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SHIFTING THE CONTRACEPTIVE SECURITY PARADIGM TOWARD A MODEL FOR DECENTRALIZED ENVIRONMENTS:

LESSONS FROM INDONESIA

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USAID | DELIVER PROJECT, Task Order 1

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ACRONYMS

Bappeda	Local Government Office of Development Planning
Bappeprop	Provincial Government Office of Development Planning
Bapenas	National Government Office of Planning Development
Biro Kesra	Bureau of Social Welfare (provincial level)
BKKBN	Badan Koordinasi Keluarga Berencana Nasional (National Family Planning Coordinating Board)
CPR	contraceptive prevalence rate
CYP	couple-years of protection
IBI	Ikatan Bidan Indonesia (Indonesia Midwives Association)
IDI	Ikatan Dokter Indonesia (Indonesia Medical Association)
ISFI	Ikatan Sarjana Farmasi Indonesia (Indonesia Pharmacists Association)
JKK	Jaminan Ketersediaan Kontrasepsi (the bahasa-Indonesia term for Contraceptive Security)
DHS	Demographic and Health Survey
Dinas Kesehatan	health office
JHPIEGO	Johns Hopkins Program for International Reproductive Health
JSI	John Snow, Inc.
NGO	nongovernmental organization
PULAP-BKKBN	Pusat Latihan Pegawai BKKBN (BKKBN National Training Office)
STARH	Sustaining Technical Achievements in Reproductive Health
MMR	maternal mortality rate
RH	reproductive health
TB	tuberculosis
TFR	total fertility rate
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
WB	World Bank

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EXECUTIVE SUMMARY

When the Indonesia family planning program decentralized in 2002, authority for managing all aspects of the program, including ensuring contraceptive supply for all, shifted from the central level to local governments at the district level. For the most part, local governments were not immediately prepared to take on the challenges created by decentralization, especially ensuring a continuous supply of contraceptives for anyone who needed them. Under a program funded by the U.S. Agency for International Development (USAID), the STARH program targeted two local district governments in East and Central Java for immediate technical assistance to address contraceptive security. Working closely with these two districts, the STARH program and BKKBN, the national family planning coordinating board, developed a process and tools to help local governments bring together key public and private sector stakeholders at the district level. The Indonesian contraceptive security (CS) approach built on an international framework that was adapted to a decentralized environment. This approach empowered local stakeholders to take on the challenge of CS. A set of practical tools and methods were introduced, which caused a dramatic paradigm shift in the CS field. The Indonesian CS approach helped develop strong commitment at the local district level, and resulted in impressive early results.

Throughout this process, which lasted almost two years, some valuable lessons were learned about CS in a decentralized environment that can provide guidance to other countries as they undertake this important issue:

1. *In a decentralized environment, a bottom-up approach focuses assistance where it is most needed; higher levels will follow as they see results from the devolved levels.* By applying the CS process and tools directly at the district level, the voice of stakeholders eventually reached the provincial and central levels as the local district governments began to see the results of their CS strategy. This multi-sectoral voice helped gain the central level's commitment and involvement.
2. *Designing a process and tool that is flexible, with the right balance of complexity and simplicity, builds local capability and empowers local stakeholders.* In both districts where STARH initially worked to introduce CS, there were products of a highly centralized system in which the central government solved problems, established regulations and policies, and provided contraceptives. The CS assessment tool STARH introduced to help districts assess their contraceptive security situation was not intended to provide a large amount of quantitative data. Rather, the assessment was to give enough of a *snapshot* of five components of the situation that would help stakeholders devise appropriate local solutions. The tool was not intended to be rigid; stakeholders were able to redesign and reemphasize questions in the assessment tool based on local priorities. This gave stakeholders a feeling of strong ownership of the process.
3. *Creating public and private sector partnerships is critical at all levels.* Members of the Boyolai District CS team acknowledge that the CS process increased partnerships between the public and private sector and raised a sense of social and community responsibility that did not previously exist. They also acknowledge that they made faster progress in implementing their CS strategy because the private sector did not have the bureaucratic process that often slows down the public sector.

At the provincial level in East Java, the multi-sectoral CS team engaged all stakeholders in providing assistance to their districts and made plans to develop a monitoring system to follow-up as local governments implement their CS strategies. By bringing government, nongovernment, and donor agencies together at the central level, BKKBN succeeded in raising CS as a national issue and encouraged donor agencies to apply the CS process and tools in their project areas.

4. *In a decentralized environment, numerous government agencies at the central level, nongovernmental organizations, and the donor community have a critical role to play in helping local governments achieve contraceptive security.* Although it was the central-level body that managed Indonesia's family planning program for more than 30 years, BKKBN was initially reluctant to fully support STARH's CS activities at the district level. After both the districts and the provincial level shared the results with BKKBN, the organization eventually realized that they have a critical role to play in helping local governments achieve contraceptive security. Through STARH and BKKBN's efforts, other government agencies, such as the Ministry of Health; nongovernmental organizations, such as the national midwives association and the national pharmacists association; as well as the donor community, joined forces in the national struggle to achieve contraceptive security.
5. *Given limited budgets at all levels to initiate and carry through the contraceptive security process, donor organizations will need to support the rollout by providing seed money to organize teams, disseminate the concept, and support assessments and strategy development at the local level.* As the STARH program learned, the total costs of this assistance is minimal when compared to the commitment made by local governments and the relatively fast results when public and private sector stakeholders work together on CS issues.
6. *A critical role of the central government is to create the awareness of contraceptive security and build the commitment by bringing all stakeholders together.* Although the central government was relatively late in joining the contraceptive security movement, once they did, their role quickly became clear. Bringing together stakeholders, creating an awareness of the need for CS, promoting the CS process and planning tools, and advocating for necessary policy changes at the central government level have all contributed to the goal of achieving contraceptive security. In addition, as BKKBN learned, achieving contraceptive security for the nation is not the responsibility of one government agency, or even one unit within one agency, but the combined responsibility of multiple stakeholders.
7. *Local champions can often be found at the local district level; they usually have easier access to local decision makers.* STARH'S speaks to the importance of strong leadership to champion CS, and STARH's work in two districts and at the provincial level in East Java demonstrates that this leadership emerged more easily at the district and provincial levels than at the central level. One reason for this could be that public and private sector members of the district and provincial CS teams already knew each other and many of them had already established close relationships with policymakers. Leaders from both districts and the province emerged easily and quickly as the process was introduced; these leaders became effective champions for CS.
8. *In a newly devolved environment, districts appreciated the opportunity to "learn by doing."* Both districts where STARH introduced the CS process and tool commented early on that their involvement from the beginning in designing the tool and assessing their own contraceptive situation helped develop the commitment needed to continue addressing their CS challenges.

This *learning by doing* approach was radically different from the centralized approach, and as a result, district CS teams realized that they had the control and power to determine their own future.

INTRODUCTION

HEALTH SECTOR REFORM AND DECENTRALIZATION IN INDONESIA

The 1990's saw an increasing number of developing countries implementing health sector reform programs in an attempt to improve the equity, access, quality, and financial sustainability of health services. Bilateral donors, multilateral agencies, and development banks have supported the reforms, which often bring about significant changes in the financing structure and support systems of ministries of health. In many countries, health sector reform has resulted in the decentralization of public health systems. The most common forms of decentralization include devolution, where authority and responsibilities are transferred to municipalities, provinces, and districts; deconcentration, which occurs within the ministries of health to the regions and districts; and delegation, which transfers responsibilities to semi-autonomous agencies. In Indonesia, decentralization took the form of devolution.

While the Ministry of Health (MOH) had devolved authority to local governments in 2001, the national family planning program did not decentralize until 2002. The Government of Indonesia (GOI) issued a decree stating that the official handover of authority must be completed by early 2004. This gave local governments a little less than two years to address management issues. The family planning management challenges faced by local governments included forecasting, procuring, and distributing contraceptives. Ensuring the continued quality of family planning services; ensuring that all clients who selected a family planning method had access to that method and could afford to purchase it; and ensuring a continuous contraceptive supply—were all daunting challenges for newly devolved local district governments with minimal experience in managing these key functions.

With the shifting responsibilities and authority, there was an urgent need to help local governments apply a practical, cost-effective process that would develop the commitment and involvement of all stakeholders in the family planning program, including public and private sector agencies. This document reviews a practical process and tool developed by the STARH program that helped two districts—with assistance from the province and central family planning board (BKKBN)—bring together the key public and private stakeholders at the district level to jointly address five key areas of their family planning program:

- *policy changes* at the national and local levels
- *financing mechanisms* to help ensure that the contraceptive needs of all clients, both poor and non-poor, are adequately met
- strengthening *logistics management systems*, specifically inventory management that collects the data needed to prepare accurate forecasts of contraceptive needs
- encouraging the *private and nongovernmental (NGO) sector* to become more involved in ensuring that all private sector point-of-sale outlets are adequately supplied

- ensuring the *quality of clinical and non-clinical family planning services* provided by both the public and private sector.

Figure 1. Five Components of STARH.

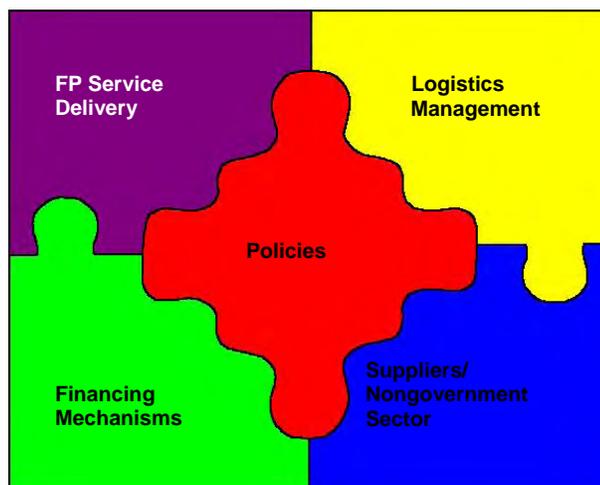


Figure 1 shows the interrelationship of the five components. STARH and the districts learned that service delivery, logistics management, financing, and the private sector all require changes in existing policies.

CONTRACEPTIVE SECURITY AND DECENTRALIZATION

Contraceptive security exists when women and men are able to choose, obtain, and use high-quality contraceptives and condoms, when they want them, for family planning and to prevent HIV/AIDS and sexually transmitted infections. In many countries, people rely on free or subsidized contraceptives provided by public health programs and international donor organizations. With recent trends showing a steady decline in donors' willingness to continue supporting family planning programs through free contraceptive donations, governments urgently need to use their own funds to meet the steadily increasing demands for contraceptives and condoms. In a decentralized environment, this responsibility becomes a major challenge for local governments where vying for funds to maintain a strong family planning program often competes with the limited funds for other priorities.

A harsh reality for many devolved local governments is the limited ability of the central government or family planning agency to solve problems associated with contraceptive supply or access to family planning services, especially at the local level. Indeed, in a devolved setting, the relationship between central and local governments is often broken, and local governments often find themselves with limited support from the very agency that once prevented stockouts by supplying emergency shipments, or provide training to improve the quality of family planning services, such as counseling. Another challenge faced by local governments in Indonesia is to ensure that the contraceptive prevalence rate (CPR) does not decline. Studies show that the economic crisis experienced during 1997/1998 did not have a major affect on the CPR, at 55 percent. But, the same studies warn that if

the CPR in future years does not increase, it would be a *defeat* for Indonesia's family planning program. As the study points out, "Any move upwards (in the CPR) will depend either upon the private sector or upon the national program (or both)." Thus, reaching out to the vibrant private sector that exists in Indonesia is yet another critical challenge local governments must address.

Given the often weakened role played by the central government, we must find a way to work directly with local governments, helping them accept that the responsibility for solving their long-term contraceptive supply. Maintaining a strong family planning program ultimately rests with governments. The STARH program developed and tested a process and tool that helped two districts in Java not only identify the unique issues they face in ensuring a secure contraceptive supply, but also developed the commitment needed to address all five key components that would ultimately ensure that the definition of *contraceptive security* is truly realized.

DEVELOPING A DISTRICT LEVEL CONTRACEPTIVE SECURITY PROCESS AND TOOLS

ADAPTING SPARHCS TO A DECENTRALIZED ENVIRONMENT

The process and tools that STARH used to introduce contraceptive security to local governments at the district and provincial level evolved from a contraceptive security framework developed by the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) committee in 2001. This framework was the collaborative initiative of 40 organizations around the world that work on reproductive health. With two local district governments in East and Central Java, Boyolali and Malang, STARH adapted the SPARHCS diagnostic tool by focusing on the issues relevant to recently devolved local governments. The program reduced the original 12 SPARHCS contraceptive security components to five, with several, such as forecasting and logistics management, merged into a single component. The end result was an assessment and strategic planning tool the two local governments of Boyolali and Malang felt were appropriate and manageable, given local district resources and time. This tool is called the *District Planning Tool for Contraceptive Security*. The SPARHCS framework and diagnostic tool was originally designed for use in a centralized environment and, therefore, needed to be adapted for use in a decentralized environment like Indonesia. STARH accomplished this by directly involving the public and private sector stakeholders at the district level.

BRINGING THE PUBLIC AND PRIVATE SECTORS TOGETHER

Because SPARHCS emphasizes the importance of the public and private sector in achieving contraceptive security, whether in a centralized or decentralized environment, STARH designed the CS planning tool in a way that brought together both public and private sector institutions at the district level, all of whom had some stake in the future of the district's family planning program. Based on guidance and lessons learned from SPARHCS, the STARH team was aware of the importance of involving all stakeholders in the CS process. Indeed, without the public and private sector involvement, SPARHCS advised, achieving the goal of contraceptive security might overlook the most vulnerable segments of the population, such as the poor, or perhaps overlook the need for

a secure contraceptive supply for those in the population who can afford to purchase their contraceptive methods from the public or private sector. Bringing together these important stakeholders helped local governments create a team, or task force, to represent the relevant public and private sector agencies; this group recognized the need to address contraceptive security in an organized way.

Armed with the CS planning tool, this multi-disciplinary team met to conduct the first-ever joint assessment that a district government had ever initiated for its family planning program.

In both districts the *public sector* was represented by—

- Kesra, the social welfare agency under the local governor (coordinates local government support for health and social issues)
- Bappeda, the local government planning agency (prepares budgets for presentation to the local parliament and also prepares a five-year strategy)
- BKKBN, the family planning coordinating board at the district level
- Department of Health (provides all family planning services through their health facilities at the district and sub-district level)
- Bapemas, the community development agency (responsible for the community activities for the development of civil society).

The *private sector* was represented by—

- Ikatan Bidan Indonesia (Indonesia Midwives Association)
- Ikatan Dokter Indonesia (Indonesia Medical Association)
- Ikatan Sarjana Farmasi Indonesia (Indonesia Pharmacists Association).

Including members from these three key professional associations was critical if all issues related to achieving contraceptive security at the district level were to be successfully addressed. With midwives being the primary frontline providers of family planning services throughout the country, and with an estimated 62 percent of the population accessing their contraceptives directly from the private sector—for example, pharmacies, physicians and midwives—including these private sector stakeholders was key to Boyolali’s ability to find innovative solutions to addressing the future of their family planning program.

HOW THE TOOL WORKS: A TWO-STAGE PROCESS

The *District Contraceptive Security Planning Tool* has two sections. Part 1, “Assessing Contraceptive Security at the District/Municipality,” includes an assessment tool that guides the district CS team as they explore issues related to policies, financing, logistics management, family planning service delivery, and the role of the private sector in helping the district achieve contraceptive security. In both districts, the CS team, from its multisectoral team, identified the most appropriate members to collect data on each of the five components. Thus, team members representing the local MOH and the local chapter of the national midwives association collected data for the “FP Service Delivery,”

component, which explored access and quality of family planning services at the district level; while team members from BKKBN collected data for the “Logistics Management.”

The second part of the CS Planning Tool, “Developing a Contraceptive Security Strategy,” applies basic planning steps (Situation Analysis; SWOT Analysis; Objectives; and a Plan of Action including indicators and a monitoring plan). This section, implemented in a three-day workshop, brings together the district-level CS stakeholders who conducted the assessment from section 1. At the end of the three days, the district has a comprehensive strategy that addresses all five components of contraceptive security: policy; financing mechanisms; logistics management; suppliers and non-government sector; and family planning service delivery.

REACHING MORE THAN 400 DISTRICTS

Even though, initially, STARH worked directly with the district of Boyolali in designing, testing, and revising the *District Planning Tool for Contraceptive Security*, STARH needed a more appropriate and sustainable way to introduce the process and tool to districts. The program’s mandate was to focus on 12 districts throughout the country; after their work was complete, they were then to use the districts as a model for developing processes and tools that would help local district governments assess and strengthen various aspects of their family planning program. While the 12 districts were an excellent way to develop and test tools and processes, the same challenges that these 12 districts faced reflect the same issues that more than 400 districts throughout Indonesia would face as a result of devolution.

Because BKKBN central did not have the human or financial resources to work with more than 400 districts, STARH introduced the concept and tool to the BKKBN provincial office in East Java. Seeing this activity as an important way to strengthen the province and district relationship, BKKBN’s provincial office established a similar group of public and private sector stakeholders at the provincial level, forming a Provincial Contraceptive Security Team. To facilitate the CS process in the Malang District, the team first introduced the concept and tools, and helped the district identify and bring together the public/private sector stakeholders. The team used the first part of the planning tool to assess their CS situation, and then facilitated the three-day workshop at the district, where they developed a comprehensive CS strategy for the district.

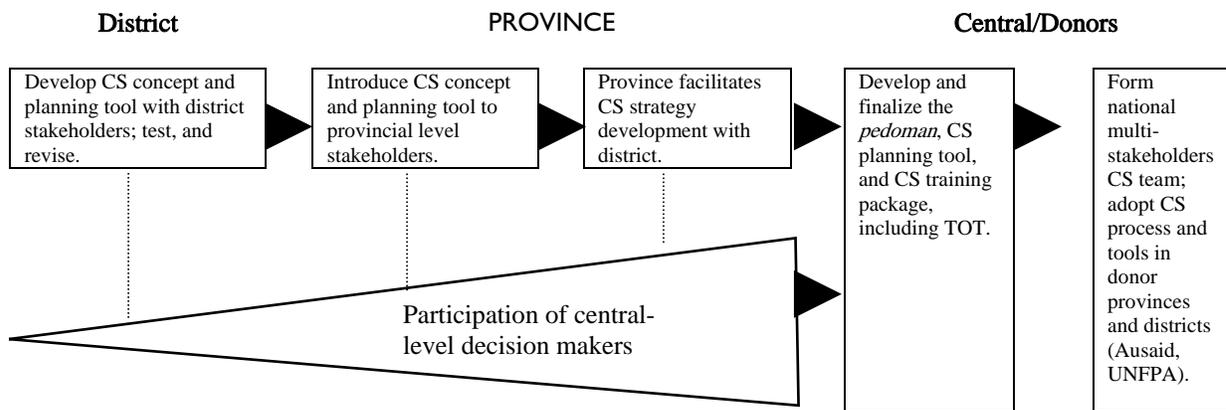
A NEW ROLE FOR THE CENTRAL LEVEL

After being highly centralized for more than 30 years, BKKBN did not initially see the opportunities created by the CS process and tools. But, through continuous active participation of key BKKBN central staff in all district and provincial activities, BKKBN personnel began to recognize the value of the process and tool, not only for districts and provinces, but more importantly for BKKBN central, as well. As a result, BKKBN drafted a *pedoman*, a set of official guidelines for provinces and districts to use when implementing government programs. Sanctioned and signed by the Director of BKKBN, the *pedoman* was the first significant activity performed by BKKBN central as they became committed to contraceptive security.

BKKBN then established a contraceptive security team comprising internal BKKBN staff. As the team became more organized and as the experiences of Boyolali and Malang Districts, including the East Java provincial level, were brought to their attention, this internal team expanded into the National Contraceptive Security Team. The team comprised government

organizations: the Ministry of Health, the national midwives association, the national pharmacists association, and donors that included USAID, UNFPA, and AusAid. BKKBN acknowledged that the central government has a critical role in helping districts address contraceptive security in an era of decentralization. Since its inception, the National Contraceptive Security Team has worked to develop a national CS strategy that will clarify the key roles the central government, provincial government, and local district governments have in addressing contraceptive security. They will also reinforce the role of the provincial level in providing the initial introduction of the CS process and tool to their districts and in monitoring each district's progress in achieving CS. This process is often reversed in centralized systems where the central-level decision makers take the initiative to develop a CS strategy.

Figure 2. Process Used by STARH.



Note in figure 2: The process STARH used to introduce contraceptive security started at the *bottom*, with local district governments. Involving central- and provincial-level staff in every CS activity at the district level ultimately resulted in a strong commitment from central- and province-level.

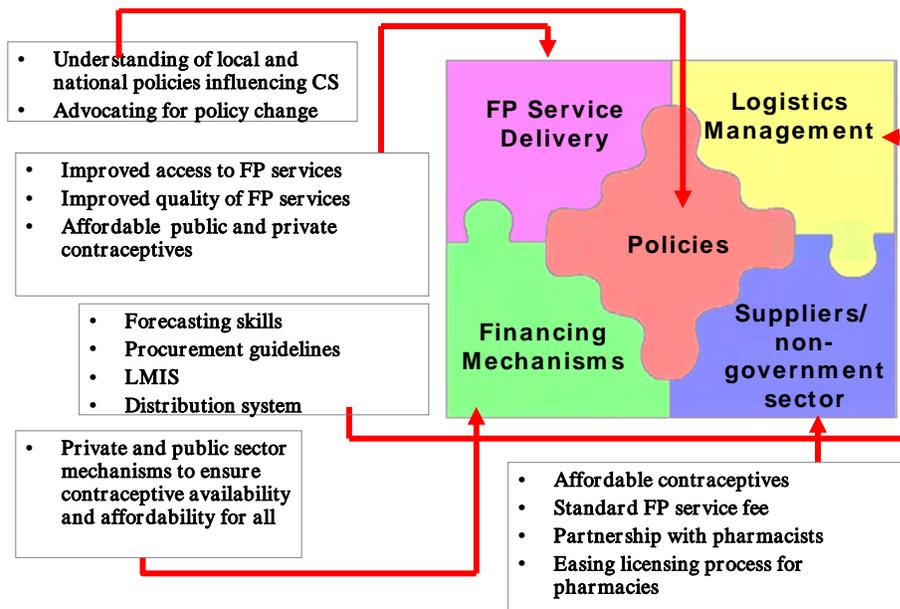
RESULTS TO DATE

As described earlier, STARH's CS activities began by applying a central-level framework developed by the SPARHCS committee to a decentralized environment. In 2001, the SPARHCS framework presented a definition of contraceptive security, whereby "every person is able to choose, obtain and use contraceptives and other essential reproductive health products whenever she or he needs them." While SPARHCS is clear that countries that use the SPARHCS framework and diagnostic tools are free to adapt them to local realities, the degree to which all levels in Indonesia debated this definition indicates the level of interest. In Indonesia, government policy limits public-funded family planning services to married couples. This policy sparked a debate at all levels, particularly at the local district level where some members of the CS team debated the unfairness of this policy. Ultimately, the following definition for contraceptive security as it applies in the Indonesian context was approved: "Contraceptive security is a condition in which every eligible couple is able to choose, obtain and use contraceptives when they need them."

Whether one agrees with this definition or not, the resolution paved the way for all future activities initiated by all levels. Indeed, had this issue not been resolved early in the process, it is unlikely that the process and tool introduced by STARH would have moved much beyond lip-service.

After the definition was agreed upon, districts were able to frame their CS strategies within Indonesia's definition. Agreeing on the definition did not imply agreement with the government's decision to limit family planning services to married couples; in fact, in their assessment of their district-level family planning program and in identifying the policies that need to be changed, CS team members in both Boyolali and Malang identified these as issues in their strategy and action plan (see figure 3).

Figure 3. Contraceptive Security Needs Identified at District Level



DISTRICT-LEVEL RESULTS: LEARNING BY DOING

Although the Boyolali District began its CS process in early 2004, and Malang began in mid-2004, both districts had achieved impressive results by March 2005, indicated in the following list:

Advocating for policy change: Advocating for policy change at the local government level resulted in an official recognition that family planning services were an integral part of the district’s basic health package. District governments now allocate annual budgets to purchase contraceptives.

Ensuring affordable public and private contraceptives: The issue of affordability of family planning services and contraceptives was resolved by creating price lists for public and private sector facilities so that the population pays affordable prices based on socioeconomic factors. With the government procuring about 30 percent of contraceptive needs for the poor, the stakeholders advocated for the local government to add a specific line item to procure contraceptives and medicines. With approximately U.S.\$16,000 budgeted for contraceptive procurement from the local government in 2004, the group requested nearly U.S.\$60,000 for contraceptive procurement in 2005.

Easing licensing process for new pharmacies: Prior to decentralization, opening a pharmacy required a lengthy bureaucratic process at the central level. After decentralization, the local district health office was given this authority. However, the process was still time-consuming and bureaucratic. Led by the local health office, the CS team facilitated a process that made it easier to acquire a license to open a pharmacy. Part of the agreement to help pharmacists get the license for a new pharmacy was a streamlined process that included an agreement that the new pharmacies would be located at the sub-district level and must provide contraceptives. By March 2005, as a result of this process, ten new pharmacies opened at the sub-district level.

Partnering with pharmacies: The CS team facilitated an agreement with pharmacies that allowed midwives and doctors to purchase contraceptives from the pharmacy and pay up to one month later.

This has benefited midwives and doctors who may not have the ready cash, has ensured contraceptive availability, and has also guaranteed the pharmacy payment. This agreement started with one pharmacy; by March 2005, three pharmacies were part of this arrangement.

Segmenting the market: To wean the population that can afford to buy their contraceptives off the publicly provided free contraceptives, which were reserved for the poor, the CS team initiated discussions on local radio stations. These talk shows, which aired four times weekly, reinforced the idea of *free contraceptives for the poor*, pointing out, among other things, that most people can afford the cost of pills—about Rp.100 per day (approximately U.S.\$12). The radio talk shows also reinforce the government’s policy decision that public health facilities must meet the contraceptive needs of the poor. In Malang, CS team members point out that the term used for free government contraceptives—*cuma-cuma* (meaning *free* in bahasa-Indonesia)—has become so engrained in the minds of the local population that they now associate *cuma-cuma contraceptives* with a brand name. NGOs who are members of the CS team are also using their own channels to reach out to the community with these messages, including regular meetings of religious groups.

Improving access to family planning services: Prior to decentralization, public sector contraceptive supplies were provided at public health centers to all clients, regardless of their economic situation. After decentralization, only the poor could use public supplies. The non-poor had no access to public health centers. The CS district team/stakeholders advocated to the local government to procure contraceptives out of local government budget to ensure contraceptive supply for the non-poor who access public health centers. These contraceptives were available for purchase at public health centers at the sub-district level but at lower prices than at private pharmacies. This policy change, facilitated by the district CS team, benefited clients who were able to purchase contraceptives but did not have ready access to private outlets.

Prior to the establishment of the district CS team, each private midwife was able to set her fee for family planning services, which included the cost of the contraceptive supplied. This price was set based on what the market could bare (free market approach), as well the reputation of a particular private midwife. The district board of IBI, the professional midwives association, facilitated a consensus agreement among their members within the district that they would apply a standard price structure to all contraceptives available through private midwives. This IBI policy change has improved access to affordable contraceptives, because clients can now access the closest private midwife.

Members of both district’s CS teams readily admit that the CS process and tools helped change the mindset of the public and private sector in their district. Whereas, before they embarked on the CS process, all sectors worked separately, rarely coming together to address matters that were ultimately everyone’s concern. CS brought these groups together. They also commented that one of the greatest benefits from this process was *learning by doing*; at the first formal presentations of their progress on CS made to the province and to BKKBN, they highlighted this as a major benefit.

PROVINCIAL LEVEL RESULTS: BUILDING CAPACITY

The process also developed similar partnerships at the provincial level. With many of the same public sector agencies and private sector associations existing at both the district and provincial level, provinces began providing technical assistance to their districts—introducing the concept, the

process and the tools, and facilitating the development of the district's CS strategy. The CS team in East Java has been very active in monitoring and following up with districts as they implement their strategies. Realizing the importance of the provincial level in CS, BKKBN will focus significant activities at building provincial capacity in CS.

CENTRAL LEVEL RESULTS: REACHING POLICY MAKERS AND DONORS

This paper describes how the STARH program initially targeted local district governments with a CS process and planning tool; while, at the same time, ensured that provincial- and central-level decision makers were aware of and involved in, whenever possible, district level CS activities. This *bottom-up* approach comes with some potential risks; one could understand the sense of threat on the part of the central level to the central authority position they had always played. With such an attitude, the central level could easily have blocked all CS activities aimed at the district level. Fortunately, the early involvement of BKKBN central staff in all CS activities at the district and province paid off; the personnel saw a clear and critical role for the central staff concerning CS. This helped these personnel advocate for BKKBN's central CS role, and for the ultimate formation of a National Contraceptive Security Team.

The National Contraceptive Security Team has also initiated other important policy changes at the central level; all changes have helped local governments in their struggle to achieve contraceptive security. In 2005, the MOH, a member of the National CS Team, decreed that family planning is a basic health service and that contraceptives should be included on the National Essential Drugs List (NEDL). Presently, the national level is advocating to include all contraceptives in the NEDL. After the national list includes all contraceptives, local governments can revise their local regulations, which will make budgeting and procurement of contraceptives easier. Although local governments are not required to provide contraceptives and budget for them, the list is often a powerful guideline in helping local governments plan and budget.

The positive role taken by BKKBN in realizing the need for central level involvement in achieving contraceptive security, and the expansion of the CS team to include a wide variety of stakeholders, demonstrates what can happen when all levels recognize the unique contributions they each bring to the CS challenge. As the SPARHCS framework says, achieving contraceptive security requires the involvement of all stakeholders at all levels.

In addition to the initial support for CS that came from USAID, other international donor agencies, like UNFPA and Ausaid, recognized the value of this district-level approach and have begun applying the process and tool in their project areas.

The STARH CS approach was first introduced to the Indonesia office of UNFPA at a regional UNFPA workshop on commodity security held in Laos in mid-2004. Dr. Wandri Mochtar, from BKKBN and a member of the CS team, presented the experience and results from Boyolali and East Java. UNFPA has now agreed to apply the CS process and planning tool in their four provinces of NTT, West Kalimantan, West Java, and South Sumatra.

AusAid funds the Women's Health and Family Welfare Project, which works in ten districts in NTT/NTB province. After learning about the CS process and tools from BKKBN and STARH, AusAid has agreed to fund CS activities in NTT/NTB. During a meeting sponsored by AusAid in March 2005, BKKBN introduced the CS process and tools to provincial and district representatives. This gave BKKBN an important opportunity to present the experiences of Boyolali and Malang

Districts, and also to support CS by presenting statistical data prepared by BKKBN and Dr. John Ross.

CONCLUSION

Bringing together public and private sector stakeholders at the district level and giving them with an opportunity to develop an appropriate process to jointly address contraceptive security is a significant contribution for other districts and provinces, and indeed other countries facing decentralization. When stakeholders from the public and private sector jointly assess their family planning program, develop a strategy to address their findings, and implement the strategy, a new paradigm emerges. The commitment local governments developed to the CS process and tools evolved out of their direct involvement and the realization that their future is truly in their own hands. Ultimately, the process has resulted in the empowerment of the public and private sectors at the local district level. Sharing their progress with provincial- and central-level managers has had a powerful influence on the commitment that developed among public and private institutions in Indonesia, as well as international donors, such as UNFPA and AusAid, who are using the CS process and tools in their targeted districts.

REFERENCES

- Family Planning Logistics Management (FPLM)/John Snow, Inc. (JSI). 2000. Implications of Health Sector Reform for Contraceptive Logistics: A Preliminary Assessment for Sub-Saharan Africa. Arlington, Va.: FPLM/JSI.
- Ross, John. 2003. Contraceptive Security in Indonesia: What Do The Data Say? Washington, D.C.: The Futures Group.
- STARH. 2004. District Planning Tool for Contraceptive Security. Indonesia: STARH.
- U.S. Agency for International Development (USAID), Commodities Security and Logistics Division, Office of Population and Reproductive Health, Bureau for Global Health. 2004. Contraceptive Security Ready Lessons. Washington, D.C.: USAID.
- U.S. Agency for International Development (USAID) and United Nations Population Fund (UNFPA). 2004. SPARHCS: Strategic Pathway to Reproductive Health Commodity Security: A Tool for Assessment, Planning, and Implementation. Washington, D.C.: USAID and New York: UNFPA.

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