

Financial Implications of Paying for Maternal and Neonatal Healthcare Services for Vulnerable Populations in Tanzania

HP+ POLICY Note

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Introduction

Improving maternal and neonatal health outcomes is a clear, longstanding priority for the Tanzanian government. This is reflected in a range of national policies, including the *Tanzania Vision 2025*, the *National Health Policy*, the *Health Sector Strategic Plan, 2015-2020*, and the *National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania (2016-2020)* (Republic of Tanzania, 2017). In line with this, Tanzania has implemented policies designed to reduce barriers and increase the use of key maternal and neonatal health services, particularly among the poor and vulnerable. Waivers and exemptions, for example, which aim to remove the cost of services at the point of care, have been in place for over two decades (see Box 1) (Mubyazi, 2004).

Despite waivers and exemptions and other efforts to improve maternal and neonatal health outcomes, the *2015 Tanzania Demographic and Health Survey (TDHS)* shows mixed results on the use of maternal and neonatal health services alongside a minimal decline in the maternal mortality ratio over the last decade (MOHC/DGEC et al., 2016). There is a clear need for new mechanisms to improve access to maternal health services, especially among poor and vulnerable women who face greater barriers to care.

In partnership with the National Health Insurance Fund (NHIF), the KfW Development Bank is piloting one potential mechanism. Active in five regions, the Tumaini la Mama program targets poor pregnant women, offering

Box 1. Health Facility User Fee Waiver and Exemptions in Tanzania

Waivers and exemptions are not formally codified into a single policy but have been in place in Tanzania in some form since 1994. They are intended to remove the cost of maternal and child health services for specific poor and vulnerable groups. Waivers cover the cost of services for individuals with certain health statuses deemed vulnerable, such as a pregnant woman or a person living with HIV. Waivers are need-based and cover the cost of services for the poor.

Effectively implemented waivers and exemptions would mean that pregnant women, especially the poor and vulnerable, would be able to access antenatal and maternity services free of charge. However, studies have found that exemptions and waivers in Tanzania have not been effectively implemented. They have suffered from a range of challenges, from citizens not knowing they're available to limited local capacity to administer and manage them (Burns and Mantel, 2006; Idd, et al. 2013; Maluka, 2013).

them the complete NHIF benefits package free of charge throughout their pregnancy through six months postpartum.¹ The pilot has shown promising results and demand for coverage under this scheme has grown (KfW Development Bank, 2016a; KfW Development Bank, 2016b). Sustainability and scalability, however, are not yet clear.

There are many mechanisms Tanzania could use to expand fully subsidized maternal and neonatal health services for poor women through insurance. Tanzania is exploring the consolidation, improvement, and scale up of the Community Health Fund, a set of community-based health insurance schemes managed by NHIF, as an intermediary step in promoting access to healthcare alongside NHIF reform and expansion. If the Community Health Fund or National Health Insurance Fund schemes are used as vehicles for expanding access and use, they will need to cover maternal and neonatal health services for the poor.

Designing and implementing any such mechanism will ultimately require understanding two key questions. First, how do financial barriers influence the use of maternal health services? This is examined in a companion brief, *Maternal Health Services in Tanzania: Determinants of Use and Related Financial Barriers from 2015-16 Survey Data*. Second, what would it cost to remove these barriers?

To address the second question, Health Policy Plus (HP+), a project funded by the U.S. Agency for International Development, explored the cost of fully subsidizing a defined package of key maternal and neonatal health interventions for poor pregnant women in Tanzania. It is not intended to provide a definitive estimate of resource needs, but rather to create a conceptual framework for examining what it might cost to scale this package and how resource needs might change under different scenarios. To this end, the analysis studied three questions:

1. How many poor pregnant women should be covered at different estimates of socioeconomic vulnerability?
2. What is the approximate unit cost of the key maternal health services to be covered for the poor?
3. What is the cost of covering the poor population now, and how might it change in the near future?

Analysis shows that expanding coverage of a fully-subsidized package of maternal and neonatal health services is feasible in Tanzania given current resources. Subsidizing such a package through an insurance-type scheme—like the Tumaini la Mama pilot (funded by KfW), NHIF, or the Community Health Fund—will require a clear understanding of the costs to the payer and how those costs might change depending on how the size of and demand for services from the beneficiary population vary. The scheme must also determine how to define the poor, properly target resources, maintain quality, and address supply-side constraints.

¹ The KfW program also covers 50% of the costs of enrollment for the woman's family in locally-administered Community Health Fund schemes. This component of the KfW initiative is beyond the scope of this analysis.

This analysis estimates the cost of providing poor pregnant women with a fully-subsidized package of key maternal and neonatal health services defined by *The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child, & Adolescent Health* of the Government of Tanzania, also known as *One Plan II*, which was costed in 2015. The analysis uses the existing comprehensive costing of *One Plan II* to determine the average unit cost per pregnant woman, including both commodity and labor costs of health workers. The unit cost calculation accounts for the likelihood that an average woman would access a maternal and neonatal health intervention, using previously-used assumptions on the occurrence of pregnancy-related complications, and indicators for baseline health-seeking behavior across socioeconomic groups.

The unit costs were used to project total resource needs across several scenarios. The scenarios are useful to inform policy as future population coverage of the scheme and the change to health-seeking behavior after a demand-side intervention like insurance is launched are both uncertain. In essence, financial implications of the scale-up of a maternal and neonatal health scheme, like those funded by KfW and NHIF, are dependent on how much of the population the scheme can cover and likelihood of that population using healthcare services.

To define the population of poor pregnant women a maternal and neonatal health scheme should cover, HP+ used two different methodologies—demographic survey data and community-based identification—to create two potential population scenarios. Based on these populations, the analysis determined the total costs for the current year. It also projected potential future costs. As the overall population grows, so will the number of women of reproductive age. We also assume that subsidizing maternal and neonatal health services through an insurance-like mechanism will reduce financial barriers and increase demand for services among the poor and vulnerable, which has implications for cost. Based on existing evidence, HP+ made assumptions on how demand (health-seeking behavior around pregnancy-related care and facility-based labor and delivery) might change. The population growth rate and potential increases in demand were applied to both baseline population scenarios to determine how the number of women seeking maternal and neonatal health services might increase. The results of these scenarios illustrate important drivers of cost to consider in evaluating the scale-up of a Tumaini la Mama-type scheme, particularly for its financial feasibility.

The analysis relied on three main sources of data:

- 1. National poverty estimates.** The analysis used two measures of poverty in conjunction with demographic data on women of reproductive age and pregnancy rates.

- **TDHS 2015.** *The Tanzania Demographic and Health Survey* assigns each household to a wealth quintile, where the quintiles are based on household asset ownership, and derived from principal component analysis (MOHCDGEC et al., 2016).

- **Tanzania Social Action Fund (TASAF).** TASAF is a poverty reduction initiative that uses a community-based system to identify and target the most poor and vulnerable households (see Box 2). Data on beneficiaries was available for five regions and extrapolated to the national level (Njau, 2017).

2. Tumaini la Mama and NHIF scheme data (2016-2017).

Operational data from the current pilot program and the broader national NHIF scheme, coupled with key informant interviews, were analyzed to understand current mechanisms, cost, data, and resource availability for scaling maternal and neonatal health coverage.

3. Tanzania One Plan II Costing

Data. The *One Plan II* costing used detailed cost commodity analysis for each selected intervention. These led to unit costs, which are the basis for cost estimates. These were supplemented by human resource cost estimates derived during an application of the OneHealth Tool (Barker and Dutta, 2015).

Box 2. TASAF Targeting System

TASAF uses community-based mechanisms, verified by means testing, to identify and prioritize the neediest households within a given community:

1. Community management committees identify vulnerable households based on indicators like child and elderly heads of household or chronically sick members.
2. Community management committees screen identified households and collect data for means testing.
3. TASAF conducts proxy means testing on a sample of households to ensure they qualify.
4. Local governing bodies validate the list and rank households to prioritize the most vulnerable if beneficiaries exceed available resources.

Sources: Morisset, 2013; Evans et al., 2014

Population Estimates of Total Poor and Vulnerable Pregnant Women in Tanzania

For the population of poor pregnant women in Tanzania, we created two scenarios based on the different ways of identifying the poor.

- **TDHS Q1 Poor Scenario:** From the TDHS estimates, the percentage of the population in the poorest quintile or quintile 1 (Q1) was determined for each of Tanzania's 31 regions, which can be applied to the total population size by region.
- **TASAF Poor Scenario:** TASAF beneficiary data were available for four regions (Lindi, Mbeya, Mtwara, Songwe, and Tanga). Based on the number of beneficiaries relative to the total population, the analysis determined the "TASAF poverty rate" by region. These rates were considerably lower than with TDHS estimates of Q1, by about 50% on average. Using the ratio of the TASAF and TDHS estimates from the five regions HP+ had data on, we determined the "TASAF poor" estimates in the 27 other Tanzanian regions for this scenario.

In both cases, these estimated poor rates were used with the total size of the population,² the number of women of reproductive age, and pregnancy rates among the poor to estimate the number of poor pregnant women in each region. The aggregated values at the national level are shown in Table 1.

Table 1. Estimated Number of Poor Pregnant Women in Tanzania, 2018

TDHS Q1 Poor Scenario	TASAF Poor Scenario
268,423	179,440

As seen in Table 1, there is a significant difference in the number of poor women across the two scenarios. Unlike TDHS, TASAF's identification of the poor is not just asset based, but includes other indicators of vulnerability and is community-specific (as shown in Box 2). Also, TASAF's methodology includes a ranking mechanism to prioritize the most vulnerable households based on resource availability. It is likely that the majority of the TASAF-identified individuals belong to a subset of the TDHS Q1 (lowest quintile). If there are resource constraints, then using the TASAF estimate may target those who are the poorest and most vulnerable. The level of overlap, however, between the two concepts is uncertain. The TASAF approach, for example, may not capture very poor households that do not have any of the other household vulnerabilities.

TDHS gives an indication of the potential underlying population in need of coverage, while the TASAF approach offers one practical option for identifying and targeting these women for inclusion in a maternal health scheme. How the scheme defines the poor and operationalizes that definition will have significant implications in terms of both coverage and costs. In Ghana, for example, the National Hospital Insurance Scheme initially defined the poor as those without income, without employment, and without housing. In practice, these individuals were difficult to identify and enrollment remained low. In 2013, the scheme began using a variety of other approaches and pro-poor mechanisms to better capture the poor population (i.e., school feeding program participants, orphans, and social welfare recipients). Enrollment of the poor increased nearly fourfold that year (NHIA, 2013). Any health financing scheme for poor women in Tanzania must carefully consider its policy objectives, resources, and target population in determining how to define *poor*.

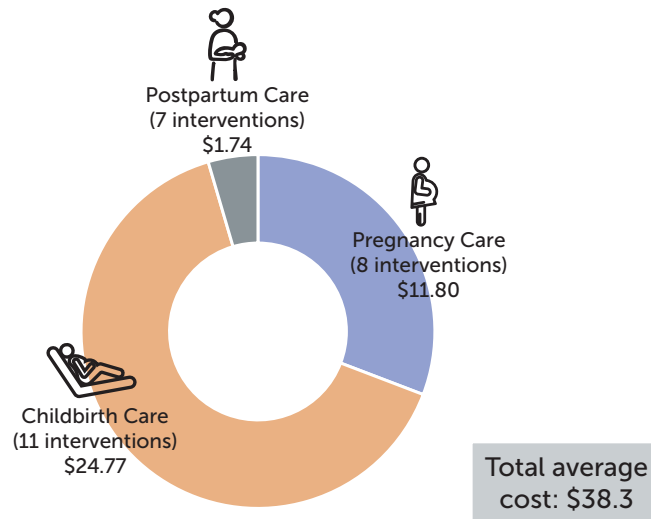
Unit Cost Estimates

The *One Plan II* defined a clear package of priority health maternal services for improving maternal and neonatal health outcomes in Tanzania. The costed interventions included eight related to pregnancy care, seven related to postpartum care, and 11 related to labor and delivery. HP+ estimated the average per woman cost of delivering this package of services is US\$38.3 (see Figure 1), including both commodity and health worker labor costs. The specific unit cost of each intervention was weighted by likelihood of underlying need, using the same assumptions as the *One Plan II* (i.e., 100% of all pregnant women need basic antenatal care, but only

² Applying Tanzania 2012 Census data, i.e., a 3.1% annual growth rate in population.

1.8% need interventions for management of pre-eclampsia). Cost calculations also accounted for the likely demand for services, using TDHS-derived rates for facility-based birth and antenatal care among the poor (Q1) as proxies for baseline health-seeking behavior in this population in 2018 (see Table 2 for specific intervention costs and utilization rates and Box 3 for a more detailed discussion of unit-cost assumptions).

Figure 1. Cost Per Woman by Intervention Area (US\$)



Box 3. Key Assumptions

Intervention costs. Individual intervention costs were based on previous costing studies. One Plan II was used for commodity costs. An application of the OneHealth Tool for costing Tanzania's Health Sector Strategic Plan provided human resource estimates, including average health worker salaries and the average time each cadre spends per intervention (Barker and Dutta, 2015; MOHCDGEC, 2016).

Percent in need. To determine the total average cost per woman, the cost of each intervention was weighted according to the prevalence of a given condition. This study used the same assumptions as the One Plan II based on available epidemiological data.

Percent likely to seek care. The study used rates of antenatal care visits and facility-based births from the bottom quintile in TDHS 2015 as proxies for the likelihood of women actually using these services (MOHCDGEC et al., 2016). Pregnancy care services were estimated at 50.6%. These services likely require multiple contacts with the health system to identify related complications, and were approximated by the percentage of poor women accessing four or more antenatal care visits. Basic antenatal care was an exception and used a weighted average of poor women accessing one to four visits. Labor, delivery, and postpartum care was estimated at 40.9%. The likelihood of poor women using labor and delivery services and postpartum care was approximated by the percentage of facility-based births among poor women.

Supply-side limitations. The study does not consider potential supply-side limitations and assumes that all women who see care will be able to access a given service.

Table 2. Unit Cost by Intervention and Service Area

Intervention	Unit Commodity Cost (2015 TZS)	Unit Human Resources Cost (2015 TZS)	Pregnant Women in Need (%)	Pregnant Women Who May Actually Seek Care (%)
Pregnancy Care				
Ectopic pregnancy	101,687	40,572	1%	51%
Tetanus toxoid	400	1,208	100%	83%
Syphilis detection and treatment	756	15,241	100%	51%
Basic antenatal care	8,179	8,151	100%	97%
Hypertensive disease management	2354	17,105	1.20%	51%
Management of pre-eclampsia	5,972	38,687	1.60%	51%
Management of anemia	6,777	7,856	1.80%	51%
Deworming of pregnant women	36	263	100%	51%
Weighted average cost per woman: TZS 26,740 (US\$11.8)				
Childbirth Care: Facility Births				
Labor and delivery management	15,000	31,938	100%	41%
Active management of third stage labor	462	361	100%	41%
Management of eclampsia	4,726	38,687	0.58%	41%
Newborn resuscitation	496	1879	10%	41%
Cesarean section	45,455	84,038	10%	41%
Induction of labor (42 weeks)	2268	33,433	5%	41%
Antibiotics for preterm premature rupture of membranes (pPROM)	742	1,966	3%	41%
Treatment of local infections	1,509	1,311	10%	41%
Kangaroo mother care	447	441,598	13%	41%
Vitamin K1 and iron for low birthweight babies	6,900	417	13%	41%
Antenatal corticosteroids for preterm labor	6,571	188,743	8%	41%
Weighted average cost per woman: TZS 56,207 (US\$24.77)				
Postpartum Care				
Preventive postnatal care (within two days)	204	167	100%	41%
Maternal sepsis case management	89,335	16,905	4%	41%
Mastitis	2,084	1,801	10%	41%
Treatment of postpartum hemorrhage	20,275	13,044	10%	41%
Newborn sepsis, full supportive care	12,503	4,341	1%	41%
Newborn sepsis: injectable antibiotics	11,309	1,493	9%	41%
Weighted average cost per woman: TZS 3,979 (US\$1.74)				

Total Cost of Reaching Poor Pregnant Women

Based on the estimates of the population to be covered and the average cost per woman, the study first estimated the total cost of subsidizing the entire package of services for all pregnant women, according to each definition of poor, for 2018. For each scenario, the amounts are as follows:

- **TDHS Q1 Poor Scenario: US\$10,260,367**
- **TASAF Poor Scenario: US\$6,705,004**

Resource requirements are obviously much higher to cover the larger, TDHS Q1-defined poor population than the more specific TASAF-targeted population. However, regardless of how the target population is ultimately defined, the resource requirements to subsidize the same set of services for poor pregnant women will increase over time. First, the population will continue to grow. The population growth rate in Tanzania is estimated at around 3.1% since 2006 (World Bank, 2016). Second, the proposed mechanism—fully subsidizing the cost of maternal and neonatal health services through insurance—will drive demand and health-seeking behavior. Once people are registered in such a scheme and become more aware of their new entitlements, they will increase their use of services as financial barriers are eliminated. Covering the cost of this maternal and neonatal health package will increase demand and increase the amount of services ultimately subsidized.

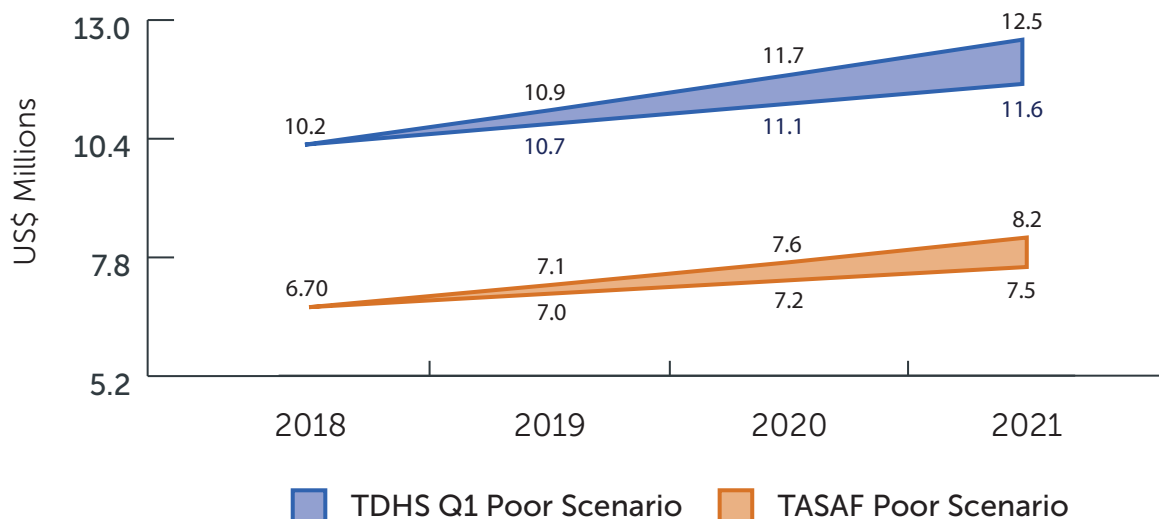
There are no available data yet from Tanzania on how insurance coverage might change the use of maternal and neonatal health services, but evidence from other country experiences can provide a useful framework for the potential change. A study of demographic health survey data assessed the levels and impact of insurance across eight countries, looking specifically at the impact of coverage on facility-based birth. Three of the countries—Ghana, Indonesia, and Rwanda—all show a significant, positive impact of insurance on facility-based births. All these countries were relatively newly insured (less than eight years) and had population coverage of at least two-thirds, useful for mirroring potential impacts of newly subsidizing maternal and neonatal health care for an entire population group in Tanzania (Wang et al., 2014).

Based on the impact of insurance in these countries, this analysis created a reasonable range for how demand for services might increase under a fully-subsidized maternal and neonatal health scheme—between 1.1% and 4.4% annually. The referenced studies do not address patterns in demand-growth rates and for the purposes of this analysis, we assumed linear growth. In reality, growth in demand may vary overtime. For example, a country may see a spike in the use of services immediately after implementing a free maternal and neonatal health scheme as pent-up demand is met. Or, it may take time for households to become aware of, or comfortable with, scheme benefits. In the latter case, growth in demand may initially be slow and then pick up pace as the scheme becomes better established.

The potential growth rates in demand were applied to the projected population for each year and used with previously determined base unit costs to estimate a

potential range of future resource needs. Based on these assumptions and projected population growth over the next four years, the total cost for covering the TDHS-defined poor population would reach approximately US\$12 million. With the scenario of TASAF-identified poor, the cost would grow to around \$8 million (see Figure 2 for upper and lower cost projections for each scenario).

Figure 2. Projected Total Annual Cost Range to Fully Subsidize Maternal Health Services for the Poor



Based on the existing evidence from other countries, the analysis determined a likely range for potential increase in demand. Figure 2 shows upper and lower cost projections for each year based on this range.

Discussion

Given the policy context in Tanzania and the desire for rapid improvements in maternal and neonatal healthcare, this analysis provides useful insight into the potential costs and considerations of subsidizing the essential package of maternal and neonatal health interventions through an insurance-type scheme. The KfW pilot—alongside NHIF, future Community Health Fund improvement and scale-up, and eventually the consolidation and scale-up of a single national health insurance scheme—all offer the possibility of a fully subsidized package of maternal and neonatal health services for the poor.

Such policy action, however, requires an understanding of the costs of a clearly-defined maternal and neonatal health package to the payer, the scope of the beneficiary population, and the likelihood of changes in the use of maternal and neonatal health services because of the scheme. There is ongoing discussion of approaches to scale insurance coverage, including a potential approach to scale coverage by level of care, rather than through defined services. At least in the initial stages, however, this restricts access to maternal services available at lower levels of care and limits access to other key services like emergency obstetric care. This analysis is an important step in this policy discussion, offering a framework to consider a specific package across levels of care and potential drivers of costs, including defining the target population and the potential growth in demand.

Further formative research will be important to build a more precise understanding of how subsidizing maternal and neonatal health services through insurance will change demand for such services and actual use in the future. The KfW pilot has reported on this effect (KfW Development Bank, 2016a), and it will be critical to quantify it when implementing at scale.

Expanding the coverage of a free maternal health scheme does not eliminate the need to address supply-side constraints. Although insurance is a primarily demand-side intervention, removing financial barriers to and paying facilities for a package of maternal and neonatal health services may induce an improvement in supply and quality. Under Tumaini la Mama, for example, accredited facilities received payment directly from NHIF for services provided. This revenue stream improved facilities' financial situation and allowed them to improve their quality of services (KfW Development Bank, 2016a). It has also encouraged facilities to gradually invest in improved information and communication technology to facilitate processing, which in turn contributes to improved efficiencies. These kinds of trends can contribute to the sustainability of improved maternal and neonatal health services, and even further improve health outcomes.

The estimates in this study also demonstrate the feasibility of expanding fully subsidized care for poor women within the context of current resources. Under the second phase of the KfW/NHIF Tumaini la Mama pilot, covering five regions, the partners together allocated nearly US\$32 million from August 2016 to July 2018 (KfW Development Bank, 2016a). The estimates above fall within this range, though there are other costs that KfW and NHIF will need to cover from the \$32 million budget. It appears that paying for the costs of maternal and neonatal health services for poor women on a national scale is feasible, if resources are properly targeted. Any proposed mechanism to scale such coverage in Tanzania must carefully consider the implications of how it identifies and targets the poor. A good targeting mechanism would advance the objectives of improving maternal health outcomes and be sustainable given the available resources. HP+ is continuing to engage in advancing coverage of the poor and vulnerable through insurance-based schemes in Tanzania in partnership with the Community Health Fund Implementers Taskforce. This collaboration will assess the benefits of different Community Health Fund scale-up strategies in terms of improved access and coverage for the poor and vulnerable.

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