

# Has Indonesia's National Health Insurance Scheme Improved Family Planning Use?

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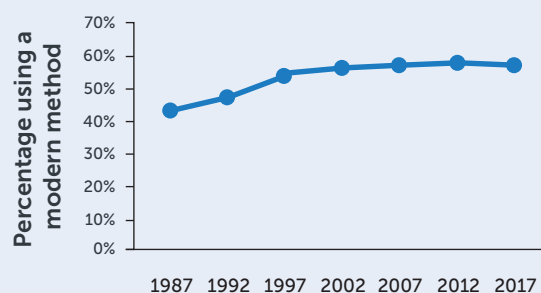
## Introduction

### Background

Indonesia has made great progress in improving access to family planning (FP) services over the last three decades. Beginning in 1976, under President Suharto, contraceptives were subsidized by the government and provided free of charge, which increased public demand for the commodities. In 1987, the Government of Indonesia made efforts to increase the private sector's role in supplying FP services under the KB Mandiri (self-reliant) FP program.<sup>i</sup> Under the "Blue Circle" campaign, the Government of Indonesia promoted use of FP services through private providers and supplied these providers with contraceptives, leaving clients responsible only for covering the cost of services. Between 1987 and 1991, the percentage of FP users who received services from private sources increased from 12% to 22% while the percentage of users who paid a fee for FP services increased from 36% to 62%.<sup>i</sup> The government's efforts were successful in including the private sector in addressing FP needs while instituting a norm of consumers paying for FP services out-of-pocket in Indonesia.

Between 1976 and 2002, the total fertility rate (TFR) decreased from 5.6 to 2.6 lifetime births per woman in Indonesia.<sup>ii</sup> Estimates for 2015 indicate that unmet need for contraception is low, at 11%.<sup>iii</sup> Data from Indonesia Demographic and Health Surveys (IDHS) over time highlight improvements in modern contraceptive prevalence rate (mCPR) between 1987 and 2012 (see Figure 1). However, recent data indicates that mCPR progress has stalled, decreasing from 57.9% in 2012 to 57.1% in 2017 among married Indonesian women.

**Figure 1. mCPR among Indonesian married women in IDHS**



### Family Planning within National Health Insurance in Indonesia

In 2014, Indonesia launched *Jaminan Kesehatan Nasional*, or JKN, a national health insurance program that aims to achieve universal health coverage (UHC) by 2019. The central purpose of the JKN scheme is to address existing inequities in access to healthcare, with particular emphasis on ensuring that the poor and near-poor can access quality care without facing financial hardship. The benefit package under JKN is a "negative list" whereby services must be explicitly excluded to be considered not covered by the scheme. FP services are not explicitly excluded, though contraceptive commodities for FP are not covered in practice under JKN reimbursements to primary or secondary facilities. All FP service delivery costs are otherwise covered by JKN and reimbursed to providers in various ways. Under Indonesia's decentralized health system, both national and local government entities procure commodities for FP, though this responsibility appears to be shifting to the latter. But much remains uncertain regarding how local governments plan for, quantify, and submit procurement orders for FP commodities and define which population groups they intend to cover.

Multiple agencies are involved in the oversight and provision of FP services, including the National Population and Family Planning Board (*Badan Koordinasi Keluarga Berencana Nasional*, or BKKBN), the Ministry of Health (MOH), and the national health insurance agency (*Badan Pelaksana Jaminan Sosial-Kesehatan*, or BPJS-K) that manages JKN. BKKBN's central role is to develop integrated programs across government sectors to meet the goals of the 2015–2019 National Medium Term Development Plan (*Rencana Pembangunan Jangka Menengah Nasional*, or RPJMN) with

## Box 1: BKKBN's Role

1. Purchase FP commodities, specifically IUDs and injectables, in coordination with BPJS-K
2. Coordinate with local government
3. Promote FP programs to young people
4. Increase FP coverage through various means, including mobile provision of FP services and increasing FP coverage among the poor

relation to FP (see Box 1). Some overlap exists between the MOH and BKKBN in FP service provision responsibility, in part because the MOH manages a youth reproductive health program alongside BKKBN's efforts to increase FP coverage among adolescents.

BPJS-K is responsible for covering all FP service delivery reimbursements to providers for long-acting reversible methods, permanent methods, FP counseling, and other sexual and reproductive health services, as well as short-acting FP commodities such as pills and condoms (see Table 1). Until recently, BKKBN was responsible for purchasing intrauterine devices (IUDs) and injectables and coordinating these purchases with BPJS-K; this responsibility will soon shift to local governments.

**Table 1: Summary of FP Services Covered Under JKN**

Services covered by primary healthcare facilities	Services covered by hospitals
<p><b>Capitation</b></p> <ul style="list-style-type: none"> <li>• FP counseling</li> <li>• Sexual and reproductive health services</li> <li>• Other FP commodities such as pills and condoms</li> </ul> <p><b>Fee-for-service*</b></p> <ul style="list-style-type: none"> <li>• Insertion and/or removal of IUD/implant</li> <li>• Injectables</li> <li>• Treatment for FP complications</li> <li>• Tubectomy/vasectomy</li> </ul>	<p><b>INA-CBGs**</b></p> <ul style="list-style-type: none"> <li>• Post-partum sterilization</li> <li>• Male sterilization</li> </ul>

\* Also referred to as "non-kapitasi" (non-capitation) fees, \*\*INA-CBGs: Indonesia case-based groups

## Challenges Surrounding Family Planning Under JKN

An Indonesia case study from 2016 indicated the potentially challenging nature of coordinating the many players responsible for FP service provision in Indonesia with relation to JKN.<sup>iv</sup> Adequate coordination between BPJS-K and BKKBN is needed to ensure FP service availability—for example, BKKBN was responsible for IUD and injectable commodity procurement while BPJS-K has been responsible for payment of most individualized FP services. In addition, coordination between BKKBN, local government, and health providers is needed to ensure that supply-side constraints do not occur at the provider level. Box 2 summarizes the challenges related to FP service provision and coordination noted in the literature.

Although FP services are offered at all healthcare levels, according to the Ministry of Health, most (46%) of BPJS-K-contracted providers at the primary level consist of public centers (*puskesmas*). Currently, BPJS-K does not directly contract with private midwives because they do not typically offer the full spectrum of primary healthcare services

## Box 2: Summary of FP Challenges in Indonesia

- Coordination between BKKBN, MOH, and BPJS-K on FP services and reducing unmet need
- Coordination between BKKBN, local government, BPJS-K, and health providers on FP commodity needs
- Limitation of FP services to cohabiting couples in Indonesia
- Limited knowledge of the inclusion of FP services in JKN benefits packages
- Inadequate capacity of public and private facilities to provide quality FP services
- Preference of midwives to practice in urban areas/lack of sufficient incentivization for healthcare providers to work in the poorest rural areas
- Limited number of BPJS-K-contracted private providers
- Reliance on FP services at uncontracted private facilities leading to out-of-pocket payments
- Ineffective referral mechanisms

Sources: Authors; Avenir Health (2016); Ensor et al. (2009); World Bank Group (2016).

at their clinics.<sup>v.1</sup> Data from the Ministry of Health indicate that there are an estimated 163,541 midwives in Indonesia, constituting 16.3% of health personnel in 2016, with many leading their own clinics. These individual practitioners do not typically employ electronic record keeping. From an administrative perspective, this lends to difficulties in BPJS-K's ability to feasibly directly contract with midwives. Additional evidence indicates that midwives are not appropriately incentivized to practice in rural areas, preferring to practice in urban areas for both financial and non-financial reasons.<sup>vi</sup> These issues are particularly problematic given that many Indonesian women, particularly the poor and those who reside in rural areas, continue to access FP services through private sector midwives and pay out-of-pocket for such services. This reliance on private providers for FP services extends beyond poor and rural—as of 2009, an estimated 40% of all women rely on private sector providers for FP services.<sup>vii</sup> From anecdotal sources, the capitation payments currently instituted by BPJS-K are discouraging wide private primary provider involvement in the scheme.

Other challenges concern quality and supply of FP services at the facility level. Findings from the 2014 Indonesia Family Life Survey noted deficiencies in the quality of FP services provided at both public and private facilities. An estimated 80% of *puskesmas* lacked a single staff member trained in FP services within the previous two years and an estimated 40% of private clinics lacked combined oral contraceptive pills while 20% lacked injectable contraceptives.<sup>viii</sup>

Given the limited evidence available on trends in FP coverage since JKN's introduction, this brief explores mCPR and modern method mix over time using household survey data. Although IDHS and surveys such as Performance Monitoring & Accountability 2020 (PMA2020) have explored mCPR and method mix by wealth quintile, such analyses have not disaggregated these measures by insurance status. As part of the Government of Indonesia-led JKN Comprehensive Assessment coordinated by the National Team for the Acceleration of Poverty Reduction (TNP2K) with support from the U.S. Agency for International Development (USAID)-funded Health Policy Plus (HP+) project, this analysis focuses on these disaggregated measures by insurance status, socioeconomic status (SES), and island grouping using Indonesia's National Socioeconomic Survey (Susenas) data. This approach allows for annual tracking of FP trends over time, and before and after and after JKN. The study provides insight to the key policy question of whether JKN has improved use of key interventions in Indonesia—specifically FP services—in the three years since its launch.

## Methodology and Data Sources

We used Susenas datasets to examine mCPR and modern method mix prior and subsequent to JKN implementation, and analyzed these measures using 2015 PMA2020 data. We expanded upon previously published PMA2020 data analysis by exploring locations where modern contraceptive methods were procured by insured and uninsured FP users and examined the average amount paid for FP services by insured and uninsured users. Table 2 further elaborates on data sources, years, and key variables used in this analysis.

**Table 2: Summary of Datasets and Key Measures**

Dataset	Years	Key Measures
Susenas	2011–2016	<ul style="list-style-type: none"> <li>mCPR</li> <li>Method mix (permanent, long-acting reversible, and short-acting methods)</li> </ul>
PMA2020	2015	<ul style="list-style-type: none"> <li>mCPR</li> <li>Method mix (permanent, long-acting reversible, and short-acting methods)</li> <li>Amount paid for FP services at last FP visit</li> <li>Modern method source mix (public facility, private facility, or other [through friends/relatives, at a shop, or other])</li> </ul>
BPJS-K INA-CBG	2014–2016	<ul style="list-style-type: none"> <li>JKN expenditure on male sterilization and female sterilization following delivery</li> <li>Male sterilization and female sterilization caseload through JKN</li> </ul>

## Results

### Has utilization of FP services in Indonesia changed since 2011?

#### *The mCPR progress has plateaued in recent years.*

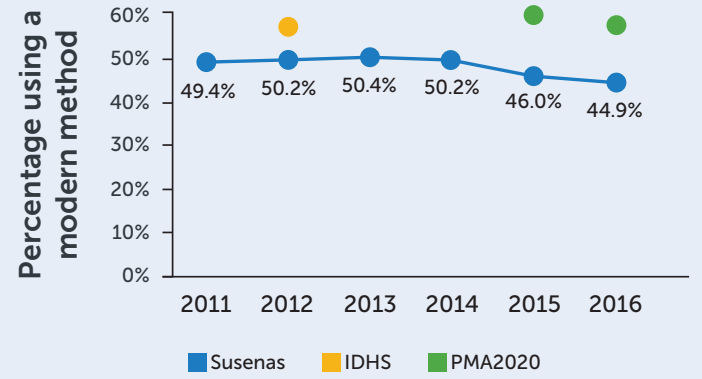
Susenas and IDHS results indicate that mCPR progress has stagnated in recent years. As Figure 2 shows, according to Susenas, the mCPR among married women decreased from 50.2% in 2014 to 44.9% in 2016. This data is lower than the rates found in PMA2020 data for 2015 (59.3%) and IDHS data for 2017 (57.1%).

<sup>1</sup> Although BPJS-K does not directly contract midwives, there are three ways in which they may receive JKN funding. (1) Midwives can be staff within a BPJS-K contracted primary care facility; (2) they can develop an agreement with a BPJS-K contracted primary care facility to have patients referred to them, and are paid non-kapitasi fees from the contracted facility once they provide the services; (3) they can also hire a doctor to provide the full package of primary care services in their clinics, thereby allowing them to be eligible for BPJS-K to contract with their facility directly.

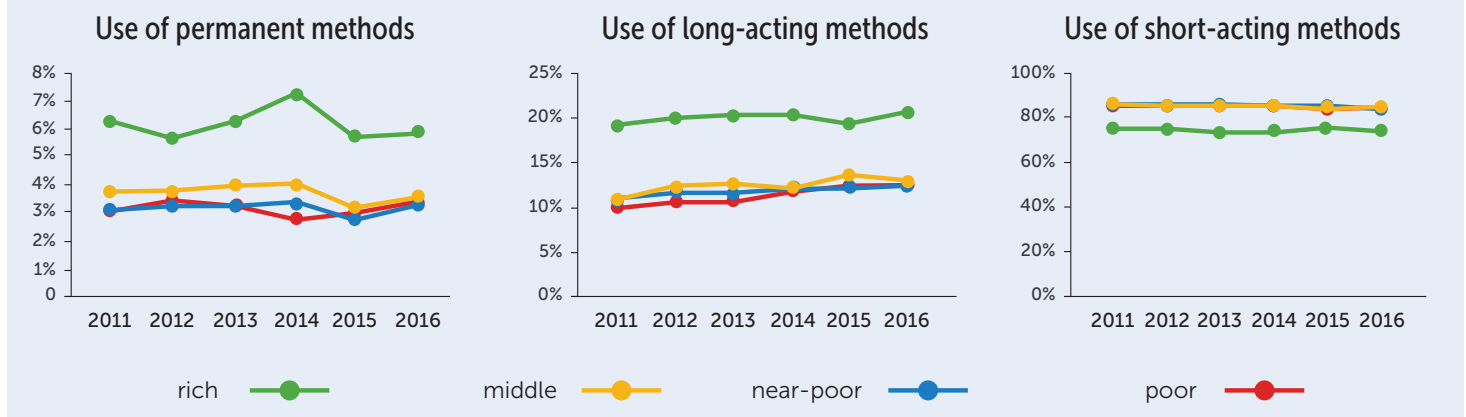
**Rich married women use long-acting and permanent contraceptive methods at much higher rates than do other SES groups.**

Use of long-acting reversible contraceptive methods is increasing over time for all SES groups in Indonesia, though a significantly higher proportion of rich married FP users use permanent and long-acting reversible contraceptive methods as compared to their poor, near-poor, and middle-income counterparts (see Figure 3). Although these groups used short-acting methods at rates much higher than the rich, the utilization of short-acting methods has decreased between 2011 and 2016 nationwide. 2015 PMA2020 data substantiates these general trends in method mix by wealth quintile.

**Figure 2. Trends in mCPR among married women, 2011–2017**



**Figure 3: Shifts in method mix nationwide among married women from 2011–2016, by SES**



Data source: Analysis using 2011–2016 Susenas data

Research incorporating data from twenty countries has shown that wealthier women are more likely than poorer women to use long-acting and permanent methods in place of short-acting methods.<sup>ix</sup> Common reasons for using short-acting methods include ease of access, lower cost, privacy, and freedom to discontinue use without involving a health provider.<sup>x</sup> These reasons may help to explain the higher use of short-acting methods among poor Indonesian women given the prevalent use of FP services in the private sector. If poor women prefer to seek FP services in the private sector and cost is a factor, they are more likely to seek out lower-cost FP services, which mainly consist of short-acting methods.

**Has use of FP services changed since JKN implementation?**

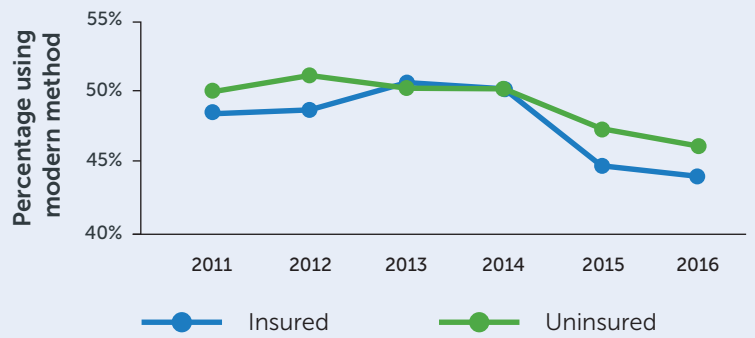
**The mCPR declined for both insured and uninsured.**

Susenas household survey data reveals that mCPR had been increasing among the insured prior to 2014 and began to decline for both uninsured and insured married women following JKN implementation (see Figure 4). The data also show that with the exception of one year (2013), mCPR is consistently higher among the uninsured compared to the insured.

**Trends indicate JKN is more important for FP use among poor women compared to rich women.**

Since JKN implementation, mCPR has consistently decreased among all SES groups, though the trend is most pronounced for insured rich women (see Figure 5). The mCPR among insured rich women decreased by 16.6% from 2011 to 2016, whereas mCPR among insured poor women

**Figure 4: mCPR among insured and uninsured married women**



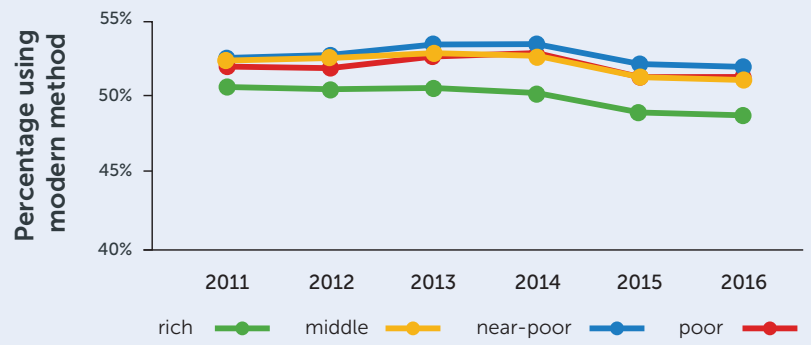
Data source: Analysis using 2011–2016 Susenas data

decreased by 5.7% during the same period. The mCPR is significantly higher among the insured poor compared to the insured rich throughout the study period, and the gap widens between 2011 and 2016: in 2011, mCPR for the insured poor was 48.6% compared to 43.4% (a 12% difference); by 2016, mCPR for the insured poor was 46.0% compared to 36.2% (a 21% difference). These results indicate that JKN insurance coverage may be more important for FP use among the poor than the rich.

**Trends indicate JKN is important for insured women's use of long-acting and permanent methods.**

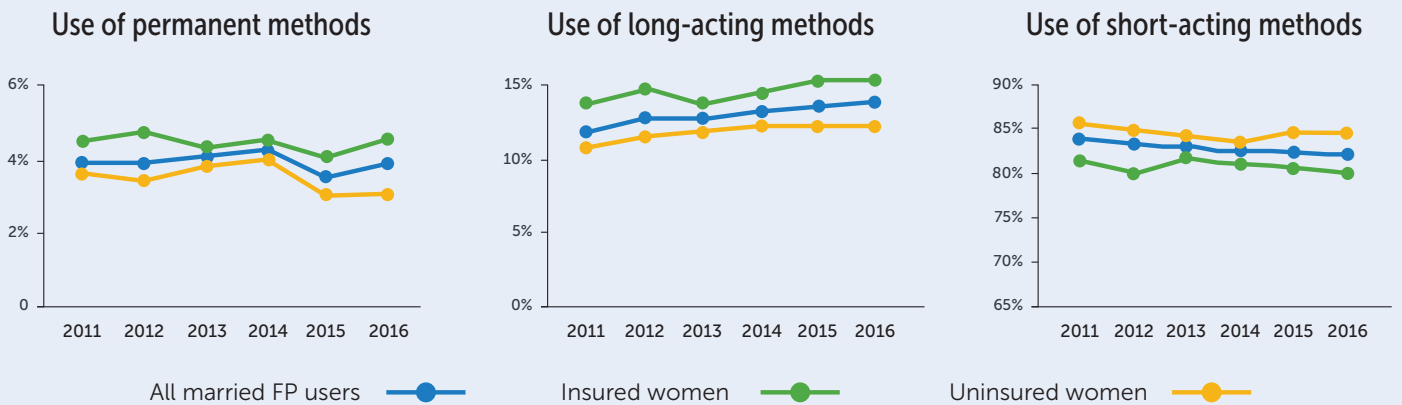
Insured married women in Indonesia use permanent and long-acting reversible methods at higher rates compared to uninsured married women (see Figure 6). Our Susenas analysis highlights an increase in use of permanent methods by insured FP users after 2015 and a steady increase in use of long-acting reversible methods among insured FP users after 2013. The data likewise reveals a steady decline in insured married women's use of short-acting methods since 2013. These results suggest that JKN coverage may be important for insured women's access to long-acting and permanent methods of contraception.

**Figure 5: mCPR among insured married women, by SES**



Data source: Analysis using 2011–2016 Susenas data

**Figure 6: Method mix among married FP users, by insurance status**



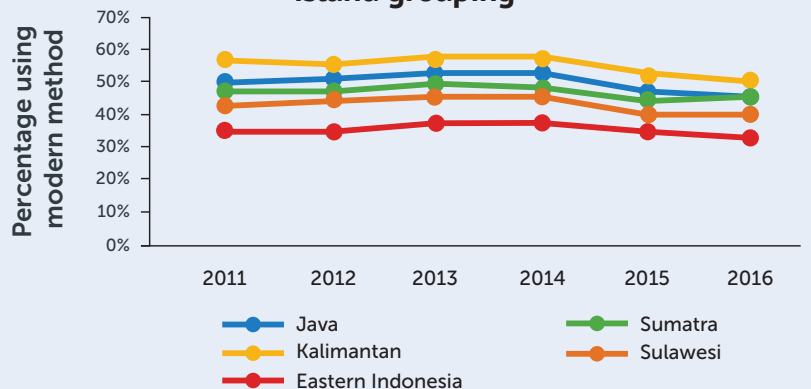
Data source: Analysis using 2011–2016 Susenas data

Method mix trends for the insured compared to the uninsured are consistent by SES, as seen previously in Figure 3. For example, the insured poor use short-acting methods at lower rates compared to the uninsured poor, and use of short-acting methods for the insured poor continues to decline following JKN implementation. Similarly, the insured rich use long-acting reversible methods at higher rates than the uninsured rich. These findings bolster the finding that JKN insurance may serve as a factor influencing method mix in Indonesia.

**Method mix is improving by island group, particularly in Eastern Indonesia.**

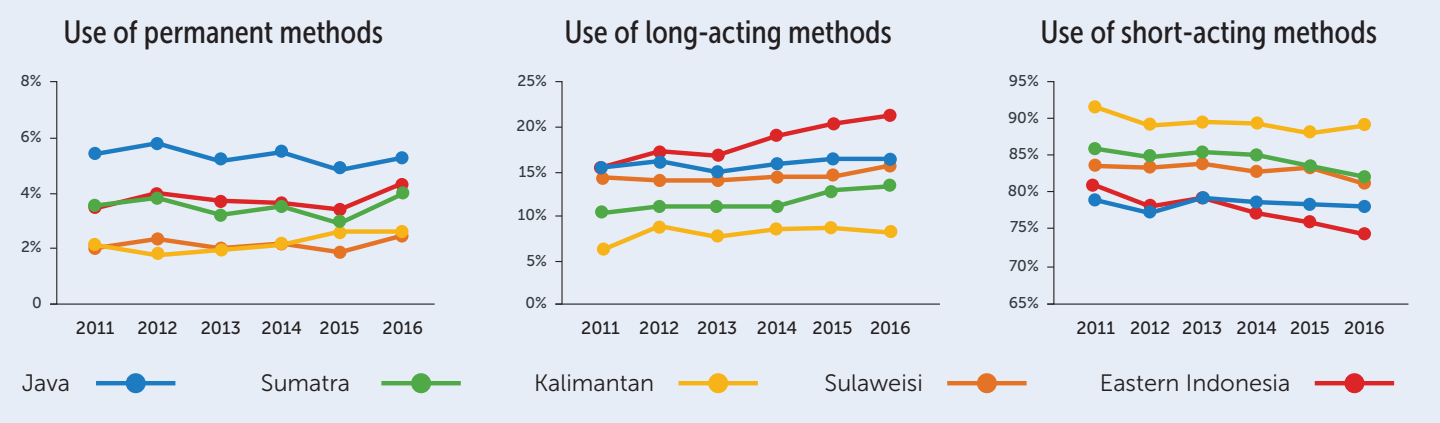
Our analysis also explored FP trends by island group (see Figures 7 and 8). We hypothesized that FP use may differ by geographical location and other influences, such as supply-side factors. We found that mCPR is consistently highest in Kalimantan, the island grouping with the highest

**Figure 7: mCPR among JKN-insured married women by island grouping**





**Figure 8: Shifts in method mix nationwide among married women from 2011–2016, by island group**



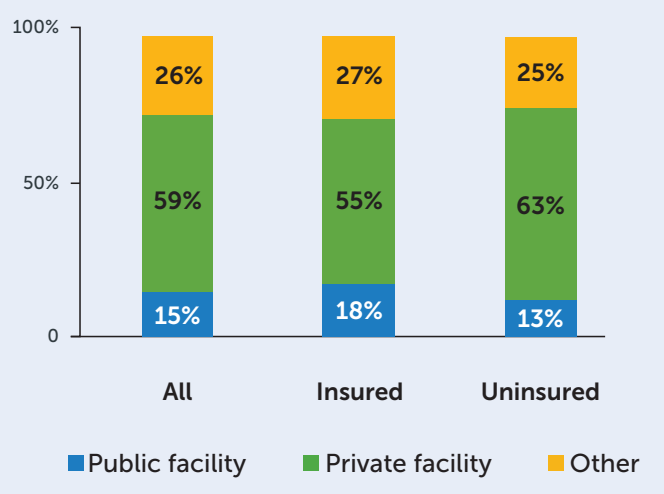
use of short-acting methods and lowest use of long-acting and permanent methods. By contrast, mCPR is lowest in Eastern Indonesia, where use of long-acting methods has increased and use of short-acting methods has significantly decreased since 2013. These changes in method mix may be the result of community-level initiatives, such as the Improving Contraceptive Method Mix (ICMM) Program, which have been implemented throughout Eastern Indonesia to improve uptake of long-acting and permanent methods of contraception.<sup>xi</sup> Following JKN implementation, mCPR decreased in Java to the levels seen in Sumatra. Use of permanent methods is highest in Java, where more than half of Indonesians live. This method mix may be due to improved access to a variety of healthcare facilities that offer FP services in Java.

**Insured women obtain modern contraceptive methods at public facilities at greater rates than do uninsured women.**

PMA2020 data highlighted the source mix for married Indonesian women in 2015 (see Figure 9). The results indicate that a greater proportion of insured married women acquire modern methods at public facilities (18%) compared to uninsured women (13%). However, the most prevalent modern method source was private facilities, where 55% of insured and 63% of uninsured women obtained their contraceptive methods in 2015.

Analysis of PMA2020 data indicated that, on average, the wealthiest quintile (Q5) paid the most out-of-pocket for FP services at their last visit (IDR 34,967, or US\$2.59) whereas the poorest quintile (Q1) paid the least (IDR 23,492, or US\$1.74). On average the insured wealthiest quintile paid more than three times the cost for long-acting reversible methods compared to the insured poorest quintile (see Table 3). The uninsured poorest quintile paid more out-of-pocket for short-acting and long-acting reversible methods compared to the insured poorest quintile. In the PMA2020 dataset, only one observation was noted for out-of-pocket payments made for permanent services.

**Figure 9: Modern method source mix among married women**



Data source: Analysis using 2015 PMA2020 data

**Table 3: Average Amount Paid for FP Services at Last Visit (in Indonesian Rupiah)**

Method mix	Insured		Uninsured	
	Q1	Q5	Q1	Q5
Short-acting	20,525	21,329	21,540	20,803
Long-acting reversible	84,004	352,729	94,406	348,602
Permanent	--	250,000	--	--

Data source: Analysis using 2015 PMA2020 data

### JKN expenditure on permanent methods at the hospital level decreased between 2014 and 2016.

JKN expenditure on permanent methods decreased from 2014 to 2016 and the majority was spent on female sterilization following vaginal labor at the hospital level (see Figure 10). Only four cases of male sterilization were recorded between 2014 and 2016 while a total of 76 outpatient and 10,849 inpatient cases of female sterilization following labor took place during the same period.

Analysis of JKN expenditure on female sterilization compared to the share of female reproductive-aged women by island grouping reveals that costs are not equitable across islands (see Figure 11). Sulawesi only accounts for 7% of Indonesia's reproductive-aged women but constitutes between 19% and 64% of total JKN expenditure on post-partum sterilization costs. Compared to Sulawesi, expenditure in Java and Kalimantan is still over-represented compared to its share of the reproductive-aged female population, but by a smaller amount. By contrast, expenditure in Eastern Indonesia shifted from being over- to under-represented in the same time period. These shifts cannot be interpreted as inherently positive or negative—for instance, a shift toward under-represented expenditure as a share of population could indicate greater use of services at the primary healthcare level (data that are not captured in this analysis).

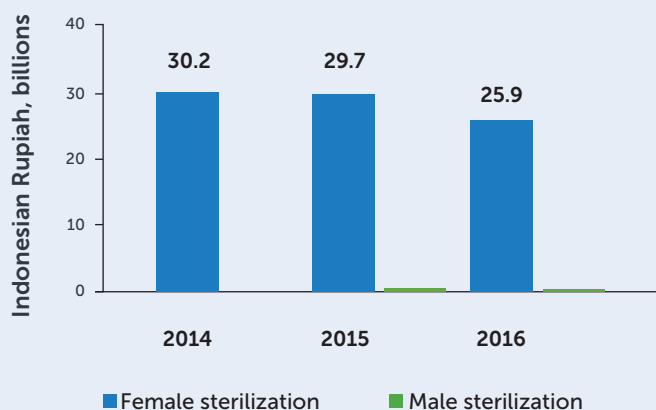
### Discussion and Conclusions

Although mCPR is quite high in Indonesia, echoing the data captured in the IDHS, our results find that mCPR is decreasing, indicating stalled FP progress. Since JKN was launched in 2014, mCPR has been higher among the uninsured compared to the insured. Many FP users face far distances to and long wait times at *puskesmas*. As a result, many continue to access FP services in clinics through private providers, which may not be BPJS-K-contracted. This arrangement may help to explain the discrepancy in mCPR between the insured and uninsured. Furthermore, in our analysis of average mCPR by SES, we found that the mCPR decrease was larger for the insured rich compared to the insured poor. These results indicate that being covered by JKN insurance may be more important for accessing FP services among the insured poor compared to the insured rich.

Short-acting methods have historically been most commonly used in Indonesia; however, our results highlight a shift in method mix since JKN implementation among the insured toward long-acting and permanent methods. Given that price can be a factor in the decision to choose short-acting methods, this shift in method mix indicates that JKN may be alleviating some of the financial burden women face when accessing long-acting and permanent methods.

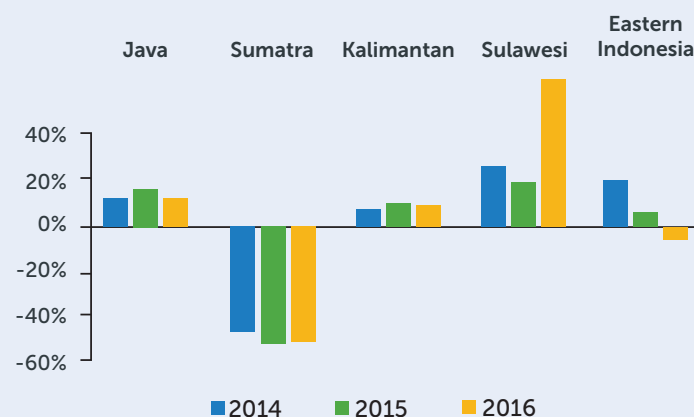
Our analysis by island grouping indicates that geographical disparities for FP access remain, with mCPR lowest in the most rural island grouping, Eastern Indonesia. These geographical inequities highlight the possibility of other barriers existing in the health system, such as lack of adequately trained health personnel and/or health facilities that do not provide a broad method mix of FP services. Given that private midwives are not incentivized to work in rural areas, higher FP uptake by more urban island groupings such as Java may at least be partially explained by this supply-side deficiency. However, improvements in method mix in Eastern Indonesia highlight that community-level initiatives can be effective in increasing long-acting and permanent method uptake.

Figure 10: JKN expenditure on permanent methods at the hospital level



Data source: Analysis using BPJS-K data

Figure 11: Share of JKN post-partum sterilization costs at the hospital level compared to share of female population, by island



Data source: Analysis using BPJS-K data

To improve FP access through JKN, policymakers and health systems decision-makers should consider the following recommendations:

- Prioritize facilitating the inclusion of more private providers as BPJS-K-contracted providers
- Improve coordination between BKKBN and BPJS-K as well as between BKKBN and health providers to ensure the availability of FP methods at all health facilities
- Ensure necessary health facilities and adequately trained health providers are available nationwide, particularly in the most geographically disadvantaged island groups such as Eastern Indonesia

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## References

- <sup>i</sup> Robey, B., P.T. Piotrow, and C. Salter. 1994. "Family Planning Lessons and Challenges: Making Programs Work." *Population Reports*. Series J, No. 40: 24.
- <sup>ii</sup> World Bank Group. n.d. "Fertility rate, total (births per woman); Indonesia." World Development Indicators. Available at: <https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=ID>
- <sup>iii</sup> Performance Monitoring & Accountability 2020 (PMA2020). 2015. PMA2015/INDONESIA-R1. Available at: [https://www.pma2020.org/sites/default/files/PMA2015-ID-WASH-2PG-Brief\\_en\\_2016-06-14.pdf](https://www.pma2020.org/sites/default/files/PMA2015-ID-WASH-2PG-Brief_en_2016-06-14.pdf)
- <sup>iv</sup> Avenir Health. 2016. *Supporting Family Planning Within National Health Financing Schemes: Indonesia Case Study*.
- <sup>v</sup> Rajkotia, Y., J. Gergen, I. Djurovia, S. Koseki, M. Coe, et al. 2016. *Re-envisioning Maternal and Newborn Health in Indonesia: How the Private Sector and Civil Society Can Ignite Change*. Washington, DC: Palladium, Health Policy Plus.
- <sup>vi</sup> Ensor T., Z. Quayyum, M. Nadjib, and P. Suahya. 2008. "Level and Determinants of Incentives for Village Midwives in Indonesia." *Health Policy and Planning*. Nov 20;24(1):26-35.
- <sup>vii</sup> Wang, H., M. McEuen, L. Mize, C. Cisek, and A. Barraclough. 2009. *Private Sector Health in Indonesia: A Desk Review*. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.
- <sup>viii</sup> World Bank Group. 2016. *Indonesia Health Financing System Assessment: Spend More, Right and Better*. World Bank, Washington, DC: World Bank.
- <sup>ix</sup> Ugaz, J., M. Chatterji, J. Gribble, and K. Banke. 2016. "Is Household Wealth Associated with Use of Long-Acting Reversible and Permanent Methods of Contraception? A Multi-Country Analysis." *Global Health: Science and Practice*. 4(1), 43-54.
- <sup>x</sup> Tibaijuka, L., R. Odongo, E. Welikhe, W. Mukisa, Ls. Kugonza, et al. 2017. "Factors Influencing Use of Long-Acting Versus Short-Acting Contraceptive Methods Among Reproductive-Age Women in a Resource-Limited Setting." *BMC Women's Health*. 17(1), 25.
- <sup>xi</sup> Titaley C., R. Wijayanti, R. Damayanti, A. Setiawan, D. Dachlia, et al. 2017. "Increasing the Uptake of Long-Acting and Permanent Methods of Family Planning: A Qualitative Study with Village Midwives in East Java and Nusa Tenggara Barat Provinces, Indonesia." *Midwifery*. Oct 1;53:55-62.

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