



Improving Planning, Implementation, and Monitoring of Minimum Service Standards for Health in Indonesia

HP+ POLICY Brief

February 2021

Lyubov Teplitskaya, Purwa Suahya, Deswanto Marbun, and M. Fajar Rakhmadi

Introduction

In this brief, the U.S. Agency for International Development (USAID) funded-Health Policy Plus (HP+) project highlights recommendations to improve health sector minimum service standard (SPM) planning, implementation, and monitoring in Indonesia, expanding upon SPM cost findings published in an accompanying HP+ report (Teplitskaya et al., 2021).

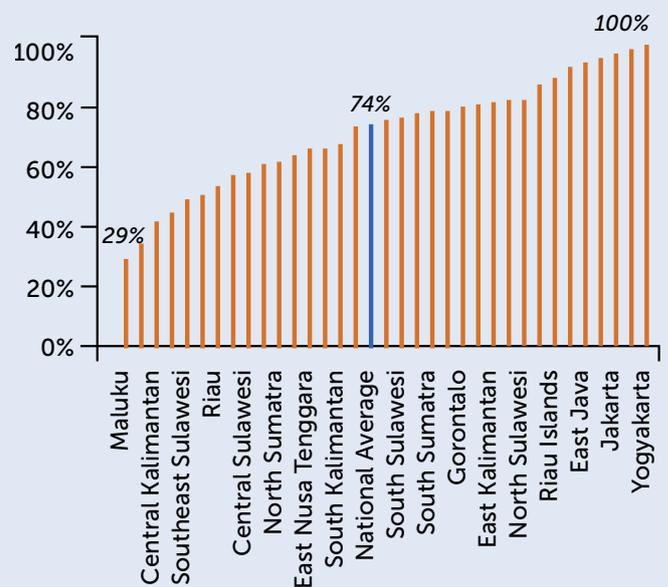
Background

The government of Indonesia has maintained its commitment to universal health coverage through the establishment of the largest single-payer social health insurance scheme (Jaminan Kesehatan Nasional, or JKN) in the world, increasing health insurance coverage to 83 percent (World Bank, 2020). However, the government of Indonesia spends 1.4 percent of gross domestic product (GDP) on health, which is approximately one-third of public health spending as a percentage of GDP in countries of similar income classification in East Asia and the Pacific (World Bank, 2020). Spending on primary healthcare remains a low proportion of total JKN payments; in October 2020, spending at first-level health facilities (FKTP) comprised 16 percent of total JKN payments (with the remainder spent at advanced referral health facilities (FKRTL) (DJSN, 2020). With the rising prevalence of non-communicable diseases and concerns regarding JKN's financial sustainability, Indonesia needs to

shift its public health spending focus from curative to primary healthcare and improve the efficiency of its public spending in the health sector.

Despite improvements in several health outcomes (e.g., infant mortality) and in access to some basic healthcare services (e.g., institutional delivery) significant geographic inequities in healthcare access and health outcomes persist among regions. For example, the percentage of live birth deliveries in a health facility is as low as 29 percent in Maluku Province and as high as 100 percent in Yogyakarta (see Figure 1).

Figure 1. Percentage of Live Births in a Health Facility



Source: BKKBN et al., 2018

The government of Indonesia has established several key programs and regulations to improve health inequities (see Box 1). Strengthening primary healthcare service delivery, mainly through improvements in infrastructure, facilities, and human resources, is a key commitment articulated in the Ministry of Health's *2020–2024 Strategic Plan* (Renstra) and in the latest *Medium-Term National Development Plan* (RPJMN). The Ministry of Health (MOH) introduced a flagship Healthy Indonesia Program (PIS-PK) in 2016 to improve health service delivery along the continuum of care, with a focus on health prevention and promotion through early identification of risk (World Bank, 2018a). The Nusantara Sehat program was launched in the same year to fulfill health workforce gaps in public primary healthcare centers (*puskesmas*) in underdeveloped, remote, border, and island areas (DTPK) in Indonesia (World Bank, 2018a; TNP2K, 2019). The MOH has set accreditation standards for *puskesmas*, private clinics, private doctors, and private dentists (Permenkes 46/2015), established an accreditation commission for facilities (KAFKTP), and identified funding sources within the Special Allocation Fund (DAK) to facilitate primary healthcare center accreditation. The MOH has also revised guidance for the use of fiscal transfers to local governments to prioritize primary healthcare challenges, via the DAK Physical Fund (DAK Fisik) and Non-Physical Fund (DAK Non-Fisik).

Box 1. Key Primary Healthcare Priorities in Indonesia

- Healthy Indonesia Program (PIS-PK)
- Nusantara Sehat Program
- Primary healthcare facility accreditation
- Revisions to the Special Allocation Fund to prioritize primary healthcare service delivery
- Minimum service standards (SPM) for health

Most notably over the past two decades, Indonesia produced several iterations of SPM at the primary healthcare level, with the most recent regulations released in the Permenkes 4/2019 (see Box 2). Whereas the MOH is responsible for providing technical guidance to provincial health offices and district health offices in planning, budgeting, managing, and delivering health services, local governments are responsible for planning and budgeting to meet SPM targets, SPM delivery, recording and reporting, and monitoring and evaluation. The new SPM regulation describes the minimum quality of mandatory services at the district level to reach 12 target populations for services throughout the lifecourse (for pregnancy, delivery, newborns, children under five years of age, school-age children, productive-age adults, and elderly) and several communicable and non-communicable diseases (see Figure 2), along with detailed technical standards of equipment, supplies, and human resources to accomplish 100 percent of health service coverage within each fiscal year. The scope of services for each population group differs one from another, but broadly includes outreach, data collection, education, screening, service delivery, referral, documentation, and reporting. The latest regulation also introduces two SPM services at the provincial level, mandating the provincial governments to provide basic health services in times of disasters and disease outbreaks.

In March 2019, the MOH Center for Health Financing and Insurance (PPJK) developed an electronic platform (Siscobikes) and associated tools to assist districts in planning and budgeting for the resources needed to meet SPM targets. Despite several modifications made in 2019 and 2020 to improve Siscobikes' functionality, an analysis of the data submitted by 67 of 514 districts indicated poor data quality and incompleteness (Sucahya and Teplitskaya, 2020). Districts rely on prior expenditure estimates to develop annual SPM budgets, which do not reflect actual costs to meet target population needs. Modifications were required to incorporate evidence-based SPM cost inputs into the revised tools, which reflect the latest Permenkes 4/2019 and

Box 2. Why Were Minimum Service Standards (SPM) Introduced in Indonesia?

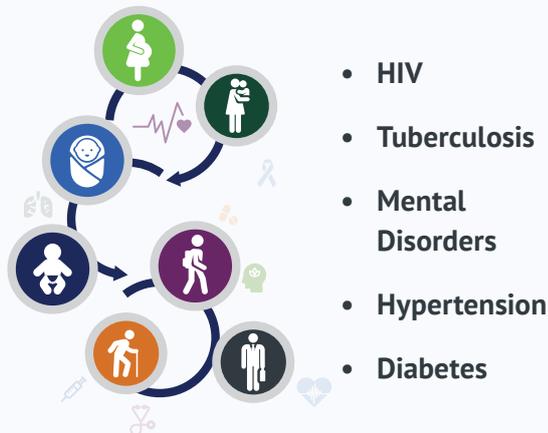
SPM were intended to address the varying quality of service provision across Indonesia to ensure the equitable coverage of basic essential services for all citizens. Regional governments were assigned obligatory functions to provide and deliver a minimum set of services regardless of their resources and capacity, which was thought to narrow regional inequities in the long term.

SPM were planned as a system to assess regional governments' performance of essential functions and hold them accountable to their constituents. It was considered that SPM performance could be used for arguments to increase local taxes when people were unsatisfied with the quality of public services.

Sources: Roudo and Chalil, 2016; Ferrazzi, 2005

Figure 2. Minimum Service Standards for Health Provided by District/Municipal Governments

Lifecourse and diseases covered:



differences in cost drivers across regions. To address these limitations, HP+ provided technical assistance to PPJK to:

1. Conduct an activity-based costing study to assess costs required to meet 100 percent of targets for 12 district-level SPM for health
2. Use cost estimates collected through the study to improve the MOH SPM budgeting tools in Siscobikes for districts to accurately budget their resource requirements to meet SPM
3. Develop an interoperability guideline for use by other ministries and government

agencies to access SPM data from Siscobikes for policy and other analyses

More details on the SPM costing study methodology and results have been published elsewhere (Teplitskaya et al., 2021). The SPM resource requirement estimates developed in the costing study were used to inform SPM recommendations in this policy brief. This policy brief also covers other SPM challenges that persist and recommended solutions.

SPM Challenges and Recommendations

Strengthen and coordinate data and information systems for SPM at the central level. Only the Bina Pembangunan Daerah (Bangda) within the Ministry of Home Affairs (MOHA) can set appropriate rewards and sanctions for local government leaders per Permendagri 100/2018. However, there is significant overlap in roles and responsibilities among PPJK, the MOH Center for Data and Information (Pusat Data dan Informasi or Pusdatin), the MOH Bureau of Planning and Budgeting (Biro Perencanaan dan Anggaran or Koren), and the MOHA, which has led to duplication in SPM data collection and information systems (see Table 1). The three MOH directorates and the MOHA use separate monitoring information systems, resulting in

redundant tracking of indicators for data on SPM planning, budgeting, and implementation. All four entities collect data on SPM targets, and all three MOH directorates monitor performance and separately collect data from districts on duplicative SPM indicators. This duplication in SPM data collection has increased district health office and puskesmas recording and reporting responsibility, leading to significant administrative burden.

A lack of interoperability among these data systems and poor coordination among stakeholders limits any meaningful use of the data to inform prioritization of health resources at both local and national levels. HP+ has supported SPM stakeholders in improving interoperability of SPM data collection systems

by developing an interoperability guideline for use by other ministries and government agencies to coordinate SPM data access. HP+ has also optimized the [Siscobikes platform](#) managed by PPJK, and supported the MOH in developing electronic modules to strengthen capacity of district health planners in gathering and submitting SPM data into Siscobikes. The new platform includes improvements to the MOH SPM budgeting tools for districts to accurately budget their resource requirements to meet SPM in upcoming years. New features in the tools include pre-filled regional SPM unit costs, which districts can select to estimate SPM funding requirements each year, in addition to an alert system to inform the user of any total resource requirements that

Table 1. Responsibilities of Government of Indonesia Stakeholders in SPM and Data Collected

	MOH PPJK	MOH Pusdatin	MOH Roren	MOHA Bangda
Role in SPM	Monitors and provides technical guidance on SPM budgeting per Permenkes 4/2019	Collects SPM performance reporting from local governments	Monitors achievement of SPM indicators per Permenkes 4/2019	Guides and oversees SPM implementation; sets appropriate rewards and sanctions for local government leaders per Permendagri 100/2018
System name	Siscobikes (Sistem Costing dan Pembiayaan Kesehatan)	SPM Komunikasi Data	Integrated monitoring and evaluation through paper-based forms	SIPD (Sistem Informasi Pembangunan Daerah)
SPM data collected	<ul style="list-style-type: none"> • Targets • Funding requirements by source • Performance • Infrastructure • Supplies and commodities • Human resources for health 	<ul style="list-style-type: none"> • Targets • Performance • Obstacles • Lessons learned 	<ul style="list-style-type: none"> • Targets • Performance • Budget allocated and realized • Obstacles • Implementation 	<ul style="list-style-type: none"> • Targets • Budget allocated and realized

exceed a budget ceiling, based on costs and targets inputted.

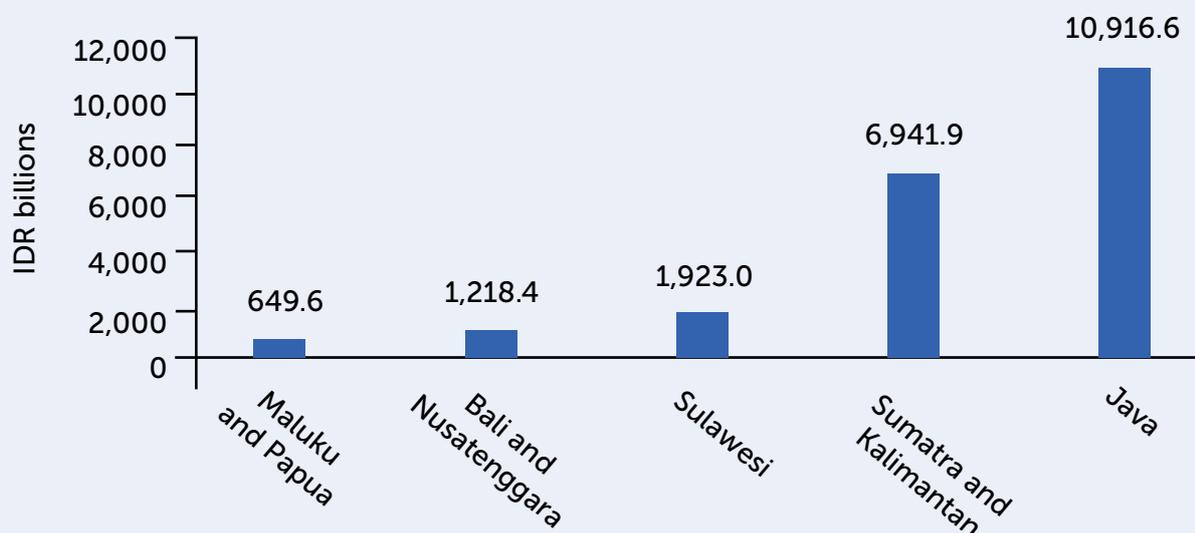
MOHA needs to ensure local government prioritization of SPM for health by assessing compliance to SPM regulations. In light of increased constraints on health resources due to COVID-19, the government of Indonesia must prioritize health spending on primary healthcare interventions, particularly for earlier screenings, to reduce average visit costs and increase treatment success. Estimated national resource requirements for direct SPM costs for 2019 total 6.7 trillion Indonesian rupiah (IDR), approximately 4.6 percent of the total subnational expenditure (APBD) for health (or an estimated IDR 25,177 per person per year) (Teplitskaya et al., 2021) (see Figure 3). Direct costs include medicines, vaccines, medical supplies, medical equipment, and transportation directly related to service delivery for SPM. With inclusion of overhead costs (or costs indirectly related to delivery of SPM services, including operating costs, fixed costs, and staff costs), total national SPM resource requirements are an estimated IDR 21.6 trillion, approximately 8.1 percent of the total APBD expenditure for health (or an estimated IDR 81,523 per person per

year) (Teplitskaya et al., 2021). To ensure the fulfillment of equipment, supplies, and human resources needed to properly implement SPM, districts need to comply with existing regulations to prioritize funding for health by allocating 10 percent of their total APBD funding for the health sector. In August 2020, the MOHA indicated that average district APBD allocations for the health sector remain below the 10 percent required, at 9.24 percent (Nugraheny, 2020). Per Law 23/2014, the MOHA must impose sanctions on local leaders who are not implementing SPM effectively and meeting their targets. The MOHA has a critical role in disseminating SPM guidance to district leaders and must clarify their responsibilities in executing SPM and the consequences if they fail to achieve 100 percent of their targets.

Currently, local governments rely significantly on DAK funding for SPM services, and should consider additional sources to increase funding for SPM.

Districts have indicated they rely significantly on DAK Fisik and DAK Non-Fisik transfers to fund SPM services (see summary of regulations in Figure 4). Based on results from a recent HP+ study, at its lowest, funding via DAK Fisik and DAK Non-Fisik accounted for 13 percent of total SPM service costs in sampled districts

Figure 3. Estimated Total SPM Resource Requirements by Region (2019, IDR Billions)



in Sumatra and Kalimantan, and at its highest, 30 percent of total SPM costs in sampled districts in Java (Teplitskaya et al., 2021). A recent fiscal space analysis indicated that most central government transfer revenue for health remains fixed and is unlikely to significantly increase (Dutta et al., 2020). The share of DAK Fisik allocated to the health sector competes with other sectors and remained at 29 percent between 2017 and 2019. The share of DAK Non-Fisik allocated to health increased marginally from 6 percent in 2017 to 9 percent in 2020; however, the majority of funding remains allocated to education. Local governments may consider increasing health allocations via more flexible subnational funding sources, which are not earmarked for specific sectors, including own source revenue (PAD), natural resource revenue (DBH-SDA), small incentive funds (DID), and village funds (Dana Desa). Other less flexible sources for SPM funding can include DBH from tobacco excise profit-sharing funds (DBH-CHT), which has had an earmark for health since 2018, and the local tobacco tax (PDRD) (Dutta et al., 2020).

As part of the ongoing process to revise the DAK Non-Fisik BOK allocation formula, use Siscobikes data to address differences in SPM service costs and needs across districts. The revised BOK resource allocation formula can also include indicators to incentivize local governments to submit SPM data into Siscobikes and meet their targets.

Central government transfers such as the DAK are comprised of rigid budget line items and resource allocation formulas that do not accurately reflect district needs or demands. One evaluation by the Directorate General of Public Health found that DAK Non-Fisik BOK budget absorption decreased nationally from 2017 to 2018 and was below 60 percent in 73 regions in Indonesia in 2018 (KOMPAK, 2020). In general, the rate of absorption of DAK Non-Fisik activities in the health sector in 2018 was low: BOK—82 percent, Jampersal—52 percent, puskesmas accreditation—78 percent, and laboratory and other accreditation—64 percent.

Currently, BOK disbursements do not address regional service needs nor differences in costs across regions, which has led to underfinancing in some regions and overfinancing in others (KOMPAK, 2020). The BOK allocation formula includes several technical indicators (population, number of puskesmas, number of pregnant women, district/municipality weights, among others), as well as indicators on regional DAK utilization performance and reporting compliance in the previous year. The KOMPAK project is reviewing the BOK allocation formula and is conducting a costing study to inform more accurate BOK allocations based on district needs and costs (KOMPAK, 2020). To inform an allocation formula for BOK that better reflects SPM needs and costs, Siscobikes data can be used to assess differences in costs across districts for specific SPM sub-activities, which are aligned with the BOK activity menus in Permenkes 86/2019.

The year 2021 is the first for which districts and municipalities will submit SPM plans per the new Permenkes 4/2019. Although SPM guidelines have been communicated extensively, the central government still has concerns about districts meeting SPM performance targets and submitting relevant data into Siscobikes. It is unclear whether all local governments will comply with SPM reporting responsibilities as outlined in Permenkes 4/2019, and whether the budgets submitted will be complete and accurate. In 2019, only 67 of 514 districts submitted SPM plans and budgets into Siscobikes and the data were incomplete and of low quality (Sucahya and Teplitskaya, 2020). The MOHA is the sole entity that may set appropriate rewards and sanctions for local government compliance with Permenkes 4/2019, though it has not yet outlined the consequences to district leaders if they do not comply with the regulation. Likewise, the MOHA has not yet released any guidance outlining incentives or rewards for districts that comply with the regulation. The government of Indonesia can incentivize improved SPM performance and submission of Siscobikes data by including

these two indicators within the revised BOK allocation formula (similar to previous indicators on DAK utilization performance and reporting compliance).

Replace rigid budget line items within DAK Fisik (regular, assigned, and affirmative) with a resource allocation formula that addresses differences in health infrastructure and equipment costs, needs, and performance across districts. The government of Indonesia has made some improvements to prioritize DAK Fisik funding for primary healthcare, including addressing health infrastructure gaps by adding funding to strengthen basic services in underdeveloped, remote, border, and island areas (DTPK) in the Affirmative DAK Fisik (Permenkes 85/2019) (see Figure 4). However, recent World Bank analyses find no evidence

that these transfers have reduced inequalities or improved health service delivery across Indonesia (World Bank, 2018b, 2020). DAK Fisik funds are comprised of rigid budget line items for health infrastructure, equipment, health facility rehabilitation, and other non-operational expenses, and do not effectively meet district needs and demands. The MOHA's process to approve or deny the annual budget line items submitted by local governments is limited to checking alignment of the funding request to an approved list of possible DAK Fisik budget line items; no assessment of districts' specific health infrastructure and equipment needs nor performance in prior years is conducted. To improve this time-intensive process and address the mismatch among funding levels, needs, and performance, the government of Indonesia may consider

Figure 4. DAK Fisik and DAK Non-Fisik Regulations

DAK Fisik	DAK Non-Fisik
<p>Regular DAK Fisik</p> <p>Funding for infrastructure, equipment, and primary healthcare facility rehabilitation to strengthen promotive and preventive efforts and increase availability of pharmaceuticals at primary healthcare centers.</p> <p>Assigned DAK Fisik</p> <p>Funding for infrastructure, equipment, and healthcare facility rehabilitation to (1) accelerate decreases in stunting, (2) improve control of infectious diseases and risk factors for non-communicable diseases; and (3) improve health system performance in equitable access to quality health services.</p> <p>Affirmative DAK Fisik</p> <p>Funding to strengthen basic infrastructure at puskesmas and funding for infrastructure, equipment, and healthcare facility rehabilitation to strengthen basic services in underdeveloped, remote, border, and island areas (DTPK).</p>	<p>Health Operational Fund (BOK)</p> <p>Operational funding for health promotion and prevention activities, including socialization at the provincial, district, and community level. Includes specific pharmaceutical BOK (to improve management and increase availability of essential medicines, vaccines, and medical consumables in puskesmas) and stunting BOK.</p> <p>Jaminan Persalinan (Jampersal)</p> <p>Funding to improve facility-based deliveries, including delivery referrals, for rent and operation of maternity waiting homes, and for labor payment assistance.</p> <p>Puskesmas accreditation</p> <p>Funding for workshops and surveys to support accreditation and implementation.</p> <p>Other operational funding</p> <p>Funding for food and drug administration, pharmaceutical service facility control, and homemade food and beverage control.</p>

Sources: Permenkes 85/2019 and Permenkes 86/2019

using available data through Siscobikes and other sources to develop a new DAK Fisik allocation formula for health. The allocation formula could include indicators to address differences by district or region for health infrastructure and equipment costs, needs, and utilization of DAK Fisik funds for health in the previous year.

Develop clear reporting, monitoring, and evaluation technical guidance for puskesmas and private clinics. Strengthen the role of puskesmas in coordinating delivery of SPM services with the private sector.

Monitoring and evaluation for SPM is not prioritized at most district health offices sampled, and there is a lack of systems currently in place for puskesmas to receive constructive feedback on their monthly report submissions (Teplitskaya et al., 2021). To improve the supervisory role of district health offices and puskesmas in recording and reporting longer term, the MOH must establish an integrated reporting system that accommodates reporting at SPM and program levels. As part of strengthening SPM delivery in private clinics, Indonesia must strengthen the role of puskesmas in coordinating with the private sector on delivery of SPM services, which includes consolidating its SPM performance reports with those reported by the private sector.

Conclusions

With the rising prevalence of non-communicable diseases and concerns regarding JKN's financial sustainability, Indonesia must improve delivery of SPM services and meet SPM targets to lower overall costs of Indonesia's healthcare system and improve health outcomes. HP+ has supported the government of Indonesia in strengthening and coordinating data and information systems for SPM by (1) improving its electronic platform for SPM (Siscobikes), (2) improving associated Microsoft Excel-based tools with pre-filled cost estimates that vary by region, (3) supporting the government of Indonesia in

communicating SPM technical guidance, (4) developing electronic modules to strengthen district health planners' use of the costing tools and the Siscobikes platform, and (5) developing an interoperability guideline for use by other ministries and government agencies to access Siscobikes data.

In this first year of implementing Permenkes 4/2019, the government of Indonesia may consider several key actions to ensure local government compliance with the regulation and to improve SPM implementation:

1. As part of the ongoing process to revise the DAK Non-Fisik BOK allocation formula, use Siscobikes data to address differences in SPM costs and needs across districts.
2. Incentivize local governments to submit accurate SPM data into Siscobikes and meet SPM targets by including new performance indicators within the DAK Non-Fisik BOK allocation formula.
3. Replace inflexible budget line items within DAK Fisik (regular, assigned, and affirmative) with a resource allocation formula that addresses differences in health infrastructure and equipment costs, needs, and performance across districts.
4. Clarify consequences to district leaders should they fail to meet SPM requirements.
5. Strengthen the role of puskesmas in coordinating service delivery for SPM with the private sector.

Note

Several acronyms in this report refer to the Indonesian term: APBD—Anggaran Pendapatan Dan Belanja Daerah; BOK—Bantuan Operasional Kesehatan; DAK—Dana Alokasi Khusus; DBH-CHT—Dana Bagi Hasil Cukai Hasil Tembakau; DBH-SDA—Dana Bagi Hasil Sumber Daya Alam; DID—Dana Insentif Daerah; DJSN—Dewan Jaminan Sosial Nasional; DTPK—Daerah Tertinggal Perbatasan

Dan Kepulauan; FKRTL–Fasilitas Kesehatan Rujukan Tingkat Lanjut; FKTP–Fasilitas Kesehatan Tingkat Pertama; KOMPAK–Kolaborasi Masyarakat dan Pelayanan untuk Kesejahteraan Kemitraan Pemerintah Australia-Indonesia); PAD–Pendapatan Asli Daerah; PDRD–Pajak Daerah Dan Restribusi Daerah; PIS-PK–Program Indonesia Sehat dengan Pendekatan Keluarga; PPJK–Pusat Pembiayaan dan Jaminan Kesehatan; Pusdatin–Pusat Data dan Informasi; Renstra–Rencana Strategis Kementerian Kesehatan; RPJMN–Rencana Pembangunan Jangka Menengah Nasional; Siscobikes–Sistem Costing dan Pembiayaan Kesehatan; SPM–Standar Pelayanan Minimal.

References

- Dewan Jaminan Sosial Nasional (DJSN). 2020. “Sistem Monitoring Terpadu.”
- Dutta, A., K. Ward, E. Setiawan, and S. Prabhakaran. 2020. *Fiscal Space for Health in Indonesia: Public Sector Opportunities and Constraints in Achieving the Goals of Indonesia’s Mid-Term Development Plan (RPJMN) 2020–2024*. Jakarta: Kementerian PPN/Bappenas.
- Ferrazzi, G. 2005. “Obligatory Functions and Minimum Service Standards for Indonesian Regional Government: Searching for a Model.” *Public Administration and Development* 25(3): 205–215.
- Kolaborasi Masyarakat dan Pelayanan untuk Kesejahteraan Kemitraan Pemerintah Australia – Indonesia (KOMPAK). 2020. Unpublished presentation: “Costing Study on DAK Non-Physical Health Operational Fund (BOK) Health Services.” Presented April 16, 2020, Jakarta, Indonesia.
- National Population and Family Planning Board (BKKBN), Statistics Indonesia (Badan Pusat Statistik–BPS), Ministry of Health (Kemenkes), and ICF. 2018. *Indonesia Demographic and Health Survey 2017*. Jakarta, Indonesia: BKKBN, BPS, Kemenkes, and ICF.
- Nugraheny, D. 2020. “[Mendagri: Masih Banyak Daerah yang Alokasi Anggaran kesehatannya Kurang dari 10 Persen APBD](#).” Kompas.com, August 18, 2020.
- Roudo, M. and T. Chalil. 2016. “[Depolarization in Delivering Public Services? Impacts of Minimum Service Standards \(MSS\) on the Quality of Health Services in Indonesia](#).” *Journal of Regional and City Planning* 27(1): 1–15.
- Sucahya P. and L. Teplitzskaya. 2020. *Analysis of Local Government Budgets to Meet Minimum Service Standards for Health in Indonesia*. Washington, DC: Palladium, Health Policy Plus.
- Teplitzskaya, L., P. Sucahya, D. Marbun, M. Rakhmadi, and Y. Leosari. 2021. *Cost of Implementing Minimum Service Standards for Health in Indonesia*. Washington, DC: Palladium, Health Policy Plus.
- TNP2K. 2019. *Improving Health of the Left-Behinds: The Case of Indonesia’s Nusantara Sehat*. TNP2K Working Paper 6-2019. Jakarta, Indonesia.
- World Bank. 2018a. *Indonesia – Supporting Primary Healthcare Reform Project: Technical Assessment*. Washington, DC: World Bank Group.
- World Bank. 2018b. *Is Indonesia Ready to Serve?: An Analysis of Indonesia’s Primary Health Care Supply-Side Readiness*. Washington, DC: World Bank Group.
- World Bank. 2020. *Indonesia Public Expenditure Review: Spending for Better Results*. Washington, DC: World Bank Group.

CONTACT US

Health Policy Plus
1331 Pennsylvania Ave NW, Suite 600
Washington, DC 20004
www.healthpolicyplus.com
policyinfo@thepalladiumgroup.com

Health Policy Plus (HP+) is a seven-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-15-00051, beginning August 28, 2015. HP+ is implemented by Palladium, in collaboration with Avenir Health, Futures Group Global Outreach, Plan International USA, Population Reference Bureau, RTI International, ThinkWell, and the White Ribbon Alliance for Safe Motherhood.

This publication was produced for review by the U.S. Agency for International Development. It was prepared by HP+. The information provided in this document is not official U.S. Government information and does not necessarily reflect the views or positions of the U.S. Agency for International Development or the U.S. Government.

