



PEPFAR'S STRATEGIC PIVOT IN TANZANIA:

IMPLICATIONS FOR THE DOMESTIC HIV BUDGET

Brief

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Background

As part of its aim to deliver “the right thing at the right place at the right time,” in 2015 PEPFAR implemented a strategic pivot in the alignment of its resources in Tanzania. This pivot shifts the focus to high-volume and high-burden sites and districts, diverting resources from generalized, country-wide responses to focused geographic areas and key populations. As a result, districts and facilities with low HIV burden and low yield are experiencing a reduction in support from PEPFAR beginning at the start of the 2015/16 fiscal year. While the pivot aims to accelerate scale-up of antiretroviral therapy (ART) by prioritizing high-prevalence and high-yield populations, additional ART scale-up will be required in non-priority districts in order to reach national treatment targets that are now more ambitious.

It is important that the Government of Tanzania (GoT), local government authorities, PEPFAR, and other partners understand the extent to which continued scale-up will be required in non-priority districts to achieve both the UNAIDS’s 90-90-90 goal in Tanzania as well as national ART targets based on adoption of “test and offer” guidelines. This brief aims to define the geographic and programmatic shifts under the PEPFAR pivot, identify activities that may face a reduction in PEPFAR support and require alternative sources of funding to support continued scale up, and clarify future scale-up targets in non-PEPFAR priority districts.

Tanzania’s HIV Epidemic and Treatment Response

The HIV epidemic in Tanzania is largely concentrated in urban areas and a few mostly rural regions, with high rates of incidence and prevalence among certain demographic groups and key and priority populations. According to PEPFAR data for its Country Operational Plan (COP), 58 percent of Tanzania’s 1.5 million people living with HIV (PLHIV) in late 2016 will be located in 48 high-burden districts out of 178 districts analyzed, based on revised district-level prevalence data (PEPFAR/Tanzania, 2016a). As of December 2015, 767,094 Tanzanians were receiving ART, a national coverage level of 52 percent of PLHIV. For patients at PEPFAR-supported sites, 58 percent were located in these 48 districts, representing a coverage rate of 48 percent against estimated local PLHIV—with 43 percent coverage in all other districts (Figure 1).ⁱ

In 2015, Tanzania’s National AIDS Control Program (NACP) set new standard treatment guidelines calling for immediate ART initiation for all children under 15 years, pregnant women living with HIV, and older adolescents and adults with a CD4 count of 500 cells/mm³ or less. The Health Policy Project (HPP) has previously estimated that NACP’s ART targets established in late 2015 under these guidelines would see 86 percent of all PLHIV on treatment by 2020 (Lee et al., 2016). This exceeds the second goal under UNAIDS’s 90-90-90 initiative, which envisages 81 percent of PLHIV on ART by 2020 based on 90 percent

of all PLHIV being diagnosed and knowing their status, 90 percent of those diagnosed on ART, and 90 percent of those on ART being virally suppressed. In March 2016, NACP estimated new targets based on adopting a universal “test and offer” approach in which PLHIV are initiated on treatment regardless of CD4 count. Under this guideline, compared to the national targets from late 2015, it was assumed that the projected number of PLHIV on ART would be higher starting in 2018.

Updated with the NACP targets, Spectrum modeling using Tanzania’s 2015 AIDS Impact Model file indicates that the total number of PLHIV in Tanzania will grow slowly over the next five years, reflecting improved survival (Health Policy Project, 2015).ⁱⁱ There may be within-country shifts if future ART scale-up is more concentrated in current high-HIV burden geographic areas. For example, the distribution of PLHIV at the district level may shift over this timeframe. Rapid ART scale-up in priority areas may reduce transmission and new infections in these areas, while previously low prevalence areas may not see such reduction in transmission. At the same time, higher survival rates among PLHIV in priority districts may increase their share of PLHIV nationally. Due to these complex effects, it is not possible at this time to estimate the size of future PLHIV populations at the district level in Tanzania or ongoing needs for ART. Further model-based analysis could be done into future subnational distribution of PLHIV under different funding scenarios.

Figure 1. Distribution of PLHIV and ART Patients

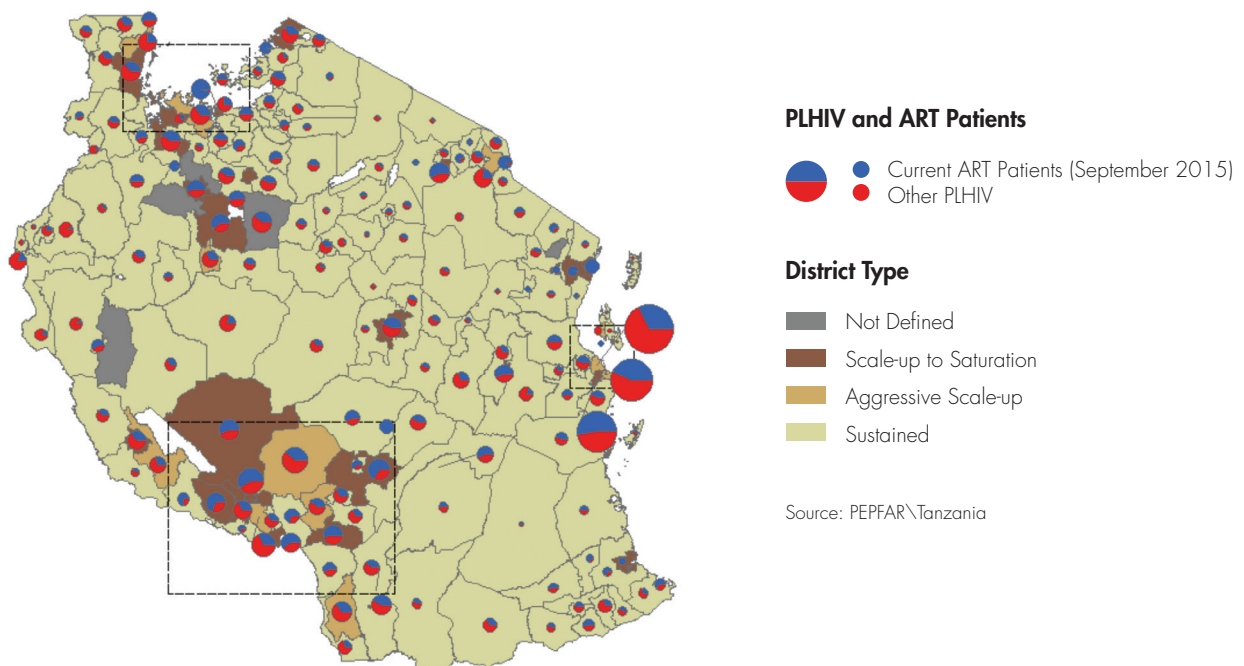
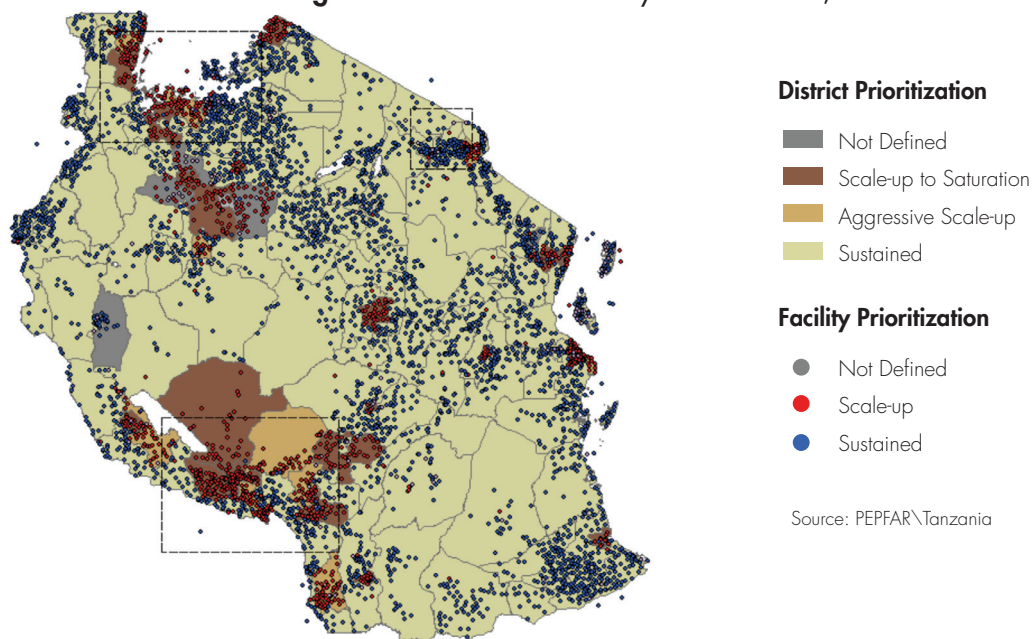


Figure 2. District and Facility Prioritization, FY16

PEPFAR Pivot in Tanzania

In late 2015, districts were re-categorized by the government and may now number 178 or 182. (The final approved count was unavailable at the time of this analysis.) Under the pivot principle of geographic prioritization and using the lower count as per PEPFAR, PEPFAR will focus resources to 48 high-burden districts designated in 2015 as “scale-up districts” (Table 1). PEPFAR continues to target scale-up of coverage for ART within these districts to 80 percent of PLHIV in two stages: 30 “scale-up to saturation” districts have a goal of 80 percent coverage by 2017, while 18 “aggressive scale-up” districts will aim for this target by 2019 (PEPFAR\Tanzania, 2015a) (Figure 2). These 48 districts are receiving additional resources to achieve these ambitious new targets. Tanzania’s remaining 130 districts are considered “sustained” districts, and for demand creation or identification of new patients they will receive support only for “passive enrollment” at the site level (PEPFAR\Tanzania, 2015a). Although PEPFAR will continue support to ensure that all ART patients continue to receive high-quality treatment and care services (PEPFAR\Tanzania, 2015b), resources for many activities to identify and link patients to treatment will by design decline (Table 2).

Prioritization under PEPFAR’s pivot goes deeper to the site level. Within sustained districts, resources are being focused to only 509 “high-volume” sites—those with 100 or more ART or prevention of mother-to-child

Table 1. PEPFAR Typology of Districts for COP 2016 (COP 2015)

District Type	Number of Districts, 2016 (2015)	PEPFAR ART Goal
Sustained	130 (129)	Not set
Scale-up to saturation	30 (27)	80% of PLHIV by 2017
Aggressive scale-up	18 (15)	80% of PLHIV by 2019

Source: PEPFAR\Tanzania, 2015a, 2016b

transmission (PMTCT) clients. An additional 2,352 sites with one to 99 clients will receive only semiannual supportive visits for supervision and quality monitoring. PEPFAR will discontinue support for 849 sites in sustained districts with no ART or PMTCT clients. PEPFAR has already discontinued support for 2,438 no- and low-yield community- and facility-based sites providing HIV testing and counseling (HTC). Sustained districts will face a reduction in PEPFAR resources in a number of areas. In particular, implementing partners (IPs) will no longer receive expanded funding for HTC, including demand creation and targeting of key and priority populations, in sustained districts. The IPs interviewed suggested that the GoT and its partners should consider whether there is a need to reallocate funds from other strategic areas to continue to reach existing testing and treatment targets.ⁱⁱⁱ In addition,

Table 2. Selected HIV Services and Interventions for PEPFAR Support by District Typology

Activities That May Receive PEPFAR Support	Scale-up Districts	Sustained Districts
Commodities support for ART (ARVs and laboratory test kits and reagents)	YES	YES
Bi-directional referral and linkages between core community and facility programs to promote retention and adherence	YES	NO
Demand creation for HTC targeting key and priority populations	YES	NO
Demand creation for HTC in general population	NO	NO
Early infant diagnosis (EID) testing	YES	YES
Identification and referral of OVC for testing, adherence, and retention	YES	NO
Pediatric HIV case finding	YES	YES
PMTCT opt-out testing	YES	NO
Provider-initiated testing and counseling	YES	NO
Viral load testing	YES	NO
Voluntary medical male circumcision (VMMC)	YES	NO

Sources: PEPFAR\Tanzania, 2015b; PEPFAR\Tanzania, 2015c

there will no longer be support for identification, referrals, linkages, and retention for orphans and vulnerable children (OVC). IPs noted that peer groups and psychosocial support aimed at reducing stigma and discrimination toward OVC would likely be discontinued entirely in sustained districts. Supportive supervision was also an area of concern for IPs, as the number of supervisory visits has been reduced from four to two annually in “low-volume” facilities of sustained districts—those with one to 99 patients (PEPFAR\Tanzania, 2015b).

PEPFAR also supports, mostly in partial form, salary and benefits for healthcare workers (HCWs). In 2015, PEPFAR supported 28,866 clinical, community, and managerial HCWs. Total financial support for all forms of staff benefits was US\$27.7 million (PEPFAR\Tanzania, 2015d). From the 2015 PEPFAR human resources for health inventory, for the 157 districts for which data could be categorized an estimated 55 percent of PEPFAR-supported district-level clinical and managerial HCWs were located in districts designated as sustained. The NACP expects PEPFAR support for human resources for health (HRH) to be suspended entirely in sustained districts under the pivot (Mwidunda, 2016), eliminating an estimated US\$13 million in related benefits support for HCWs in these districts (PEPFAR, 2015d, 2015e). PEPFAR could expect the GoT to absorb some of these HCWs; however, this is not likely to occur until the new fiscal year begins in July

2016 (PEPFAR\Tanzania, 2015c). It is unclear if any will be transitioned to scale-up districts as additional resources are made available there. The discontinuation of salary and benefit support for HCWs will likely have an immediate and significant impact on sustained districts. It is unclear how many positions will be absorbed by the GoT and how, and whether, the transition for some HCW to government pay scales may pose a challenge. These additional challenges have to be viewed in the context of the health sector currently facing a vacancy rate of roughly 60 percent (PEPFAR, 2015f).

Key and Priority Populations

In addition to its geographic shift, the strategic pivot aims achieve more rational scale-up of HIV prevention services by focusing on key and priority populations. Consensus estimates in Tanzania indicate that with high prevalence rates among men who have sex with men, female sex workers, and people who inject drugs—25 percent, 26 percent, and 36 percent respectively—the total number of PLHIV belonging to key populations is approximately 64,000 (PEPFAR, 2015f). In addition, the number of priority populations identified for intensive HTC and ART scale-up has been consolidated from seven to just one: adolescent girls and young women (AGYW) ages 15 to 24. PEPFAR estimates that there are approximately 131,000 AGYW living with HIV in Tanzania.

In 2014, PEPFAR contributed about 80 percent of the total funding targeted for key population prevention and 42 percent for priority population prevention (PEPFAR Tanzania, 2015f). In addition, through its DREAMS (Determined, Resilient, AIDS-free, Mentored, and Safe) partnership, PEPFAR has committed significant new funds to reduce the disproportionately high rate of new HIV infections among AGYW with targeted prevention interventions and increased ART enrollment for AGYW and their sexual partners. PEPFAR has also increased funding for pediatric treatment under its Accelerating Children's HIV/AIDS Treatment (ACT) Initiative and aims to more than double the number of children on ART to 77,256 by September 2016 (PEPFAR, 2015f). Both initiatives are aligned with PEPFAR's geographic shift, focusing resources only in scale-up districts, and will contribute directly to the goal of enrolling 122,949 new patients on ART in scale-up districts in fiscal year 2016 (PEPFAR Tanzania, 2015f).

Recent PEPFAR Expenditures by District Type

PEPFAR is discontinuing or drawing down support for a broad range of activities in sustained districts under its strategic pivot, as discussed in this brief. It will be critical for GoT/NACP to identify those activities it can lead in sustained districts that can contribute directly to national goals for treatment coverage. For example, in sustained districts, where PEPFAR will only support facility-based testing and treatment services, additional investment may be needed in identification and linkage to care for PLHIV.

Based on its expenditure assessment, in FY 2014/2015, PEPFAR spent US\$204 million at the district level, of which approximately US\$94 million (47 percent) was spent in districts now designated as sustained districts (PEPFAR Tanzania, 2015e). Expenditures per PLHIV in sustained districts was US\$131, compared to US\$121 in scale-up districts. Of total PEPFAR expenditures in Tanzania, an estimated 6.4 percent was on HTC (PEPFAR, 2015). This

amounts to US\$8 per PLHIV or US\$22 per patient on ART in sustained districts based on disaggregated data for the same period (Table 3). Use of the FY 2014/2015 expenditure assessment data is limited because of a lack of disaggregation of expenditures at the district level. The FY 2014/2015 expenditures reflect the state of affairs before complete rollout of the PEPFAR pivot. Also, in the future, as the remaining number of undiagnosed PLHIV decreases, the marginal unit expenditure of identifying a new HIV-positive person and linking them to care may change.

Achieving the National ART Targets in Tanzania Under the PEPFAR Pivot

PEPFAR's prioritization of high-HIV burden areas and high-volume facilities can improve economies of scale in the delivery of HIV services, accelerate epidemic control, and increase the value for money of PEPFAR's investments. However, with PEPFAR supporting a goal of 80 percent ART coverage among PLHIV in 48 priority districts by 2019, there may be complications in meeting the recent national NACP targets which beginning in 2016 assume a "test and offer" treatment protocol. Analysis was conducted by the HPP on whether achieving these targets will require investment of additional resources by the GoT or other partners. We expect that achieving the national target means additional efforts to go beyond PEPFAR's ART coverage goal (i.e., above 80%) in scale-up districts or to expand ART in PEPFAR's sustained districts. Also, as discussed above, shifts in PEPFAR support to HCW benefits must be an important consideration for the GoT. The GoT may need to consider additional investment in sustained districts, especially to continue scale-up in ART.

The HPP estimates that, to achieve 80 percent coverage in the 48 PEPFAR scale-up districts, a net 213,132 additional patients will need to be enrolled on ART in these districts by 2019 compared to 2015. This amounts to an increase of 58 percent above the current number of ART patients in PEPFAR-supported sites in scale-up districts in late 2015, and 48 percent above the overall total of ART patients in these areas (Figure 3).^v Although

Table 3. FY 2014/2015 PEPFAR Expenditures by COP 2015 District Categorization (US\$)^{iv}

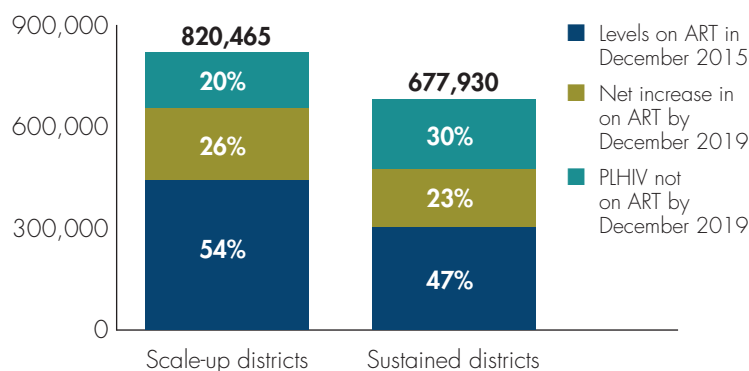
District Type	Total Expenditures	Total Expenditures per PLHIV	HTC Expenditures per PLHIV*	HTC Expenditures per ART Client*
Scale-up (N=42)	\$104,479,121	\$121	\$8	\$18
Sustained (N=129)	\$93,526,623	\$131	\$8	\$22
All districts	\$204,149,597	\$125	\$8	\$20

* Disaggregation of expenditures to HTC based on overall PEPFAR Tanzania expenditures. Totals by district type are based on district-specific expenditure data.

PEPFAR will continue support in sustained districts for passive enrollment and to ensure high-quality treatment and care services, it is unclear what effect this will have on the total number of patients on ART in these districts. Facility-based identification of patients will continue; however, partners interviewed suggested that continued scale-up will not be possible without community-based interventions and identification. As per Table 4, PEPFAR made an assumption that coverage in sustained districts will grow 15 percent per year to reach 72 percent of PLHIV by 2020--this assumption can be further varied. With this assumption and in the event that the scale-up aligned with PEPFAR's goal under its pivot is achieved, the total number of PLHIV enrolled on ART nationally will be 1,143,403.^{vi} This total will represent 79 percent of the total estimated PLHIV population by 2019.

For Tanzania to reach the national NACP targets for ART by 2020, ART will have to be expanded beyond PEPFAR's current goals in either scale-up or sustained districts. Assuming that the national coverage target is the second part of 90-90-90 (i.e., 81% coverage of PLHIV), HPP estimates based on Spectrum that approximately 1.24 million PLHIV would need to be on ART as of December 2020 (Table 5). If scale-up districts

Figure 3. PLHIV and ART Patients by District Type, December 2019



Source: Table 4. HPP calculations based on ART patient numbers and PLHIV estimates from PEPFAR, NACP, and Spectrum. Figure is illustrative; does not represent individuals.

achieve 80 percent ART coverage between 2017 and 2019—as per PEPFAR's stated goal—continued focusing of resources could achieve even higher coverage levels there by 2020. However, even if ART coverage increases to 85 percent by 2020 in scale-up districts, there will need to be significant achievement in sustained districts to meet the overall national target—a net addition of about 205,470 patients would be needed in these localities by 2020 compared to 2015. This equates to

Table 4. Current Achievements for ART and Projected Scale-up under PEPFAR Pivot

	Scale-up Districts	Sustained Districts	All Districts
PEPFAR Reporting (Annual Program Results, September 2015)			
PLHIV estimates	767,502	624,164	1,391,666
Current ART patients	367,501	256,438	623,939
Coverage based on PEPFAR PLHIV estimate	48%	41%	45%
National Figures (December 2015)			
District PLHIV estimates adjusted for national Spectrum projection	793,672	655,792	1,449,464
NACP forecast, ART patients (split calculated)	443,240	323,854	767,094
Coverage of all PLHIV	56%	49%	52%
Target Achievement by December 2019			
Estimated PLHIV by district type*	820,465	677,930	1,498,395
PEPFAR target coverage (by 2018/2019)	80%	Assumed to reach 72%**	79% (estimated)
ART patients total, to meet PEPFAR target	656,372	487,031	1,143,403
Total change in ART patients, 2019 vs. 2015	213,132	163,177	376,309

Source: HPP calculations based on ART and PLHIV estimates provided by PEPFAR/Tanzania and NACP, and Spectrum version 5.43 using national AIM file (2015).

* Assumed the proportion of PLHIV by district type does not change due to differential epidemiological effects.

** PEPFAR COP 2016 assumption of 15% growth per year in coverage for three years (2016–2019 with passive enrollment, from 49% in December 2015 (PEPFAR/Tanzania 2016c).

Table 5. Implications for Sustained Districts of National Targets and Achievement in Scale-up Districts

National ART Targets		Ambition for Scale-up Districts		Remaining ART Patients to Meet National Target (to come from sustained districts)	Implications for Sustained Districts	
Desired Coverage of PLHIV	Total ART Patients, Dec. 2020	Target Coverage	Total ART Patients as per Target		Net Patients to Add Beyond Dec. 2015	Coverage Rate in Dec. 2020
90-90-90 (81% ART coverage)						
81%	1,244,592 (estimated)	85%*	697,395	529,326	205,471	78%
		95%	779,442	447,279	123,425	66%
NACP targets with CD4<500 eligibility for certain adults						
87% (estimated)	1,321,850 (target)	88%*	729,755	592,095	268,240	86%
		95%	787,803	534,046	210,192	78%
NACP targets with universal test and offer from 2016						
94% (estimated)	1,423,911 (estimated based on targets)	90%	746,340	677,571	353,716	99%
		95%	787,803	636,107	312,253	93%

* Assumes PEPFAR goals of 80% ART coverage by 2019 for aggressive scale-up districts and same by 2017 for scale-up to saturation districts are met. Then by the end of 2020, more progress could be made for all scale-up districts.

a notional value of 305 patients added per each of the 130 sustained district per year 2016–2020, all identified through passive enrollment. If the achieved coverage rate in scale-up districts were as high as 95 percent, this requirement would drop to 177.

Switching to the recent NACP performance framework targets, which imply greater ambition, a similar analysis suggests even more intense requirements of sustained districts to do their part. If scale-up districts could achieve 85 percent coverage by 2020, which would imply achieving all PEPFAR goals by 2019 and then continuing to add new patients in those districts, the demand from sustained districts to meet national goals would be 268,240 net new patients added over 2015–2020 (equivalent notionally to 413 PLHIV per district per year), with a required coverage as of December 2020 of 86 percent. With new targets based on test and offer, the requirement for sustained districts is even higher still, approaching levels above 90 percent coverage (Table 5). This appears unfeasible, as this would be higher than the assumption for coverage achievement in scale-up districts under this scenario—especially as sustained districts conduct only passive enrollment activities and have other reductions in PEPFAR support. This illustrates the key dilemma.

Conclusion

As PEPFAR shifts its resources to align with a focus on high-burden populations and areas, it is important that the GoT at the national and district levels understands the implications for the need for domestic investment and that additional investments will be needed to reach national ART targets. HRH and community-based programs for the identification and linkage of new ART patients (HTC) will be the areas of most immediate need for sustained districts in order to continue the scale-up of ART. The GoT and NACP must also consider the commitment of new resources to other programs, e.g., OVC, for which PEPFAR is suspending funding in sustained districts. Some of these programs have important links to ART, e.g., between OVC programming and the retention and linkage to care and treatment for pediatric patients.

Given PEPFAR's geographic prioritization, the GoT must consider where the greatest value for its money can be achieved—adding to PEPFAR's efforts in scale-up districts, or focusing on sustained districts. Although additional investment may be able to take advantage of economies of scale in scale-up districts, as coverage rates rise—and eventually surpass 80 percent here—it will become more difficult to identify and link to treatment additional new patients in these areas. In

fact, our analysis suggests that achieving 90-90-90 or NACP targets for ART coverage nationally will require significant scale-up in sustained districts.

Based on its desired response to the PEPFAR pivot, the GoT must consider new mechanisms for domestic resource mobilization. In addition, better understanding of high payoff strategies of HTC—particularly in sustained districts—may inform the best use of scarce domestic resources. Retention of treatment aimed at viral suppression and additional combination prevention must also be prioritized in sustained districts in order to ensure that there are no unforeseen shifts in the Tanzanian epidemic that may reverse the current understanding of which districts require urgent attention.

Notes and References

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ⁱ District-disaggregated data reflect information for PEPFAR-supported sites only. PEPFAR-supported sites accounted for 83% of the estimated number of ART patients. Comparisons to national targets are complicated, as most recent PEPFAR site-level ART data are for September 2015 vs. NACP national estimates for December 2015. Disaggregation of PLHIV to the district level in PEPFAR documents was initially based on Spectrum 2012 national estimates.

ⁱⁱ Tanzania’s 2015 Spectrum file projects the number of PLHIV as of December 2015 as 1.465 million when updated with December 2015 ART achievements. Spectrum estimates that if ART coverage increases as per NACP’s targets, then the national number of PLHIV, adults and children, would increase to 1.54 million by 2020. The HPP used this figure for PLHIV in 2020 to estimate required ART scale-up to achieve various levels of coverage among PLHIV, as well as other comparisons. All analyses were conducted using Spectrum version 5.34.

ⁱⁱⁱ Information on IP activities was collected by the HPP through interviews with 10 PEPFAR partners.

^{iv} Includes five districts not defined as scale-up or sustained.

^v The HPP estimated the total number of ART patients in PEPFAR scale-up districts by applying the district-level distribution of PEPFAR-supported ART patients to the total number of ART patients projected by NACP for December 2015.

^{vi} Calculation uses PEPFAR’s assumption that some scale-up does occur in sustained districts, despite the qualitative information from partners suggesting otherwise. It increases coverage at 15% per year (not percentage points).

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The Health Policy Project is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-10-00067, beginning September 30, 2010. The project’s HIV activities are supported by the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). HPP is implemented by Futures Group, in collaboration with Plan International USA, Avenir Health (formerly Futures Institute), Partners in Population and Development, Africa Regional Office (PPD ARO), Population Reference Bureau (PRB), RTI International, and the White Ribbon Alliance for Safe Motherhood (WRA).

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