Health insurance is a viable strategy to facilitate accessibility of health care but it favors the formal sector workers while leaving behind the informal sector workers who are the majority. This mixed methods study involved 889 informal sector workers from Dar es Salaam, Tanzania. Income, membership to economic groups, education, age, insurance regulations, fragmentation of insurance providers, cultural beliefs and low priority on health insurance were significantly associated with uptake of health insurance. Low uptake of health insurance increases inaccessibility of health care. Subsidizing the premium and using innovative strategies to increase understanding will improve health service accessibility.

**KEYWORDS**

Health Insurance, Uptake, Informal Sector Workers, Tanzania

1. Introduction

Promoting well-being by ensuring healthy lives is the key agendas in the Sustainable Development Goals (SDG) adopted by the United Nation (UN) member states in 2015. The main targets on this front is to Universal Health Coverage (UHC) including financial risk protection, access to quality essential health-care services and safe, effective and affordable essential medicines and vaccines for all (United Nations 2018; OECD 2019). Increased cost for healthcare has made its accessibility to be still a major problem which attests to the elusive health for all principles. Affordability of the health service is a significant indicator of healthcare access. Inability of households with limited income to afford health care due to increased costs forces them to forgo seeking health care (Id et al., 2021).

Social health insurance (SHI) has been introduced as a key mechanism for achieving universal healthcare by preventing catastrophic healthcare expenditure costs by pooling funds to allow cross-subsidization between the rich and poor and between the healthy and the sick (Atake, 2018; Security and House, 2018). Health insurance operates differently with the aim of ensuring majority accessibility to health services without financial constraints. The World Social Protection Report 2017/19 showed that only 45 per cent of the global population is effectively covered by at least one social benefit while the remaining 55 per cent – 4 billion people – are left unprotected (Goals, 2017).

At present, in European countries there are few countries which have already achieved universal health insurance (Dror et al., 2016; OECD 2019). In these industrialized nations, universal health care is mainly financed through government tax systems. Individuals on formal sectors benefit from the social protections and other compensation shared between the employer and the employees while the informal sectors have to dig deep into their pockets in order to access the health services (Chireshe and Ocran, 2020). The major challenge on SHI is to integrate the poor and the people from the informal sector who have low and irregular incomes which make them incapable to pay the insurance premium on time (Kimani et al., 2012).

Regardless the level of socio-economic development, informal sector workers exist in all countries, although it is more prevalent in developing countries. About 61% of the world’s working population are actively involved 889 informal sector workers from Dar es Salaam, Tanzania. Income, membership to economic groups, education, age, insurance regulations, fragmentation of insurance providers, cultural beliefs and low priority on health insurance were significantly associated with uptake of health insurance. Low uptake of health insurance increases inaccessibility of health care. Subsidizing the premium and using innovative strategies to increase understanding will improve health service accessibility.

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literature in terms of understanding the factors which are associated with uptake of health insurance among informal workers in the context of developing countries such as Tanzania.

2. MATERIAL AND METHODS

This study was conducted in Dar es Salaam region in Eastern Tanzania. Dar es salaam was purposely selected due to the fact that it is the most populated region in Tanzania that accounts for 10% of the of the total population in Tanzania Mainland. Majority (75%) of people in this region are involved in informal sectors (United Republic of Tanzania (URT), 2015). The study applied a sequential mixed method design, and the study population were informal sector workers as well as insurance providers. A total of 889 informal sector workers were randomly selected for the quantitative part of the study while 72 respondents were purposely selected for the qualitative part of the study (16 interviewees and 56 in 8 focus group discussions (FGDs). Interviewer administered questionnaires were used to collect data from the informal sector workers, while in-depth interview guides were used to collect data from the insurance providers as well as the informal sector workers group leaders. Focus group discussions guides were used to collect data from informal sector workers.

Analysis followed the data collection strategy. At first, the quantitative data were cleaned and coded before entering into excel and later transferred to SPSS version 23 for analysis. The outcome variable (uptake of health insurance) was treated as a binary outcome (1 for member of health insurance and 0 for non-member of health insurance). The predictor variables were grouped into 3 main categories as socio demographic and economic, health systems and individual factors. Chi-square test was performed to test the association between the independent variables and health insurance and the independent variables. The adjusted odds ratio (AOR) with a 95% confidence interval and a P-value <0.05 were used to determine the association between health insurance and the independent variables.

On qualitative data, content analysis whereby it involved systematic reduction of data without distorting the intended original meaning. At first, the assigned codes were grouped into categories that were later reorganized and arranged into themes which were presented in a sequence that answered the research questions. Quotes that were most useful in explaining the quantitative finding were selected and attached under each quantitative finding. The research protocol was approved by National Health Research Ethics Review Committee (NHRERC) with reference number (NMR/HQ/R/8a/VolIX/3375) under the National Institute of Medical Research (NIMR) in Tanzania. All participants provided both written and verbal informed consent prior to participation.

3. RESULTS

The objective of this study was to determine the uptake status of health insurance among the informal sector worker and to determine the factors associated with uptake of health insurance among informal sector workers in Dar es Salaam, Tanzania. However, the presentation will start with the characteristics of the respondents.

3.1 Socio-economic and Demographic Characteristics of The Respondents

From the study participants, 565 (63.6%) were males, the age of the respondents ranged from <20years to 61+ years while the average age of the respondents was 34.8 years (SD ± 10.4). Regarding marital status, most, 574 (49.4%) respondents were married. Considering the level of education of the respondents, most, 439 (49.4%) informal sector workers had primary education while 40 (4.5%) had no formal education. Besides, more than half, 540 (60.7%) were engaged in small businesses. Further, majority of the respondents, 426 (47.9%) had an income ranging from 100,001-300,000Tshs to (43.3-129.9) (Table 1).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Attributes</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Female</td>
<td>324</td>
<td>36.4</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>565</td>
<td>63.6</td>
</tr>
<tr>
<td>Age</td>
<td>≤ 20</td>
<td>33</td>
<td>3.7</td>
</tr>
<tr>
<td></td>
<td>21 - 30</td>
<td>348</td>
<td>39.1</td>
</tr>
<tr>
<td></td>
<td>31 - 40</td>
<td>258</td>
<td>29.0</td>
</tr>
<tr>
<td></td>
<td>41 - 50</td>
<td>178</td>
<td>20.0</td>
</tr>
<tr>
<td></td>
<td>51 - 60</td>
<td>55</td>
<td>6.2</td>
</tr>
<tr>
<td></td>
<td>61+</td>
<td>17</td>
<td>1.9</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Married</td>
<td>574</td>
<td>64.6</td>
</tr>
<tr>
<td></td>
<td>Unmarried</td>
<td>315</td>
<td>35.4</td>
</tr>
<tr>
<td>Education</td>
<td>No Any Formal Education</td>
<td>40</td>
<td>4.5</td>
</tr>
<tr>
<td></td>
<td>Primary Level</td>
<td>439</td>
<td>49.4</td>
</tr>
<tr>
<td></td>
<td>Secondary Level</td>
<td>313</td>
<td>35.2</td>
</tr>
<tr>
<td></td>
<td>Tertiary Level</td>
<td>97</td>
<td>10.9</td>
</tr>
<tr>
<td>Household Size</td>
<td>1-3</td>
<td>297</td>
<td>33.4</td>
</tr>
<tr>
<td></td>
<td>4-6</td>
<td>484</td>
<td>54.4</td>
</tr>
<tr>
<td></td>
<td>7-9</td>
<td>98</td>
<td>11.0</td>
</tr>
<tr>
<td></td>
<td>10+</td>
<td>10</td>
<td>1.1</td>
</tr>
<tr>
<td>Income ($)</td>
<td>&lt;43.3</td>
<td>287</td>
<td>32.3</td>
</tr>
<tr>
<td></td>
<td>43.3-129.9</td>
<td>426</td>
<td>47.9</td>
</tr>
<tr>
<td></td>
<td>129.9-216.5</td>
<td>115</td>
<td>12.9</td>
</tr>
<tr>
<td></td>
<td>216.5-303.0</td>
<td>26</td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td>303.0+</td>
<td>35</td>
<td>3.9</td>
</tr>
<tr>
<td>Economic Activity</td>
<td>Small Businesses(Petty Traders)</td>
<td>540</td>
<td>60.7</td>
</tr>
<tr>
<td></td>
<td>Driver (Car and Tricycle and Motorcycle)</td>
<td>115</td>
<td>12.9</td>
</tr>
<tr>
<td></td>
<td>Mechanical Workers</td>
<td>106</td>
<td>11.9</td>
</tr>
<tr>
<td></td>
<td>Food Vendors</td>
<td>97</td>
<td>10.9</td>
</tr>
<tr>
<td></td>
<td>Farmer and Herdsman</td>
<td>31</td>
<td>3.5</td>
</tr>
<tr>
<td></td>
<td>Government Health Facilities</td>
<td>489</td>
<td>55.0</td>
</tr>
<tr>
<td></td>
<td>Private Health Facilities</td>
<td>350</td>
<td>39.4</td>
</tr>
<tr>
<td></td>
<td>Over The Counter Medication</td>
<td>31</td>
<td>3.5</td>
</tr>
<tr>
<td></td>
<td>Tradition Healer</td>
<td>19</td>
<td>2.1</td>
</tr>
</tbody>
</table>
3.2 Informal Sector Workers’ Uptake Status to Health Insurance

Out of the total 899 study participants, 810 (91.1%) were currently not members of health insurance and only 79 (8.9%) were members of health insurance (Figure 1). Among the members, most of them 41 (51.9%) paid the health insurance premiums by themselves, 11 (13.9%) their insurance cover used to be paid by their respective wives while 4 (5.1%) their insurance cover was paid by their relatives and friends. More than three quarters 60 (77.2%) of the members of health insurance (NHI), while 13 (16.5%), were enrolled in private health insurance and 6 (7.6%) enrolled to Community Health Fund (CHF). Majority 60 (74.7%) of the uninsured informal sector workers were willing to uptake health insurance.

Figure 1: Uptake of health insurance among informal sector workers

3.3 Factors Associated With Uptake of Health Insurance Among Informal Sector Workers

This study has categorised factors with are associated with uptake of health insurance into three major categories which are social demographic and economic factors, health systems factors, and individual factors as described below and figure 2 has summarized the factors.

Table 2: Association of Socio-Demographic and Economic Factors on Uptake of Health Insurance

<table>
<thead>
<tr>
<th>Socio demographic factor</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>Df</th>
<th>Sig.</th>
<th>Exp(B)</th>
<th>95% C.I. for EXP(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.752</td>
<td>.127</td>
<td>35.053</td>
<td>1</td>
<td>.000*</td>
<td>2.120</td>
<td>1.653-2.719</td>
</tr>
<tr>
<td>Education Level</td>
<td>.600</td>
<td>.176</td>
<td>11.565</td>
<td>1</td>
<td>.001*</td>
<td>1.821</td>
<td>1.289-2.573</td>
</tr>
<tr>
<td>Marital Status</td>
<td>-3.28</td>
<td>.347</td>
<td>.896</td>
<td>1</td>
<td>.344</td>
<td>.720</td>
<td>.365-1.421</td>
</tr>
<tr>
<td>Income</td>
<td>.546</td>
<td>.123</td>
<td>19.536</td>
<td>1</td>
<td>.000*</td>
<td>1.726</td>
<td>1.355-2.198</td>
</tr>
<tr>
<td>Membership to Economic Group</td>
<td>-2.064</td>
<td>.314</td>
<td>43.125</td>
<td>1</td>
<td>.000*</td>
<td>.127</td>
<td>.069-.235</td>
</tr>
<tr>
<td>Constant</td>
<td>-3.520</td>
<td>1.006</td>
<td>12.251</td>
<td>1</td>
<td>.000</td>
<td>.030</td>
<td></td>
</tr>
</tbody>
</table>

Note: * = Significant p<0.05  B = Beta Coefficient  SE = Standard Error  Exp (B) = Exponential Value of B (Beta)

3.3.2 Health Systems Factors

In this study, out of the total respondents, 300 (37.0%) reported low understanding on operation of health insurance is a factor not to uptake health insurance. Besides, fifty-one informal sector workers (8.5%) said difficulties in accessibility of health insurance services is a factor not to uptake health insurance. The association with the uptake of health insurance showed that there was a statistically significant relationship ($\chi^2=67.765$, df =1, p=0.000* and $\chi^2=5.277$, df =1, p=0.02*) respectively (Table 3).

Table 3: Association of Health Systems Factors With Uptake of Health Insurance

<table>
<thead>
<tr>
<th>Health systems factors</th>
<th>Frequency</th>
<th>Percentage</th>
<th>Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient Information About Health Insurance</td>
<td>300</td>
<td>37.0%</td>
<td>$\chi^2=44.162$, df =1, p=0.000*</td>
</tr>
<tr>
<td>Difficulties in Accessibility of Health Insurance Services</td>
<td>69</td>
<td>8.52%</td>
<td>$\chi^2=7.269$, df =1, p=0.007*</td>
</tr>
</tbody>
</table>

Furthermore, from the interviews it was revealed that inaccessibility of the health insurance office is currently a challenge for the informal sector workers to uptake health insurance. The fact that the offices are located at the regional centers and there are no subsidiary offices at the districts and close to the residential areas, it becomes difficult for some people to access the services as indicated in the following quote.

Figure 2: Factors associated with uptake of health insurance among informal sector workers

3.3.1 Socio-Demographic and Economic Factors Associated With Uptake of Health Insurance

Socio-demographic and economic factors which were included in this study were, age, sex, marital status, income, economic activities, education level, household size, membership to economic groups and facility of preference. In multivariable analysis, the significant factors which were associated with insurance uptake (P<0.05) were; education level, age, income and membership to economic group. The study revealed that as the income increased the informal sector workers were 1.726 times more likely to uptake health insurance [A0R=1.726; 95%CI (1.355-2.198)]. Also, informal sector workers who were members of economic groups were 12.7% less likely take up health insurance [A0R= .127; 95%CI (0.069-.235)]. In addition, the findings showed that as the level of education increased the informal sector workers were 1.821 more likely to uptake health insurance [A0R= 1.821; 95%CI (1.289-2.573)] and as the age increases the informal sector worker is 2.120 times more likely to enroll into health insurance [A0R=2.120;95%CI (1.653-2.719)] (table 2).
insurance offices increased the inaccessibility.

“…. you know what, sometimes these insurance offices are scaring for before you arrive at the reception, you meet with the security guards who will ask you a lot of questions and he/she will question even on how you have dressed without knowing the nature of work, by doing this I see am being stereotyped due to dressing code.....” (FGD 2, Informal sector workers, 2020).

Another essential finding is that the present insurance policy is a hindering factor for the informal sector workers to uptake health insurance. The fact that an insurance member has to wait for either one month, three months, or one year before starting to access some health services through health insurance (the duration depend on the membership category and types of services). Therefore, the gate keeping mechanism (waiting time) seems to be a problem for most of the informal sector worker expect services immediately after they have paid the premiums as the result some opt not to uptake health insurance.

“....the insurance beneficiaries need to wait for three months/one year after they have paid the premium and do the registration before they can access some types of services. This is contrary to their expectations for many people pay the premium for joining into health insurance while they are sick already, therefore when you tell them to wait for some time before they can access some services through the insurance card it becomes a burden to them. Once this experience is shared to the public, many possible members become reluctant to join the insurances.....” (KII 2, insurance provider, 2020).

The qualitative results showed that majority of the informal sector workers are willing to enroll in health insurance but low- and inconsistent-income lead to inability to pay premiums to uptake health insurance. As one of the informal sector group leader stated:

“.... the problem is money, we all need to have health insurance in order to access quality health care but the problem is money. Thinking of my small income that is not even enough for food, what about that one million which I have to pay in order to obtain an insurance card? Those employed in the formal sector are more advantaged because they have monthly deductions with their salary. We from the informal sector are supposed to deposit all amount once before accessing health services.....” (KII 2, Informal sector group leader, 2021).

Limited knowledge, understanding and information on the actual operation of health insurance from the process of registration to accessibility of health services were stated as hindering factor to uptake health insurance. Failure to understand the premium amount, mode of payments and service coverage lowers the value of insurance membership.

During interview, an insurance provider said that some informal sector workers thought prudently not to pay for health insurance before one gets sick.

“.... It’s better they wait with their money to get sick for they can’t pay for the insurance premium while they are not sick..... once they get sick, they will go to the health facility and get the services. They even ask as to whether they will get back the money they paid for the insurance and don’t get sick. Therefore, a person who asks such a question implies that he/she has insufficient understanding about health insurance.....” (KII 3, insurance provider, 2020).

Moreover, low priority on health insurance among the informal sector workers is a factor for low uptake. The key informant who was the insurance provider explained that the informal sector workers fail to enroll into health insurance because they do not consider health insurance as a priority therefore, they weigh out between paying for insurance and doing some other things.

“....we sensitise the community about health insurance schemes but in rural areas the challenges we face are some families are willing to pay for health insurance but they don’t have income and they end up selling their goods like chicken so as to get the premium while in town there is not only an issue of income but also priorities, after they have been sensitised most of people consider paying school fees and buying food rather than paying for health insurance. Most of them end up paying school fees and buy food and ending up not paying for the health insurance. They do what they think it’s a priority to them at that moment as per available ....” (KII 1, insurance provider, 2020).

Cultural beliefs affect the demand for health insurance to an extent that it affects the population’s risk aversion. The informal sector workers believe if one pays for the insurance premium before they are sick it implies that they make a covenant with the devil.

“....when we go to the field to sensitize community to join health insurance we are also dealing with their cultural beliefs. At some places, people do not want to join health insurance because they believe that when you join health insurance, you are making covenants with the devil that they will be sick, others say that why should you pay today for the sickness which have not happened?...” (KII 7, insurance provider, 2020).

4. DISCUSSION

The findings revealed that the uptake of health insurance among the informal sector workers is low 79(9.1%). Several studies have documented low enrollment to health insurance among the informal sector workers (Id, et al., 2020; Alesane and Anang, 2018). This finding is similar to that of other studies in LMIC who also found that members of informal sector hardly enroll in health insurance schemes (Lee et al., 2018; Shreve et al., 2017). The possible reasons for this discrepancy might be due to the fact that significant number of people who falls on informal sectors have lower and unreliable income and yet the insurance policies require them to pay the premium in single installment and they fail. Given the opportunity of flexible way to pay the insurance, more informal sector workers would have joined it for majority 605 (74.7%) of the informal sector workers are willing to join the the health insurance. The fact the informal sector workers have low understanding about operation of health insurance it becomes difficult for them to understand the risk pooling concepts and hence they fail to pay the premium before they get sick. Exclusion of the informal sector workers from the social security systems which implies less protection against health shocks is also a cause of low uptake.

According to the findings, age was among the statistically significant factor associated with the uptake. Majority of the insurance members were the older people, and this can be related to age ailments hence they consider health insurance as their priority. This result is in line with studies by which reported increased age increases the likelihood of being insured...
(Alsesane and Anang, 2018; Lukhale et al., 2017; Mutaqien et al., 2021). This finding may be attributed by the fact that older people are more likely to understand that older age is associated with ill health and thus possession of health insurance will enable easy and timely access to health services when the need arises. Also, age acts as an important determinant of the propensity to insure because it is related with high indirect vulnerability, higher medical consumption and possible increased stock of wealth.

Regarding income, it was observed that people with higher income are likely to enroll in health insurance programs. This result confirms arguments made by that the informal sector worker with higher income had the greater possibility of purchasing and renewing their health insurance (Mushi and Millamzi, 2019; Hussien and Azage, 2021). This is likely due to the fact that increased income makes an individual to be able to pay for premiums while we were limited financial ability to purchase insurance premiums. Furthermore, the study showed that higher level of education has the greater possibility of enrolment into health insurance. The positive effect of the higher education levels enhances the health seeking behavior of individuals, better knowledge and understanding about the effects of illness on health care expenditure. This finding was supported by that higher level education is associated with enrolment into health insurance (Fadlallah et al., 2018; Mwaura, et al., 2021).

Contrary to studies by which showed that membership to economic groups/association has a great role on facilitating uptake of health insurance; this study pointed out that there is no statistical association between being a member of economic group and uptake of health insurance (Oraro and Wyss, 2018; Mladovsky et al., 2014). This is perhaps due to the fact that the size of the group set by some insurance schemes are very big such that it becomes difficult to get such number of people with similar perspective on health services accessibility. If the number of people in groups would have been reasonable, it would have been easy for the informal sector workers to access some funds which would have helped them to get some money to pay the premiums despite of getting some funds for income generating activities.

Moreover, this study pointed out that insufficient knowledge about health insurance is the hindering factor for uptake of health insurance. This finding is along with two studies by who reported that lack of basic knowledge and understanding about health insurance are the barriers to enrolment into health insurance (Atafu, 2018; Tadidesse et al., 2020). In Ghana and Ethiopia studies documented that limited knowledge about the role of insurance in terms of risk sharing and resource redistribution are likely to reduce enrolment and renewal into the health insurance (Mebratie et al., 2015; Kotoh and Geest 2016). This is mostly probably related to the notion that the insurance provider think that the community are knowledgeable enough about how health insurances operate while in reality most of the community members have very limited knowledge. Strategic awareness creation campaigns will facilitate improvement on enrolment among the informal sector workers.

The informal sector workers members mentioned that the available insurance regulations hinder uptake of health insurance. This can be attributed by the low understanding on the operation of health insurance and the fact that many people pay the insurance premiums at the point of sickness, and they need to access health services immediately without considering the gate keeping mechanisms from the schemes as well as the risk pooling effect between the sick and healthy people. In Kenya, similar findings have been reported that presence of some policies made large proportion of people not to be attracted with health insurance program and those enrolled also are leaving the program. Furthermore, it was reported that the NHIF has faced a lot of criticism on its regulation of penalty of up to five times of the premium to the contributors who do not make their payments on time. This imparts negatively especially those who have low and no consistent income that would enable them pay their contributions regularly (Kimani et al., 2014; Okungu et al., 2018).

Fragmentation of the insurance providers contributed to the low uptake of health insurance. This finding is similar to the literature which showed that the gaps in coverage, comprehensiveness and adequacy inefficiencies are due to the need for many companies to face a high degree of fragmentation within their social protection systems and a lack of integration among their social protection institutions (ILID, 2021). Tanzania has been investing in several health insurance schemes but instead of leading to more coverage this has led to a fragmented health financing system as well as low enrollment numbers to insurance schemes while in Japan, the fragmentation of health insurance is a source of inefficiency in the system and inequity in premiums and hence low uptake (Lambrecht, 2017; Sakamoto et al., 2018). This may be attributed by competition for some insurance providers whereby they advocate a wide coverage on coverage of services as a way to attract customers while in reality they are incapable to deliver those promised services. This situation has made many people not to uptake health insurance with the fear of unmet expectations after being insured.

The perception that paying for health insurance is against their belief has made some informal sector workers not to uptake health insurance for it implies that they make a covenant with the devil that they will be sick. This is attributed by the fact some of the informal sector workers are not knowledgeable enough on insurance schemes and how they operate (risk pooling) hence they think paying for health insurance is against their belief that God will heal them once they get sick. This result is similar to a study conducted in Kenya which reported that cultural norms such as beliefs that enrollment into health insurance invites illness hindered uptake to CHI scheme (Kamau and Njiru, 2014). Gitau, 2016 pointed out that historically, many religious people believe that a reliance on insurance results from distrust of God protecting care. Unlike other studies on cultural belief and uptake of health insurance, observed that persistent gender gap has made women to face a number of legal, economic, and socio-cultural barriers that could disproportionately impede their access to insurance (GIZ et al., 2017).

5. Conclusion

High premium which is being paid in one installment, low understanding of the knowledge of health insurance and risk pooling together with dissatisfaction with services and insurance regulations were the identified factors associated with the uptake of health insurance among the informal sector workers. Therefore, to enhance the uptake among the informal sector workers, the policy makers and other stakeholders should consider to subsidize the premium for the informal sector workers by contributing part of it like on the formal employees and the schemes should be flexible on amount and frequency of paying the premiums. The insurance providers should design collaborative and innovative strategies to increase knowledge and understanding about health insurance as well as to ensure the services of the accredited health facilities are available at a required quality.

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Authors Contributions

BM designed the study, collected data, analyzed the data and prepared the draft of the manuscript. EE and JMN reviewed and provided input to improve the manuscript. All authors read and approved the final version of the manuscript.

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Conflict of Interest

The authors declare that they have no competing interests.

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