All letters should be addressed to the Municipal Director]

Tell: +255 22-2851054
Fax: +255 22-2850640
E- mail: temekemanispaa@raha.com
website: temekemanispaa-tz.org

P.O.Box: 46343,
Mandela Road
DAR ES SALAAM,
TANZANIA.

Ref. No. TMC/MD/ U.29/30

Date: 01/07/2014

[illegible], CHANGOMBE, [illegible]
TEMEKE MUNICIPAL COUNCIL

RE: RESEARCH/PROJECT PERMIT FOR: EVALINE GABRIEL MLOARO

Please refer to the heading above

This is to inform you that, permission is granted to the above mentioned student from UNIVERSITY OF NAIROBI to conduct research on FACTORS ASSOCIATED WITH UTILIZATION OF POSTABORTION CARE SERVICES IN TANZANIA: A CASE STUDY OF TEMEKE MUNICIPALITY IN DAR-ES-SALAAM

This permit will effect from date of this letter.

Please give them necessary assistance.

J.W.Temihango
For: MUNICIPAL DIRECTOR
TEMEKE

ILALA MUNICIPAL COUNCIL

ALL COMMUNICATIONS TO BE ADDRESSED TO THE MUNICIPAL DIRECTOR

P.O. BOX 20950
PHONE NO: 2128800
2128805
FAX NO. 2121486

MUNICIPAL OFFICE
ILALA

Ref: IMC / MED / R.18 / 5VOL.X/163

Date: 30 May, 2014

Medical Officer in Charge
Amana Hospital
ILALA MUNICIPALITY

RE: PERMISSION TO CONDUCT A RESERCH

Please refer to the heading above.

Evaline G. Mcharo is a PhD candidate at University of Nairobi in Kenya. She is doing a PhD intervention project titled; "**Factors associated with Utilization of Post abortion care (PAC) services in Tanzania: A case study of Ilala Municipal-Dar es Salaam".** Evaline is expecting to visit **Amana hospital** for implementation purposes aimed to improve maternal, newborn and family health in the country.

For this reason the office of MMOH has given her a permission to access the required information from your health facility.

I kindly request your assistance in the whole period of intervention at your facility.

Dr Yusuph A. Nangeda

For: **MMOH Office- Ilala**

Copy: **Researcher**

CONSENT FORM

I am Evaline Gabriel Mcharo, a research student at the University of Nairobi Kenya. I am doing a research on **Factors Associated with Utilization of Postabortion Care (PAC) Services in Tanzania: A Case Study of Temeke District of Dar es Salaam.** I would like to discuss with you some issues regarding this topic. You are being chosen to take part in this research because you have used these services, therefore your experience as a user may facilitate the understanding of the topic.

Your participation in this study is voluntary. You are free to take part or not. You are also free not to respond to some questions and also to quit from the interview at any time you wish. Your choice not to participate in this study will not have any effect on your treatment at this health facility. That means nothing will change regarding services you receive at this health facility. During the interview, you will be asked to share some confidential and personal information which you may not be comfortable to talk about. You are free not to share such information and you do not have to explain to the investigator the reasons for not sharing.

During the interview, I will sit with you in a room in this health facility where no one else except the researcher will be present. The entire interview will be tape recorded but your name will not be identified. If you do not want the interview to be tape recorded, please feel free to do so. The information recorded is confidential and no one else except the researcher will have access to the recorded information. If you have any question or an area, you need more clarification please feel free to ask.

The information you are going to provide will help us to understand factors associated with utilization of post abortion care services in Tanzania. It will also be of help to the government, policy makers as well as organizations dealing with provision of post-abortion care services in Tanzania.

For more information, you may contact the following:

1. Dr. Emiliana Mwita
Dean, Faculty of Humanities and Social Sciences
Dar es Salaam University College of education
Box 2329
Dar es Salaam
Mob: +255 754 809 878
Email: emyrh@yahoo.com

2. Prof Lawrence Ikamari
University of Nairobi P.0.BOX
P.O BOX 30197, 00100
Nairobi-Kenya
Tel +254 318262
Email likamari@uonbi.ac.ke

FOMU YA KUSHIRIKI KATIKA UTAFITI

Mimi ninaitwa Evaline Gabriel Mcharo, mtafiti kutoka chuo kikuu cha Nairobi, Kenya. Ninafanya utafiti juu ya: **Mambo yanayohusiana na matumizi ya huduma zitolewazo baada ya mama kuharibikiwa/kuharibu mimba**. Utafiti huu unafanyika katika wilaya ya Temeke, Dar es Salaam. Nitapenda kujadiliana nawe juu ya suala hili kwa sababu wewe ni mmoja wa watumiaji wa huduma hii. Ninaamini kuwa uzoefu wako kama ukiwa ni mtumiaji wa huduma hii utasaidia katika uelewa wa mada yetu. Ushiriki wako katika mjadala huu ni wa hiari. Pia una hiari kujibu au kutojibu baadhi ya maswali, unaweza kujitoa katika mahojiano mara utakapojisikia kufanya hivi. Kushiriki au kutoshiriki kwako hakutakuathiri kwa namna yoyote ile katika kupatiwa huduma katika kituo hiki.

Baadhi ya maswali utakayoulizwa yanaweza kuhitaji uongee mambo yako ya siri, na unaweza usijisikie vizuri kuyazungumzia. Una uhuru wa kukubali kujibu maswali kama haya au la, bila kuwajibika kujieleza ni kwanini hutaki kuyazungumzia.

Majadiliano yatafanyika kwenye chumba chenye utulivu na usiri na yatarekodiwa, lakini jina lako halitawekwa wazi. Iwapo hutapenda majadiliano yetu yarekodiwe jisikie huru kulisema hili. Taarifa zitakazorediwa zitatunzwa kwa usiri mkubwa, hakuna mtu atakayeruhusiwa kuziona isipokuwa timu yetu ya utafiti tu. Iwapo una swali lolote tafadhali uliza na niko tayari kukujibu.

Taarifa utakazotoa zitatusaidia kuelewa mambo yanayohusiana na matumizi ya huduma zitolewazo baada ya mama kuharibu/kuharibikiwa na mimba nchini mwetu. Tunatarajia kuwa matokeo ya utafiti huu yatatupa mwanga juu ya maeneo yanayohitaji kuboreshwa. Pia yatasaidia serikali, watunga sera na taasisi mbalimbali zinazojihusisha na utoaji wa huduma hizi nchini mwetu.

Kwa maelezo zaidi, tafadhali wasiliana na wafuatao:

Dr. Emiliana Mwita
Dean, Faculty of Humanities and Social Sciences
Dar es Salaam University College of education
Box 2329
Dar es Salaam
Mob: +255 754 809 878
Email:emyrh@yahoo.com

Prof Lawrence Ikamari
University of Nairobi P.0.BOX
P.O BOX 30197, 00100
Nairobi-Kenya
Tel +254 318262
Email likamari@uonbi.ac.ke

Appendix II: Research Instruments

INTERVIEW GUIDE FOR THE USERS OF PAC SERVICES

This questionnaire was administered to the users of PAC services when they were about to leave the health facility. The aim of the interview was to solicit information on the factors that facilitated their seeking of care and their perceptions on the quality of services they have received. Questions on quality of PAC were based on the international recommendations of quality PAC services.

FACILITY AND CLIENT'S BACKGROUND INFORMATION

Facility's Code*: ______________________Date of Interview: ___________________

Ward _______________________

Type of Facility: 1. Government __❒ 2. Private__❒

Level of the Facility: _____________________________ (e.g., Health Center, Hospital)

Interviewer's Names _________________________

(Codes were assigned to each participating facility instead of using their actual names for confidentiality purposes).*

A: CLIENTS' SOCIOECONOMIC AND DEMOGRAPHIC INFORMATTION

(i) Age of the client (in years) _________

(ii) Marital status: Single _❒ Married_❒ Cohabiting_ ❒Separated/Divorced _❒

(iii) Client's religion 1. Christian_ ❒ 2. Muslim_ ❒ 3. No religion_ ❒

(iv) Client's highest level of education: 1. No education _❒ 2. Primary_❒
3. Secondary_❒4. College_❒ 5. University_❒

(v) Current place of residence: Ward ________District _________Region_______

(vi) Occupation: 1. Employed_ ❒2. Farming_ ❒3. Housewife _❒4. Petty trade
5. Under family support_ ❒6. Other (Specify) ____________

B: CONTRACEPTIVE USE HISTORY

(i) Have you ever used a contraceptive method (s)? 1. Yes_ ❒ 2. No_ ❒

(ii) Which method have ever used *(put a tick).*

(a) Male condom ()
(b) Female condoms ()
(c) Pills ()
(d) Norplant ()
(e) Cervical diaphragm ()
(f) Spermicides ()
(g) Injectable ()
(h) Loop ()
(i) Natural methods ()

(iii) Were you using a contraceptive method in the time of conception?
1. Yes_ ❒ 2. No_ ❒
(iv) If **NO**, why? _____

D: FACTORS THAT BROUGHT THE CLIENT TO A HEALTH FACILITY

(i) When did your problem start? ______________________
(for clients who stayed more than one-day probe why they didn't seek care immediately)
(ii) Did you communicate your health problem to someone? 1. Yes_ ❒ 2. No_ ❒
(iii) If YES pleas indicate whom you communicated your health problem with 1. Partner_ ❒ 2. Friend_ ❒ 3. Relative_ ❒ 4. Parent_ ❒ 5. Neighbour_ ❒
6. Provider_ ❒ Other (specify) ________
(iv) Who made the decision for you to seek care? 1. Myself_ ❒ 2. Partner/husband_ ❒
3. Parents_ ❒ 4. Other (specify) _______
(v) Did you know about PAC services before? 1. Yes_ ❒ 2. No _ ❒
(vi) Where did you get information about PAC?
1. Healthcare provider_ ❒ 2. Friend _❒ 3. Mass media_ ❒4. Parents_ ❒
5. Posters ❒ 6. Other (specify) ______
(vii) Did you visit any other facility for the same services before you came here?
1. Yes_ ❒ 2. No_ ❒
(viii) If **YES,** what type of facility did you visit? 1. Pharmacy_ ❒
2. Public health centre_ ❒ 3. Private health centre _ ❒ 4. Private dispensary _ ❒ Public dispensary 5. Private Hospital_ ❒ 6. Public hospital _ ❒ 7. Traditional healer 8. Self-medication _ ❒9. Other (specify) ___________
(ix) If you visited that facility, why did you come to this facility? __________
(x) How did you reach the facility? 1. On foot_ ❒ 2. Public bus_ ❒
3. Hired car (taxi) ❒ 4. Private Transport_ ❒ 5. Motorcycle/Bajaj_ ❒
Other (specify) _________________
(xi) Who catered for the transport costs? 1. Myself_ ❒
2. Partner/husband _ ❒ 3. Relatives_ ❒ 4. Parents_ ❒ 5. Friend_ ❒
6. Other (specify) _________
(xii) How much time did you use to reach this facility?
1. Less than an hour_ ❒2. One hour_ ❒ 3. More than one hour_ ❒
4. Other (specify) _______________

E: PROVIDERS' GENDER

(i) What is the gender of the provider (s) attended you today?
1. Male_ ❒ 2. Female_ ❒ 3. Both _ ❒
(ii) Did you feel comfortable attended by the provider you have stated above?
1. Yes_ ❒ 2. No _ ❒
(iii) Between male and female provider whom are you more comfortable to be attended to?
1. Male_ ❒ 2. Female_ ❒

(iv) Why do you prefer the provider's gender you have mentioned above? __________

F: PLACE OF UTERINE EVACUATIN, PAIN MANAGEMEN AND RECOVERY ROOM

(i) Where were you treated? 1. Ward_ ❒ 2. Operating theatre_ ❒ 3. Other ______
(ii) Was there someone to assist you to the procedure room? 1. Yes_ ❒ 2. No _ ❒
(v) Did you feel pain during the procedure? 1. Yes _ ❒ 2. No_ ❒
(vi) Were you given any medication for pain control? 1. Yes _ ❒ 2. No_ ❒
(vii) Was there a room where you rested after the procedure? 1. Yes _ ❒ 2. No_ ❒
(viii) Were you assisted to the recovery room after the procedure? 1. Yes _ ❒ 2. No_ ❒

For adolescents (clients below 18 years)

(ix) Were you in the same recovery room with the adult? 1. Yes _ ❒ 2. No_ ❒
(x) Did you feel comfortable there? 1. Yes _ ❒ 2. No_ ❒
(xi) Do you think young people should be mixed with adults for this type of care?
1. Yes _ ❒ 2. No_ ❒
Please explain ________

G: POS-TABORTION CARE COUNSELLING PRIVACY AND CONFIDENTIALITY

(i) Were you given counselling in this health facility? 1. Yes _ ❒ 2. No_ ❒
(ii) If NO, have you been referred to another health facility? 1. Yes _ ❒ 2. No_ ❒
(iii) If YES, were you given any information/document showing that your case is referral?
1. Yes _ ❒ 2. No_
(Continue if the client was given counselling at the facility)
(iv) Where was the counselling done? 1. Counselling room ❒ 2. Ward ❒
3. Other (Specify) _______
(v) How many people were in the counselling room? ______
(vi) Were there any interruptions during counselling session? 1. Yes❒ 2. No_ ❒
(vii) Do you think your issues about care were overheard during the discussion?
1. Yes _ ❒ 2. No_ ❒
(viii) Do you think the privacy of the room was satisfactory? 1. Yes _ ❒ 2. No_ ❒
(ix) If NO, please explain _______
(x) Were you reassured that the information and treatment records will be kept confidential? 1. Yes _ ❒ 2. No_ ❒

H: POSTABORTION CARE FAMILY PLANNING

(i) Were you given a contraceptive method? 1. Yes _ ❒ 2. No_ ❒
(ii) If NO, have you been referred to another health facility? 1. Yes _ ❒ 2. No_ ❒
(iii) If YES, were you given any information/document showing that your case is referral?
1. Yes _❒ 2. No_

(*Continue if the client was given family planning at the facility)*
(iv) Was the contraceptive method given the one you desired?

1. Yes _ ❒ 2. No_ ❒

(v) Have you ever used that method? 1. Yes _ ❒ 2. No_ ❒

(vi) Were you given information on how method works? 1. Yes _ ❒ 2. No_ ❒

(vii) Were you given information on common side effects of various contraceptive methods including the one you have been given? 1. Yes _ ❒ 2. No_ ❒

(viii) Were you told where to obtain new supplies? 1. Yes _❒ 2. No_ ❒

I: INTERACTION WITH THE PROVIDER

(i) Do you think the healthcare providers treated you well? 1. Yes _ ❒ 2. No_ ❒

(ii) Was the provider (s) concerned about the cause of your problem?
1. Yes _ ❒ 2. No_ ❒

(iii) Did you notice anywhere where abusive language was used? 1. Yes _ ❒ 2. No_ ❒

(iv) Were you blamed by anyone for your condition? 1. Yes _ ❒ 2. No_ ❒

(v) How do you rate the interaction with the service provider (s)?
1. Poor_ ❒2. Unsatisfactory_❒3. Satisfactory_❒4. Good_ ❒5. Excellent__❒

J: WAITING TIME

(i) How long did you have to wait today before you saw a doctor, a counsellor or nurse?
A. Nurse____ minutes/Hours
B. A doctor? ____minutes/Hours
C. A counsellor? _____minutes/Hours

(ii) In which section/s do you think you spent long time? ___________
1. What is your opinion on the time you waited before receiving care?
2. Short __❒ 2. Too Long __❒ 3. Satisfactory__❒

K: COST OF POST-ABORTION CARE SERVICES

(i) Did you pay any money for the services you received today?
1. Yes _❒ 2. No_ ❒

(ii) How much did you pay for the services? ______________

(iii) Was it affordable to you? 1. Yes _ ❒ 2. No_ ❒

(iv) If NO, who catered for your services? 1. Myself_ ❒ 2. Partner_ ❒ Husband_ ❒
3. Parents_ ❒ 4. Other (specify) ____________

(v) Do you think the services in this facility are affordable to most people in the community? 1. Yes _ ❒ 2. No_ ❒

(vi) What is your opinion on the cost of the services?
1. Cheap___ ❒ 2. Affordable___ ❒ 3. Very expensive __❒

L: INFORMATION FOR FOLLOW UP

(i) Did the provider tell you re you told when to return for routine follow-up care?
1. Yes _ ❒ 2. No_ ❒

(ii) Did the provider tell you why you need to return for follow up? 1. Yes _ ❒ 2. No_ ❒

(iii) Were you told where to return for follow-up care? 1. Yes _ ❐ 2. No_ ❐
(iv) Did the provider tell you the importance of seeking medical attention if problems arise? 1. Yes _ ❐ 2. No_ ❐

M: RECOMMENDATIONS

(i) Would you recommend someone with similar condition as yours to come for services in this facility? 1. Yes _❐ 2. No_ ❐
(ii) Please explain______________________
(iii) What do you think can be done to better provide these services? ________________

Thank you for your time

DODOSO KWA AJILI YA AKINA MAMA AMBAO WAMETUMIA HUDUMA ZITOLEWAZO BAADA YA MIMBAKUHARIBIKA/KUHARIBIWA

Nia ya mahojiano haya ni kupata taarifa juu ya masuala yaliyosababisha wafike kwenye kituo cha huduma za afya pia kupata mtazamo wao juu ya ubora wa huduma walizopata. Maswali yatakayoulizwa yatafuata vigezo vya kimataifa vya utoaji wa huduma baada ya mimba kuharibiwa/kuharibika.

TAARIFA ZA KITUO CHA HUDUMA ZA AFYA NA MGONJWA

Namba ya kituo*_____________Tarehe ya mahojiano: ____________

Kata: _______________________

Mmiliki wa kituo: **1. Serikali ❐ 2. Binafsi ❐**

Ngazi ya kituo: _______________________ (Mfano, hospitali, kituo cha afya)

Jina la mhojaji: _______________________

* (Kwa sababu ya kuzingatia usiri, namba zitatumika badala ya majina)

A: TAARIFA ZA MGONJWA

i) Umri (miaka) _________
ii) Hali ya ndoa: 1. (Sijaolewa ❐ 2. Nimeolewa❐ 3. Naishi kinyumba ❐
4. Tumeachana/Talaka ❐
iii) Dini 1. Mkristo ❐ 2. Muislamu ❐ 3. Sina dini ❐
iv) Kiwango elimu 1. Sijasoma ❐ 2. Msingi ❐ 3. Sekondari ❐
v) 4. Chuo❐ 5. Chuo kikuu ❐
vi) Mahali unapoishi: Kata_________Wilaya_________Mkoa_________
vii) Kazi: 1. Nimeajiriwa ❐ 2. Mkulima ❐ 3. Mama wa nyumbani ❐
4.Mjasiriamali ❐ 5. Nasaidiwa na serikali ❐ 6. Mengineyo (eleza) _________

B: MATUMIZI YA NJIA ZA UZAZI WA MPANGO

i) Je, umewahi kutumia njia yoyote/zozote za uzazi wa mpango
1. Ndio ❐ 2. Hapana ❐
ii) Je, ulitumia njia ipi/ zipi? (weka alama ya vema)
a. Mpira wa kiume ()
b. Mira wa kike ()
c. Vidonge ()
d. Vipandikizi ()
e. Kiwambo cha kuzuia uzazi ()
f. Dawa za kuua mbegu za kiume ()
g. Sindano ()
h. Kitanzi ()
i. Njia za asili ()

iii) Je, ulikuwa ukitumia njia yeyote ya uzazi wa mpango/kuzuia mimba wakati uliposhika ujauzito? 1. Ndio ❒ 2. Hapana ❒

iv) Kama **HAPANA**, tafadhali eleza sababu ________

C. SABABU ZILIZOKUFANYA UFIKE KATIKA KITUO CHA KUTOLEA HUDUMA

i) Tatizo lako lilianza lini? ________

ii) *(kwa wale ambao walisubiri zaidi ya siku moja wadodose sababu za kuchelewa kupata matibabu)*

iii) Je, ulimshirikisha/ulizungumza/ na mtu yeyote juu ya tatizo la kiafya ulilo nalo?

iv) 1. Ndio ❒ 2. Hapana ❒

v) Kama NDIYO, Je ulimshirikisha/ulizungumza/ na nani juu ya tatizo la kiafya ulilo nalo? 1.Mwenza ❒ 2. Rafiki ❒ 3. Ndugu ❒ 4. Mzazi ❒ 5. Jirani ❒

vi) 6. Mtoa huduma za afya ❒ 7. Mwingine (eleza) ________

vii) Je, nani alitoa uamuzi juu ya wewe kupatiwa/kutafuta huduma ya matibabu?

viii) 1. Mimi mwenyewe ❒ 2. Mwenza/mume ❒ 3. Wazazi ❒

ix) 4. Wengineo (taja) ________

x) Je, ulikuwa unaifamu huduma hii kabla ya kufika hapa? 1. Ndio ❒ 2. Hapana ❒

xi) Je, ulipata wapi taarifa kuhusu huduma hii? 1. Mtoa huduma za afya ❒
2. Rafiki ❒ 3. Matangazo ❒ 4. Wazazi ❒ 5. Mabango❒ 6. Mengineyo (eleza)___

xii) Je, ulikwenda kupata/Kutafuta? Huduma hiyo katika kituo kingine kabla ya kuja hapa? 1. Ndio ❒ 2. Hapana ❒

xiii) Kama jibu ni NDIO, Je ulikwenda kuitafuta huduma hiyo wapi?

xiv) 1. Duka la dawa❒ 2. Kituo cha afya cha serikali ❒ 3. Kituo cha afya cha binafsi ❒
4. Zahanati ya serikali ❒ 5. Zahanati ya binafsi ❒
6. Hospitali serikali ❒ 7. Hospitali ya binafsi ❒ 8. Mganga wa kienyeji ❒
9. Nilijitibu ❒ 10. Mengineyo (eleza) ________

xv) Kama ulishakwenda kupata/kutafuta huduma kwenye kituo kingine, kwa nini umekuja hapa? ________

xvi) Je, Ulifikaje kwenye kituo hiki cha kutoa huduma? 1. Kwa miguu ❒
2. Kwa basi ❒ 3. Gari ya kukodi ❒ 4. Kwa usafiri wangu ❒
5. Boda boda/bajaj ❒ 6. Mengineyo ❒ (elezea) ________

xvii) Je, nani alilipia gharama za usafiri? 1. Mimi mwenyewe ❒ 2. Mwenza/mume

xviii) 3.Ndugu ❒ 4. Wazazi ❒ 5. Rafiki ❒ 6. Mwingine (mtaje/eleza) ________

xix) Je, imekuchukua muda gani kupata huduma katika kituo hiki?

xx) 1. Chini ya saa moja ❒ 2. Saa moja❒ 3. Zaidi ya saa moja ❒
4. Mengineyo (eleza) ________

D. JINSIA YA MTOA HUDUMA

i) Je, leo umehudumiwa na mhudumu wa jinsia gani? 1. Mwanamume ❐
2. Mwanamke ❐ 3. Mwanamume na Mwanamke ❐

ii) Je, ulijisikia vizuri kuhudumiwa na mhudumu aliyekuhudumia? ________
1. Ndio ❐ 2. Hapana ❐

iii) Je, ungejisikia vizuri zaidi kama ungehudumia na mhudumu wa kiume au wa kike?
1. Kiume ❐ 2. Kike ❐

iv) Kwa nini ungependa kuhudhuria na mhudumu wa jinsia uliyoitaja? ________

E. SEHEMU YA HUDUMA, KUPAMBANA NA KUZUIA MAUMIVU NA SEHEMU YA KUPUMZIKA

i) Je, ni wapi ulipatiwa huduma? 1. Wodini❐ 2. Chumba cha upasuaji❐
3. Kwingineko (eleza) ________

ii) Je, Kulikuwa na mtu wa kukusaidia ulipokuwa katika chumba cha kutolea huduma?
1. Ndio ❐ 2. Hapana ❐

v) Je, ulijisikia maumivu wakati unahudumiwa? 1. Ndio ❐ 2. Hapana ❐

vi) Je, ulipewa dawa zozote za kuzuia maumivu? 1. Ndio ❐ 2. Hapana ❐

vii) Je, kulikuwa na chumba cha kupumzika baada ya kupatiwa matibabu?

viii) 1. Ndio ❐ 2. Hapana ❐

ix) Je, ulisaidiwa wakati wa kwenda kwenye chumba cha mapumziko?

x) 1. Ndio ❐ 2. Hapana ❐

xi) (Kwa walio na umri wa chini ya miaka 18)

xii) Je, uliwekwa chumba cha mapumziko pamoja na watu wazima?

xiii) 1. Ndio ❐ 2. Hapana ❐

xiv) Je ulijisikia vizuri kuwa pale? 1. Ndio ❐ 2. Hapana ❐

xv) Je, unadhani ni vema wenye umri mdogo kuchanganywa na watu wazima katika huduma za aina hii? 1. Ndio ❐ 2. Hapana ❐
Tafadhali elezea________

F: USHAURI NASAHA NA USIRI BAADA MATIBABU KWA MAMA ALIYEHARIBIKIWA NA MIMBA

i) Je, ulipewa ushauri nasaha katika kituo hiki? 1. Ndio ❐ 2. Hapana ❐

ii) Kama **HAPANA**, je, ulishauriwa kwenda katika kituo kingine? Ndio ❐ 2. Hapana ❐

iii) (ii) Kama **NDIO**, je, ulipewa taarifa/ waraka kuonesha kuwa unatakiwa kwenda kwenye kituo kingine? 1. Ndio ❐ 2. Hapana ❐
(Kama magonjwa amepewa ushauri nasaha endelea na haya maswali)

iv) Ushauri nasaha ulifanyika wapi? 1. Kwenye chumba cha ushauri nasaha ❐
2.Wodini ❐ 3. Pengine (eleza) ________

v) Je, kulikuwa na watu wangapi kwenye chumba cha ushauri nasaha? ________

vi) Je, kulikuwa na kuingiliwa/usumbufu wowote ulipokuwa unapata ushauri nasaha?
1. Ndio ❐ 2. Hapana ❐

vii) Je, unafikiri mazungumzo yako na mhudumu yalisikiwa na watu wengine?
1. Ndio ❒ 2. Hapana ❒

viii) Je, unafikiri kulikuwa na faragha ya kutosha kwenye chumba cha huduma?
1. Ndio ❒ 2. Hapana ❒

ix) Je, ulihakikishiwa kuwa taarifa na rekodi/kumbukumbu za matibabu yako zitatunzwa kwa usiri? 1. Ndio ❒ 2. Hapana ❒

H: HUDUMA ZA UZAZI WA MPANGO KWA MAMA ALIYEHARIBIKIWA NA MIMBA

i) Je, ulipewa huduma za uzazi wa mpango? 1. Ndio ❒ 2. Hapana
ii) Kama **HAPANA**, je, ulishauriwa kwenda katika kituo kingine?
iii) Ndio ❒ 2. Hapana ❒
iv) (ii) Kama **NDIO**, je, ulipewa taarifa/ waraka kuonesha kuwa unatakiwa kwenda kwenye kituo kingine? 1. Ndio ❒ 2. Hapana ❒
v) *(Kama magonjwa amepewa uzazi wa mpango endelea na haya maswali)*
vi) Je, umewahi kutumia njia hii? 1. Ndio ❒ 2. Hapana ❒
vii) Je, ulielezwa jinsi njia hiyo ya uzazi wa mpango inavyofanya kazi?
1. Ndio ❒ 2. Hapana ❒
viii) Je, ulijulishwa madhara yanayoweza kusababishwa njia za mpango uliyopewa wewe?
1. Ndio ❒ 2. Hapana ❒
ix) Je, ulielezwa ni wapi unaweza kupata tena huduma hii? 1. Ndio ❒ 2. Hapana ❒

I: MAHUSIANO NA MHUDUMU

i) Je, unafikiri mhudumu alikuhudumia vizuri? 1. Ndio ❒ 2. Hapana ❒
ii) Je, m/wahudumu waliguswa na chanzo cha tatizo lako? 1. Ndio ❒ 2. Hapana ❒
iii) Je, ulisikia lugha chafu/ ambayo sio nzuri ikitumika wakati ukiwa katika kituo hiki? 1. Ndio ❒ 2. Hapana ❒
iv) Je, ulilaumiwa na awaye yeyote kwa ajili ya hali yako? 1. Ndio ❒ 2. Hapana ❒
v) Je, unaweza kupima vipi mahusiano yako na waliokuhudumia? 1. Mabaya ❒
2. Hayaridhishi ❒ 3. Yanaridhisha ❒ 4. Mazuri ❒ 5. Mazuri Sana ❒

J: MUDA ULIOTUMIA KUPATA HUDUMA

i) Je, leo umetumia muda gani kabla ya kumuona Daktari, Nesi au Mshauri nasaha? A. Nesi: Dakika/Saa ________
B. Daktari: Dakika/Saa________.
C. Mshauri: Dakika/Saa________

ii) Unafikiri umetumia muda mwingi katika idara gani? ________

iii) Una maoni gani juu ya muda ulioutumia kupata huduma?
1. Mfupi❒ 2. Mrefu sana ❒ 3. Unaridhisha ❒

K: GHARAMA ZA HUDUMA ZITOLEWAZO BAADA YA MIMBA KUHARIBIKA

i) Je, umelipa fedha zozote kwa huduma ulizopata leo? 1. Ndio ❒ 2. Hapana ❒
ii) Je, umelipa shilingi ngapi? ________
iii) Je, gharama hizi unazimudu? 1. Ndio ❒ 2. Hapana ❒
iv) Kama hapana, je nani amekulipia gharama? 1. Mimi mwenyewe ❒
2. Mwenza/Mume ❒3. Wazazi ❒ 4. Wengineo (eleza)
v) Je, unafikiri huduma zitolewazo katika kituo hiki watu wengi wanazimudu?
1. Ndio ❒ 2. Hapana ❒3. Sijui❒
vi) Nini maoni yako juu ya gharama za huduma hizi? 1. Nafuu ❒ 2. Kawaida ❒
3. Ghali sana ❒

L. TAARIFA ZA UFUATILIAJI BAADA YA KUPATA HUDUMA

i) Je, umeambiwa siku ya kurudi kwa ajili ya huduma za ufuatiliaji?
1. Ndio ❒ 2. Hapana ❒
ii) Je, mhudumu alikuambia ni kwanini unatakiwa kurudi tena? 1. Ndio ❒ 2. Hapana ❒
iii) Je mhudumu alikueleza ni wapi utakwenda kwa ajili ya huduma za ufuatiliaji?
1. Ndio ❒ 2. Hapana ❒
iv) Je, mhudumu alikueleza juu ya umuhimu wa kwenda hospitali iwapo matatizo yatajitokeza tena? 1. Ndio ❒ 2. Hapana

M. MAPENDEKEZO

i) Je, unaweza kumshauri mtu mwenye tatizo kama lako aje kwa ajili ya huduma katika kituo hiki? 1. Ndio ❒ 2. Hapana ❒
ii) Tafadhali eleza________
iii) Unadhani nini kifanyike ili huduma hizi ziboreshwe zaidi? ________

Asante sana kwa muda wako

INTERVIEW GUIDE FOR NON-USERS OF PAC SERVICES

This instrument was administered to women who previously experienced unsafe abortion complications but did not seek care from a formal health facility. The main aim was to identify factors that hindered their utilization PAC services from a health facility.

A: **SOCIOECONOMIC AND DEMOGRAPHIC CHARACTERISTICS**

(i) What is your current age? (years)_________

(ii) What is your current marital status? 1. Single _❒ 2. Married_❒
3. Cohabiting_ ❒ 4. Divorced_ ❒

(iii) What is your religious affiliation? 1? Christian_ ❒ 2. Muslim_ ❒
3. No religion_ ❒ 4. Other ____________

(iv) What was your education level? 1. No Education _❒ 2. Primary_❒
3. Secondary_❒4. College_❒ 5. University_❒

(v) What is your current level of education?

(vi) Where were you living? Ward _____District ________Region________

(vii) What is your current place of residence? District t ________Region _______

(viii) What was your Occupation? Employed_ ❒2. Farming❒3. Housewife _ ❒4. Petty trade 5. Under family support_ ❒6. Other (Specify)_______

(ix) What is your current occupation? Employed_ ❒2. Farming_ ❒
3. Housewife _❒4. Petty trade 5. Under family support_ ❒
6. Other (specify) _______________________

B: REASON FOR NOT AN ABORTION TERMINATION AND SEEKING CARE AFTER AN ABORTION

(i) When did the incidence happen to you? __________

(ii) What factors/conditions that made you decide to end up the pregnancy?

(iii) Where did you get abortion services from?

(iv) What are the possible side effects of an induced abortion?

(v) What did you do after you experienced the complications?

(vi) Where did you seek care after the complication?

(vii) Why did you prefer the source of care you have mentioned? *(probe for socio-cultural factors, religious, healthcare system factors, privacy, cost)*

(viii) What is your advice to women who are experiencing or may experience a similar condition?

Thank you for your time

DODOSO KWA KINAMAMA WASIOTUMIA HUDUMA ZITOLEWAZO BAADA YA MIMBA KUHARIBIKA

Dodoso hili lilitumika kwa kinamama ambao waliwahi kupata matatizo ya kuharibu mimba kwa njia zisizo salama na hawakwenda hospitali kupata matibabu. Nia ni kufahamu kwa nini hawa kutumia huduma zitolewazo na vituo vya afya baada ya mama kuharibikiwa na mimba.

A: TAARIFA ZA KIDEMOGRAFIANA ZA KIUCHUMI

i) Kwa sasa una umri gani? (miaka) _________

ii) Hali yako ya kindoa ya sasa ikoje? 1. Sijaolewa❒ 2. Nimeolewa❒ 3. Kinyumba❒ 4. Nimeachika❒

iii) Dini yako ni: 1. Mkristo❒ 2. Muislamu ❒ 3. Sina dini❒ 4. Nyingine (eleza) _________

iv) Kiwango chako cha elimu kilikuwa ni: 1. Sikusoma❒ 2. Msingi❒ 3. Sekondari ❒ 4. Chuo ❒ 5. Chuo kikuu❒

v) Kwango chako cha sasa cha elimu ni _________

vi) Je, ulikuwa unaishi wapi? 1. Kata_________ Wilaya_________ Mkoa_________

vii) Kwa sasa unaishi wapi? Wilaya_________ Mkoa_________

viii) Ulikuwa unajishughulisha na nini? 1. Niliajiriwa ❒ 2. Mkulima❒ 3. Mama wa nyumbani ❒ 4. Mjasiriamali ❒ 5. Nasaidiwa na serikali ❒ 6. Mengineyo (eleza) _________

ix) Ajira yako ya sasa ni: 1. Nimeajiriwa ❒ 2. Mkulima ❒ 3. Mama wa nyumbani ❒ 4. Mjasiriamali ❒ 5. Nasaidiwa na serikali ❒ 6. Mengineyo (eleza) ________

C: SABABU ZA KUHARIBU MMBA NA UTAFUTAJI HUDUMA BAADA YA KUHARIBU MIMBA

i) Je, ulipata matatizo hayo (kuharibu/kutoa mimba) mwaka gani? _________

ii) Nini kilisababisha uamue kuharibu/kutoa mimba? _________

iii) Je, ulipata wapi huduma hiyo?

iv) Je, unafahamu madhara ya utoaji mimba? (*yataje*).

v) Je, ulifanya nini baada ya kupata matatizo yaliyosababishwa na kutoa mimba?

vi) Baada ya kupata matatizo, ulikwenda wapi kutafuta msaada wa kitabibu?

vii) Kwa nini uliamua kwenda kutibiwa huko? *(Dadisi sababu za kimila, kidini, mfumo wa utoaji huduma hospitalini, usiri, gharama n.k*)

viii) Unawashauri nini akina mama wenzio wanaopata matatizo kama yako?

Asante sana kwa muda wako

INTERVIEW GUIDE FOR THE PROVIDERS OF PAC SERVICES

This interview was administered to the providers of PAC services in the study facilities. The aim was to gather information on their perceptions about abortion and the quality of PAC services.

Facility's Code*: __________________________Date of Interview: _________________
Type of Facility: Government___________ Private____________
Level of Facility: ___________________________________ (e.g., Health Center, Hospital)
District: _______________________ Ward___________________
Provider's Names ____________________________________
Provider's Designation/Title __________________________ (eg Nurse, Doctor,)
Sex/Gender of the provider __________________________________
Interviewer's Name ___________________________________
*(*Instead of using the actual names of the facilities codes will be assigned to each participating health facility for confidential purposes)*

A: POSTABORTION CARE PROVIDER'S TRAINING

(i) For how long have you been working in this health facility? _________
(ii) Are you trained in PAC? 1. Yes_ ❐ 2. No_ ❐
(iii) What kind of PAC training do you have?
1.College/University as a part of curriculum ____ ❐
2. In service training____ ❐3. Short course __❐
4.Reproductive health training__❐4. Other (specify)______
(iv) When was your last training? On PAC? _________
(v) Do you have regular in service training? 1. Yes_ ❐ 2. No_ ❐
(vi) How often do you have in service training? _________

B: TYPE OF PAC SERVICES OFFERED BY A HEALTH FACILITY

(i) What PAC services does this facility offer?
(ii) At what time do these services are provided? ______
(iii) Who is the provider of PAC services in this facility by title? ____________
(iv) Are PAC providers in this facility adequate in number?1. Yes_ ❐ 2. No_ ❐
(v) Are you comfortable in providing PAC services?1. Yes_ ❐ 2. No_ ❐
(vi) Please provide reason (s) for you answer above__________________

C: EQUIPMENT SUPPLY AND MEDICATION

(i) What are essential medicine and equipment needed for PAC services? _________
(ii) What method/s do you use to perform uterine evacuation? _________
(iii) Are essential equipment and medicine available all the time?
1. Yes_ ❐ 2. No_ ❐
(iv) If **No,** what does the facility do in case of the short supply? _________

(v) Are essential equipment and medication adequate compared to post-abortion cases you handle per day? 1. Yes_ ❒ 2. No_ ❒

(vi) Is running water available all the time. 1. Yes_ ❒ 2. No_ ❒

(vii) Is electricity available all the time? 1. Yes_ ❒ 2. No_ ❒

(viii) What are the options does the facility during power cut?

(ix) What are other challenges you encounter in providing PAC services in this facility?

D: FACILITY LOCATION AND SET UP

(i) Please explain where (in which department) PAC services are provided in this health facility________

(ii) Do you think it is ok for them to be treated here? 1. Yes_ ❒ 2. No_ ❒

(iii) Please explain your answer________

(iv) Do you think is easy for a first time patient identify where PAC service are offered? 1. Yes_ ❒ 2. No_ ❒

(v) What is your comment on the location and set up of the serves? _________

(vi) Do you think there is a need for improving the set-up of the facility for PAC? 1. Yes_ ❒ 2. No_ ❒

(vii) please explain your answer __________

E: PROVIDER'S ATTITUDE TOWARDS ABORTION AND PAC CLIENTS

(i) How do you perceive/think of a woman who have had an induced abortion?

(ii) How do you perceive/think of a woman who have had a spontaneous abortion?

(iii) Do you think women with unsafe abortion complications should be denied services? 1. Yes_ ❒ 2. No_ ❒

(iv) Please give reasons for your response__________

(v) Do Women who have undergone unsafe abortion deserve equal attention like any other patients? 1. Yes_ ❒ 2. No_ ❒

(vi) Please give reasons for your answer ______

(vii) How do you perceive/think of PAC services?

(viii) Do you feel comfortable to provide services? 1. Yes_ ❒ 2. No_ ❒

(ix) Please explain______

(x) Do you think unmarried women may have additional challenges in accessing PAC compared to married women? Yes_ ❒ 2. No_ ❒

(xi) Please provide reasons for your answer ________

F: POSTABORTION COUNSELLING AND PRIVACY

(i) Does this facility offer counselling services to PAC clients?
1. Yes _❒ 2. No_❒

(ii) If **NO,** do you refer PAC clients to other facilities? 1. Yes_ ❒ 2. No_❒

(iii) If **YES,** where do you refer PAC clients for counselling? ________

(iv) Why do you refer them to the facility (s) you have mentioned above?

(v) Who offers counselling to PAC clients? 1. Doctor__❒ 2. Nurse__ ❒ 3. Trained counselor (s) __ ❒4. Other (specify) _

(vi) Where is counselling provided? 1. In a ward____ ❒ 2. Special counselling room__ ❒3. Other (specify) __

(vii) Do you think counselling is important to PAC clients? (please explain)

(viii) Do you think confidentiality is maintained during counselling? 1. Yes_ ❒ 2. No_ ❒

(ix) Please explain ________________

G: POSTABORTION FAMILY PLANNING

(i) Does this facility offer family planning? 1. Yes _❒ 2. No_❒

(ii) If **NO**, do you refer PAC clients to other facilities for FP services? 1. Yes _❒ 2. No_❒

(iii) If **YES,** where do you refer PAC clients for FP services? ________

(iv) Why do you refer them to the facility (s) you have mentioned above?

(v) Does the facility have wide range of contraceptive methods? 1. Yes _❒ 2. No_❒

(vi) Please mention the available methods________

(vii) Do you think most PAC clients leave home with a family planning method? 1. Yes _❒ 2. No_❒

(viii) If **NO,** please provide reasons _________

H: COST OF PAC SERVICES

(i) Does the facility have charges for PAC services?

(ii) What are the clients' costs for PAC services? ________

(iii) What is your opinion on the cost of PAC services? 1. Cheap_❒ 2. Affordable_❒ 3. Very expensive _

I: POSTABORTION CARE FOLLOW UP

(i) Do you provide any information for follow up to post-abortion care patients? 1. Yes _❒ 2. No_❒

(ii) From your experience with PAC clients what is the rete of post-abortion care patients returning for follow up? 1. Poor _❒2. Good__ ❒ 3. Satisfactory _❒

(iii) If clients do not return for follow-up care, do you try to find out why? 1. Yes _❒ 2. No_❒

J: RECOMMENDATIONS

(i) What do you think can be done to improve the provision of PAC services?

Thank you for your time

DODOSO KWA WATOA HUDUMA YA AFYA KWA AKINA MAMA WALIOHARIBU/HARIBIKIWA NA MIMBA

Dodoso hili lilitumika kwa wahudumu wa afya wanaotoa huduma kwa akina mama waliopata matatizo ya kuharibu/kuharibikiwa na mimba. Lengo ni kupata mtazamo wao kuhusu kuharibu/kuharibikiwa mimba na ubora wa huduma zinazotolewa baada ya mimba kuharibika/kuharibiwa.

Namba ya kituo*: ________**Tarehe ya mahojiano** ________

Mmiliki wa kituo: Serikali ________Binafsi________

Ngazi ya kituo: ________ (Mf. kituo cha afya, hospitali)

Wilaya: ________**Kata**: ________

Jina la mtoa huduma: ________

Cheo cha mtoa huduma: ________ (Nesi, Daktari)

Jinsia ya mtoa huduma ________

Jina la mhojaji: ________

* *(Kwa sababu ya kuzingatia ya usiri, namba zitatumika badala ya majin*a)

A: MAFUNZO KWA WATOA HUDUMA KWA AKINA MAMA WALIOHARIBU/ WALIOHARIBIKIWA NA MIMBA

i) Je, umefanya kazi kwenye kituo hiki kwa muda gani? ________
ii) Je, umepata mafunzo ya huduma kwa akina mama walioharibikiwa/haribu mimba?
 1. Ndio ❐ 2. Hapana ❐
iii) Je, ulipata mafunzo gani? 1. Chuoni/chuo kikuu kama sehemu ya mafunzo
 2. Mafunzo kazini ❐ 3. Kozi fupi ❐ 4. Mafunzo ya afya ya uzazi ❐
 5. Mengineyo (fafanua) ________
iv) Mara ya mwisho kupata mafunzo ilikuwa lini? ________
v) Je, mara kwa mara mnapata mafunzo mkiwa kazini? 1. Ndio ❐ 2. Hapana ❐
vi) Je, ni kawaida kwenu kupata mafunzo kazini? 1. Ndio ❐ 2. Hapana ❐

B: HUDUMA ZITOLEWAZO KWA AKINAMAMA WALIOHARIBIKIWA AU WALIO HARIBU MIMBA

i) Je, kituo hiki kinatoa huduma zipi kwa akina mama walioharibikiwa/haribu na mimba?
ii) Je, huduma hizi zinatolewa wakati gani? ________
iii) Je, anayetoa huduma hii kwenye kituo hiki anaitwa nani kwa cheo? ________
iv) Je, idadi wa watoa huduma hii inatosheleza mahitaji? 1. Ndio ❒ 2. Hapana ❒
vii) Je, unaridhika/unafurahia kutoa huduma hii? 1. Ndio ❒ 2. Hapana ❒
Tafadhali toa sababu za jibu lako________

C: UPATIKANAJI WA VIFAA TIBA NA DAWA

i) Je, mnatumia vifaa gani kusafisha kizazi?
ii) Je, vifaa muhimu na dawa vinapatikana wakati wote? 1. Ndio ❒ 2. Hapana ❒
iii) Je mnafanya nini iwapo dawa au vifaa tiba vinakosekana?
iv) Je, vifaa muhimu na dawa vinatosheleza kulinganisha na idadi ya wagonjwa mnaowahudumia kwa siku? 1. Ndio ❒ 2. Hapana ❒
v) Je, maji ya bomba yanapatikana wakati wote? 1. Ndio ❒ 2. Hapana ❒
vi) Je, umeme unapatikana wakati wote? 1. Ndio ❒ 2. Hapana ❒
vii) Je, kituo kina utaratibu gani iwapo umeme utakatika?
viii) Je, kuna changamoto gani nyingine mnazokumbana nazo katika kutoa huduma hii?

D: MAHALI KILIPO KITUO NA MPANGILIO WAKE

i) Ni katika idara/ sehemu gani huduma hizi zinatolewa katika kituo hiki?
ii) Unadhani ni sawa kwa akina mama hawa kupatiwa huduma hizi hapa?
1. Ndio ❒ 2. Hapana ❒
iii) Tafadhali toa maelezo kufuatia jibu lako_______
iv) Unafikiri ni rahisi kwa mama mwenye matatizo anayekuja hapa mara ya kwanza kulitambua eneo hili? 1. Ndio ❒ 2. Hapana ❒
v) Una maoni gani juu ya mpangilio wa sehemu ya kutolea huduma
vi) Je, unadhani kuna umuhimu wa kubadili mpangalio wa eneo hili?
1. Ndio ❒ 2. Hapana ❒
vii) Tafadhali toa maelezo kufuatia jibu lako ________

E. MTAZAMO WA WATOA HUDUMA KUHUSU UTOAJI MIMBA NA HUDUMA ZITOLEWAZO BAADA YA MIMBA KUHARIBIKA

i) Wewe unamchukuliaje/una mtazamo gani juu ya mama ambaye ameharibu mimba?
ii) Wewe unamchukuliaje/una mtazamo gani juu ya mama ambaye mimba imeharibika?
iii) Je, unafikiri akina mama ambao wameharibu mimba kwa njia zisizo salama wasipewe huduma? 1. Ndio ❒ 2. Hapana ❒

iv) Tafadhali toa sababu kufuatia jibu lako________
v) Je, akina mama walioharibu mimba kwa njia zisizo salama wanastahili kupata huduma kama wagonjwa wengine? 1. Ndio ❒ 2. Hapana ❒
vi) Tafadhali toa sababu kufuatia jibu lako________
vii) Je una mtazamo gani kuhusu huduma zitolewazo kwa akina mama ambao mimba zimeharibika/zimeharibiwa?
viii) Je, unajisikia vizuri kutoa huduma hizi? 1. Ndio ❒ 2. Hapana ❒
ix) Tafadhali toa maelezo________
x) Unadhani akina mama ambao hawajaolewa wana changamoto zaidi katika kupata huduma hizi? 1. Ndio ❒ 2. Hapana ❒
viii) Tafadhali toa sababu kufuatia jibu lako________

F: USIRI NA USHAURI NASAHA BAADA YA HUDUMA (MTOA USHAURI)

i) Je, kuna huduma za ushauri nasaha katika kituo hiki? 1. Ndio ❒ 2. Hapana ❒
ii) Kama ndio, je huwa mnatoa maelezo gani kwa wagonjwa wakati wa ushauri nasaha?
iii) Kama hapana, je huwa mnawashauri wagonjwa waende kwenye kituo kingine kwa ajili ya huduma ya ushauri? 1. Ndio ❒ 2. Hapana ❒
iv) Kama ndio, je huwa mnawashauri waende wapi kwa ajili ya ushauri nasaha?
v) Kwa nini huwa mnawashauri waende kwenye kituo ulichokitaja?
vi) Je, nani anaitwa huduma ya ushauri nasaha? 1. Daktari ❒2. Nesi ❒
3. Mtoa ushauri nasaha aliyesomea❒ 4. Wengine ❒
vii) Je, huduma hii kutolewa wapi? 1. Wodini❒
2. Chumba maalum cha ushauri nasaha ❒ 3. Pengine (eleza) ________
viii) Je, unafikiri usiri unazingatiwa wakati wa ushauri nasaha?
1. Ndio ❒ 2. Hapana ❒

G. HUDUMA ZA UZAZI WA MPANGO BAADA YA MIMBA KUHARIBIKA

i) Je, kituo hiki kinatoa huduma za uzazi wa mpango? 1. Ndio ❒ 2. Hapana ❒
ii) Kama jibu ni hapana, je, huwa mnawashauri wagonjwa kwenda kwenye kituo kingine kwa ajili ya huduma za uzazi wa mpango? 1. Ndio ❒ 2. Hapana ❒
i) Kama ndio, je huwa mnawashauri waende wapi kwa ajili ya huduma hii? Kwanini huwa mnawashauri waende kwenye kituo hicho?
ii) Je, huwa mnawapa wagonjwa wenu waraka wowote kuonesha kuwa wamepewa rufaa? 1. Ndio ❒ 2. Hapana ❒
iii) Je, mnahakikishaje kuwa kule mlikowapeleka wamepata huduma za uzazi wa mpango? 1. Ndio ❒ 2. Hapana ❒
iv) Je, kituo kina aina tofauti za njia za uzazi wa mpango? 1. Ndio ❒ 2. Hapana ❒
v) Tafadhali zitaje ________

vi) Je, unaamini kuwa wagonjwa wenu wengi wanarudi nyumbani wakiwa na njia za uzazi wa mpango? 1. Ndio ❐ 2. Hapana ❐

vii) Kama jibu ni hapana, tafadhali toa sababu________

viii) Je, mnahakikishaje kuwa njia za uzazi wa mpango mnatoa zinawafaa zaidi vijana?

H: GHARAMA ZA MATIBABU KWA KINAMAMA WALIOHARIBIKIWA/HARIBU MIMBA

ix) Je, kituo hiki kinatoza gharama zozote kwa ajili ya huduma kwa mama walioharibu au kuharibikiwa mimba?

x) Gharama za huduma hii ni kiasi gani?

xi) Je, una maoni gani juu ya gharama za huduma hizi?

1. Rahisi ❐ 2. Kawaida ❐ 3. Ghali Sana ❐

I: UFUATILIAJE BAADA YA MAMA KUPATA HUDUMA

i) Je, huwa mnawapa wagonjwa taarifa juu ya huduma za ufuatiliaji baada ya huduma? 1. Ndio ❐ 2. Hapana ❐

ii) Kwa uzoefu wako, unazungumziaje kiwango cha wagonjwa kurejea kwa ajili ya ufuatiliaji baada ya kupata huduma?

1. Hafifu ❐ 2. Kizuri ❐ 3. Kinaridhisha❐

iii) Je, iwapo mgonjwa hatarejea, huwa mnamfuatilia kufahamu nini sababu za kutorejea? 1. Ndio ❐ 2. Hapana ❐

J: MAPENDEKEZO

Je, unadhani nini kifanyike ili kuboresha huduma hizi?

Asante sana kwa muda wako

FOCUS GROUP DISCUSSION GUIDE

Focus Group Discussion with Community members

The focus group discussion was expected to shade light on community's perceptions on abortion and PAC services. It was administered to women (15-24), (25+) and men (15-24), (25+).

Ward _________________

Date __________________

Number of FGD members __________________

Themes

Community understanding of induced abortion and spontaneous abortion

1. Defining abortion *(ability to distinguish between induced and spontaneous abortion)*
    - Is abortion a problem in the community
    - Where do they seek abortion services and why?

Perception on abortion

2. How do you perceive a woman who had had a spontaneous abortion? (please provide reasons for your answer)
3. How do you perceive a woman who had had an induced abortion? (please provide reasons for your answer)
4. How does the community perceive, talk about a woman who had had an induced abortion? (please explain)
5. How does the community perceive, talk about a woman who had had a spontaneous abortion? (please explain)

Community Attitude on PAC services

6. What are your views on PAC services?
7. Should it be available or not available and why?

Thank you for your time

MAHOJIANO NA KIKUNDI CHA WANAJAMII

Mahojiano haya yalilenga kupata mtazamo wa jamii katika suala la utafutaji huduma za afya baada ya mama kuharibu au kuharibikiwa na mimba. Wahusika walikuwa ni wanawake wenye umri wa miaka (15-24) na wanaume (15-24), (25+).

Kata__________________

Tarehe__________________

Idadi ya wanajamii wanaoshiriki mahojiano**__________________**

Uelewa w jamii kuhusu kuharibu mimba au mimba kuharibika

1. Kutoa/kuharibika mimba ni nini? (*uwezo wa kutofautisha kutoa mimba na mimba kuharibika*)
    - Je utoaji mimba au mimba kuharibika ni tatizo la kiafya katika jamii hii
    - Huduma za kuharibu mimba zinapatikana wapi katika jamii hii

Mtazamo wa jamii kuhusu kuharibu mimba au mimba kuharibika

mwanamke

2. Je wewe unamchukuliaje, unamwonaje au una mtazamo gani juu ya Mwanamke aliyetoa/haribu mimba ambaye mimba imeharibika yenyewe? (tafadhali toa sababu za mtazamo wako).
3. Je wewe unamchukuliaje, unamwonaje au una mtazamo gani juu ya Mwanamke aliyetoa/haribu mimba (tafadhali toa sababu za mtazamo wako).
4. Je, jamii hii inamchukuliaje/ina mtazamo gani juu ya Mwanamke aliyetoa/haribu mimba? (tafadhali toa sababu).
5. Je, jamii hii inamchukuliaje/ ina mtazamo gani juu ya Mwanamke ambaye mimba imeharibika yenyewe? tafadhali toa sababu).

Mtazamo wa jamii kuhusu huduma zitolewazo baada ya mama kupata matatizo yatokanayo na mimba kuharibika/kuharibiwa

6. Nini mtazamo wenu kuhusu huduma zitolewazo baada ya mama kupata matatizo yatokanayo na mimba kuharibika/kuharibiwa
7. Je, mnafikiri hizi huduma ziwepo au zisiwepo? (Tafadhali elezea)

Asanteni sana kwa muda wenu

INTERVIEW GUIDE FOR COMMUNITY HEALTH WORKERS

The interviews centered around and the individual, provider and community factors which they thought are likely to influence utilization of PAC services. CHWs are knowledgeable about abortion and PAC services since they deal with health issues at community level.

Guiding questions

1. Is unsafe abortion an important health problem in this community?
2. Where do you think women obtain abortion services?
3. How do you perceive a woman who had had a spontaneous abortion? (please provide reasons for your answer)
4. How do you perceive a woman who had had an induced abortion? (please provide reasons for your answer)
5. How does the community perceive, talk about a woman who had had an induced abortion? (please explain)
6. How does the community perceive, talk about a woman who had had a spontaneous abortion? (please explain)
8. What are your views on PAC services?
9. Should it be available or not available and why?

Thank you for your time

MAHOJIANO NA WATOA HUDUMA ZA AFYA KATIKA JAMII

Mahojiano haya yalilenga kuangalia jinsi mtazamo wa wahudumu wa afya katika jamii na jamii kwa ujumla inavyoweza kuwa na ushawishi katika matumizi ya huduma zitolewazo baada ya mama kuharibu/kuharibikiwa na mimba. Wahudumu wa afya katika jamii wana uelewa juu ya suala zima la kuharibu/kuharibika kwa mimba kwani wanahusika na mambo ya afya katika ngazi ya jamii.

Kata________

Tarehe________

1. Je, tatizo la utoaji mimba usio salama ni tatizo katika jamii hii?
2. Je wewe unamchukuliaje, unamwonaje au una mtazamo gani juu ya Mwanamke ambaye mimba imeharibika yenyewe? (tafadhali toa sababu za mtazamo wako).
3. Je wewe unamchukuliaje, unamwonaje au una mtazamo gani juu ya Mwanamke aliyetoa/haribu mimba (tafadhali toa sababu za mtazamo wako).
4. Je, jamii hii inamchukuliaje/ina mtazamo gani juu ya Mwanamke aliyetoa/haribu mimba? (tafadhali toa sababu).
5. Je, jamii hii inamchukuliaje/ ina mtazamo gani juu ya Mwanamke ambaye mimba imeharibika yenyewe? tafadhali toa sababu).
6. Mtazamo wa jamii kuhusu huduma zitolewazo baada ya mama kupata matatizo yatokanayo na mimba kuharibika/kuharibiwa
7. Nini mtazamo wenu kuhusu huduma zitolewazo baada ya mama kupata matatizo yatokanayo na mimba kuharibika/kuharibiwa
8. Je, mnafikiri hizi huduma ziwepo au zisiwepo? (Tafadhali elezea)

Asante sana kwa muda wako

INTERVIEW GUIDE FOR RELIGIOUS LEADERS

This instrument was administered to religious leaders. The aim was to solicit information on their perceptions and opinion towards abortion and postabortion care

Religion ___________________

Dominion___________________

Position of the religious leader ___________________

1. How do you perceive a woman who had had an induced abortion? (please provide reasons for your answer)
2. How do you perceive a woman who had had a spontaneous abortion? (please provide reasons for your answer)
3. In your opinion how religious teaching may affect abortion?
4. What is the attitude of the church/religion towards abortion?
5. What are your views on PAC services?
6. Should it be available or not available and why?

Thank you for your time

MAHOJIANO NA VIONGOZI WA DINI

Dodoso hili lilitumika kukusanya maoni kutoka kwa viongozi wa dini. Lengo hasa ilikuwa ni kupata maoni na mtazamo wao juu ya utoaji mimba na huduma zitolewazo baada ya mimba kuharibiwa/kuharibika.

Dini __________________

Dhehebu__________________

Cheo Cha Kiongozi wa Dini __________________

1. Je wewe unamchukuliaje, unamwonaje au una mtazamo gani juu ya Mwanamke ambaye mimba imeharibika yenyewe? (tafadhali toa sababu za mtazamo wako).
2. Je wewe unamchukuliaje, unamwonaje au una mtazamo gani juu ya Mwanamke ambaye ameharibu/ametoa mimba (tafadhali toa sababu za mtazamo wako).
3. Kw maoni yako unafikiri ni jinsi gani mafundisho ya dini yanaweza kuathiri utoaji wa mimba?
4. Ni nini mtazamo wa Dini/Kanisa juu ya utoaji mimba?
5. Je dini/Dhehebu lako linamchukuliaje muumini ambaye ametoa mimba?
6. Je, mnafikiri hizi huduma ziwepo au zisiwepo? (Tafadhali elezea)

Asante sana kwa muda wako

DIRECT OBSERVATION CHEKLIST

Items to be observed	YES	NO	N/A
Facility easy to be identified from the reception			
Treatment room clean			
Counselling services offered			
Privacy maintained			
Family planning available			
The facility had a wide range of family planning methods			
The facility has running water			
The facility had a special room for counselling			
The facility has electricity			
Room/space available for post procedure recovery			
Clients sharing bed			
Provider client interactions			