SHIFTING THE CONTRACEPTIVE SECURITY PARADIGM TOWARDS A MODEL FOR DECENTRALIZED ENVIRONMENTS: Lessons from Indonesia

H. Daniel Thompson
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1. EXECUTIVE SUMMARY AND LESSONS LEARNED

With the decentralization of the Indonesia family planning program in 2002, authority for managing all aspects of the FP 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 decentralization created, especially ensuring a continuous supply of contraceptives for anyone who needed them. Under a program funded by the United States Agency for International Development (USAID), the STARH program targeted immediate technical assistance to two local district governments in East and Central Java, 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 that helped local governments bring together key public and private sector stakeholders at the district level. The Indonesian 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, causing a dramatic paradigm shift in the CS field in Indonesia. The Indonesian CS approach helped develop strong commitment at the local district level, and resulted in impressive early results.

Throughout this two year process, some valuable lessons have been learned about contraceptive security 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 can focus 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 local district governments began to see results of their CS strategy. This multi-sectoral voice helped gain the commitment and involvement of the central level.

2. Designing a process and tool that is flexible and has the right balance of complexity and simplicity builds local capability and empowers local stakeholders. Both districts where STARH initially worked to introduce CS 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 purpose of the assessment was to give enough of a "snapshot" of five components of the situation that would help stakeholders find appropriate local solutions. The tool was not intended to be rigid; stakeholders were able to re-design and re-emphasize questions in the assessment tool based on local priorities. This allowed stakeholders to feel a 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 resulted in increasing partnerships between the public and private sector, raising a sense of social and community responsibility that did not previously exist. They also acknowledge that the progress they made in implementing their CS strategy was speeded up because the private sector was often able to move faster since they 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 plans to develop a monitoring system to follow up as local governments implement their CS strategies. And by bringing together government, non-government, and donor agencies 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, non-governmental organizations, and the donor community have a critical role to play in helping local governments achieve contraceptive security. Though the central-level body that managed Indonesia's FP program for more than 30 years, BKKBN, was initially reluctant to give full support to STARH's CS activities at the district level, results shared with BKKBN by both districts and the provincial level eventually created an awareness within the organization that there was a critical role for BKKBN to play in helping local governments achieve contraceptive security. Through STARH and BKKBN's efforts, other government agencies such as the Ministry of Health, non-governmental 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 with the CS process, donor organizations will need to support the rollout of CS by providing seed money to formulate CS teams, disseminate the CS concept, and support CS assessments and strategy development at the local level. As STARH learned, the total costs of this assistance is minimal when compared to the commitment taken on by local governments and the relatively fast results demonstrated when public and private sector stakeholders come together to tackle CS issues.

6. A critical role of the central government is to create the awareness of contraceptive security and build the commitment by bringing together all stakeholders. Though the central government was relatively late in joining the CS movement, once they did their role quickly became clear. Bringing together stakeholders, creating awareness of the need for CS, promoting the CS process and planning tools, and advocating for necessary policy changes at 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 role of one government agency, or even one unit within one agency, but the combined responsibility of multiple stakeholders.

8. Local champions often exist naturally at the local district level and usually have easier access to local decision-makers. SPARHCS 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 closely established relationships with policy-makers. "Leaders" from both districts and the province emerged easily and quickly as the process was introduced, and these leaders became effective champions for CS.

9. 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 in developing 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.

10. Several key outcomes have already been realized including: agreement of an Indonesian specific definition of CS, establishment and funding of local budget lines for contraceptives, better targeting of free public contraceptives, better market segmentation supported by BCC efforts, introduction of expanded fee for service public provision, expansion of private provision through more streamlined procedures for establishing pharmacies, stronger partnerships between pharmacies and private service providers, and standardization of private provider fees.

2. INTRODUCTION

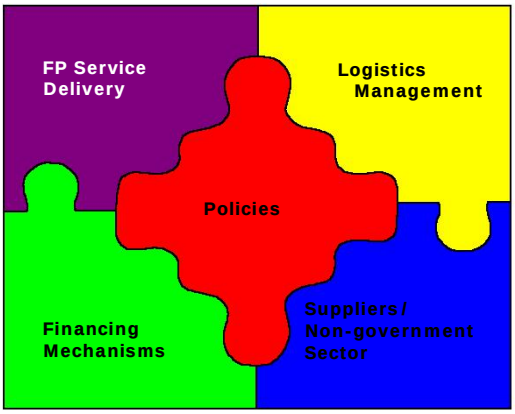
Health Sector Reform and Decentralization in Indonesia:

The 1990's saw an increasing number of developing countries implementing donor supported health sector reform programs in an attempt to improve the equity, access, quality and financial sustainability of health services. 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 MOH to 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 had devolved authority to local governments in 2001, the national family planning program did not devolve until 2002 with a decree from the GOI stating that the official handover of authority must be completed by early 2004. This gave local governments less than two years to address management issues. Local governments faced daunting new family planning logistics cycle management challenges. For the first time they were expected to forecast, procure and distribute contraceptives to ensure continuous supply while ensuring the quality of FP services, so that all clients choosing a family planning method have affordable access to that method.

With this shifting of responsibilities and authority, there was an urgent need to help local governments apply a practical, cost-effective process to build commitment and involvement of all public and private sector stakeholders in the family planning program. This document presents a practical process and tool developed by the STARH Program that helped two districts, build local ownership, partnership and commitment to address fundamental FP logistics management challenges. With assistance from the province and central family planning board (BKKBN), key public and private stakeholders at the district level worked together to address five key areas of their family planning program:

1. ***Policy changes*** at the national and local levels;
2. ***Financing mechanisms*** to help ensure that the contraceptive needs of all clients, both poor and non-poor, are adequately met;
3. Strengthening ***logistics management systems,*** specifically inventory management that collects the data needed to prepare accurate forecasts of contraceptive needs;
4. Encouraging the ***private and NGO sector*** to become more involved in ensuring that all private sector point-of-sale outlets are adequately supplied; and
5. Ensuring the ***quality of clinical and non-clinical family planning services*** provided by both public and private sector.



This diagram demonstrates the inter-relationship of these five components. STARH and the districts learned that service delivery, logistics management, financing and the private sector all required changes in existing policies.

Contraceptive Security and Decentralization

Contraceptive security exists when people are able to choose, obtain and use high quality contraceptives and condoms when they want them for family planning and prevention of 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. Internationally there has been an increased emphasis on national governments taking responsibility for funding their FP programs. In a decentralized environment this responsibility becomes a major challenge for local governments as funding for FP faces many competing demands 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 local problems associated with contraceptive supply or access to family planning services. 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 was once able to prevent stockouts by supplying emergency shipments, or provide training to improve the quality of FP services such as counseling. Another challenge local governments face in Indonesia is ensuring that the contraceptive prevalence rate (CPR) does not decline. Studies point out that the economic crisis experienced during 1997/98 did not have a major affect on the CPR, at 55%. But the same studies warn that no increase in the CPR in future years 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.

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

3. DEVELOPING A DISTRICT-LEVEL CS PROCESS AND TOOLS

Adapting SPARHCS to a Decentralized Environment

The process and tools STARH used to introduce contraceptive security to local governments at the district and provincial level evolved from a contraceptive security framework developed by USAID known as the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS)[1]. Working with two local district governments in East and Central Java, Boyolali and Malang, STARH adapted the SPARHCS diagnostic tool, focusing on the issues relevant to recently devolved local governments. The six core SPARHCS contraceptive security components were adjusted to five focus areas by STARH as illustrated below.

SPARHCS Components	**STARH Adaptation**	**Variation between SPARHCS and STARH frameworks**
Context		Implicitly considered at the local level
Commitment		Local commitment and leadership is implicit in the STARH approach
Coordination →	Private suppliers and NGOs	Coordination is also crucial between BKKBN and the local levels
Capital →	Financing mechanisms	
Capacity →	Policies Logistics management Service delivery	These were explicitly examined as separate elements in the STARH framework
Client		Implicitly considered at the local level

The end result of this process 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 became known as 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

SPARHCS emphasizes the importance of the public and private sector in achieving contraceptive security. STARH designed the CS Planning Tool to bring together district level public and private sector institutions who 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 involvement of the public and private sector, SPARHCS advised, achieving the goal of contraceptive security might overlook segments of the population most vulnerable such as the

[1] Hare, L., Hart C., Scribner, S., Shepherd, C., Pandit, T (ed.), and Bornbusch, A. (ed.)SPARHCS, Strategic Pathway to Reproductive Health Commodity Security. A Tool for Assessment, Planning and Implementation, USAID.

poor, or the needs of 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, representing relevant public and private sector agencies that recognized the need to address contraceptive security in an organized way. Armed with the CS Planning Tool, this multi-disciplinary team conducted the first ever joint assessment 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 (this agency coordinates local government support for health and social issues);
- Bappeda, the Local Government Planning Agency (this 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;
- the Department of Health, which is the provider of all family planning services through their health facilities at the district and sub-district level; and
- Bapemas, the Community Development Agency that takes care of 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); and
- 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. Midwives are the primary providers of family planning services throughout Indonesia while an estimated 62% of the population accessing their contraceptives directly from the private sector. Including private pharmacies, physicians and midwives 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* consists of two sections. Part 1, "Assessing Contraceptive Security at the District/Municipality", provides an assessment tool that guides the district CS team as they explore issues related to policies, financing, logistics management, FP service delivery and the role of the private sector in helping the district achieve contraceptive security. In both districts the CS team identified from among its multi-sectoral team 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 carried out data collection for the "FP Service Delivery" component that explored access and quality of FP services at the district t level, while team members from BKKBN carried out the "Logistics Management" data collection.

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The second part of the CS Planning Tool, "Developing a Contraceptive Security Strategy", applies basic planning steps - Situation Analysis; SWOT Analysis; Objectives; a Plan of Action including indicators and a monitoring plan. This is implemented in a three-day workshop that brings together the district-level CS stakeholders who conducted the assessment from section 1. At the conclusion 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 FP service delivery.

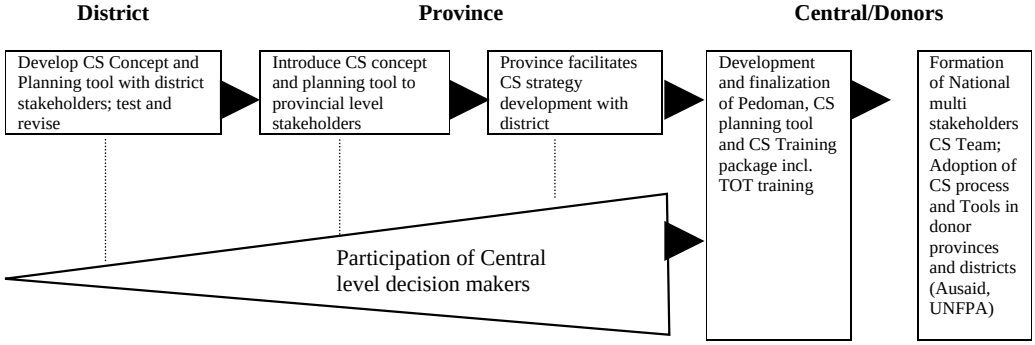
Reaching Over 400 Districts

Though initially STARH worked directly with the district of Boyolali in designing, testing and revising the *District Planning Tool for Contraceptive Security*, a more appropriate and sustainable method of introducing the process and tool to districts was needed. The STARH program was mandated to focus on 12 districts throughout the country, using them 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 these 12 districts were an excellent way of developing and testing tools and processes, the same challenges faced by these 12 districts reflect the same issues that more than 400 districts throughout Indonesia were expected to face as a result of devolution. Since BKKBN central did not have the human or financial resources to work with more than 400 districts, STARH introduced the concept 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 brought together a similar group of public and private sector stakeholders at the provincial level, forming a Provincial Contraceptive Security Team. This team facilitated the CS process in Malang District by first introducing the concept and tools, helping the district identify and bring together the public/private sector stakeholders, assessing their CS situation using the first part of the Planning Tool, then facilitating the three-day workshop at the district in which a comprehensive CS strategy for the district was developed.

A New Role for the Central Level

Having been 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 in implementing government programs. Sanctioned and signed by the Director of BKKBN, this *pedoman* became the first significant activity BKKBN central performed as they became committed to contraceptive security. BKKBN then established a Contraceptive Security Team consisting of internal BKKBN staff. As this team became more organized and as the experiences of Boyolali and Malang Districts, as well as East Java provincial level, were brought to their attention, this internal team expanded into a National Contraceptive Security Team consisting of government organizations such as the Ministry of Health, the national midwives association, the national pharmacists association, and donors such as USAID, UNFPA and AusAid. BKKBN came to acknowledge that the central government has a critical role in helping districts address contraceptive security in an era of decentralization.

Since its inception the National CS Team has been working to develop a national CS strategy that will clarify the key roles the central government, the provincial government, and local district governments have in addressing contraceptive security, and will 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 contraceptive security. This process is often reversed in centralized systems where the initiative to develop a CS strategy is taken by central-level decision-makers.



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 province and central.

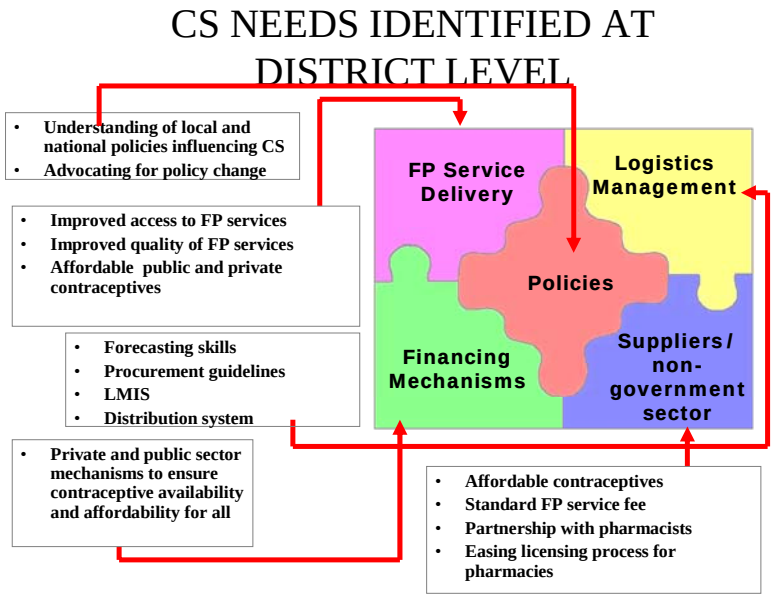
4. RESULTS TO DATE

As described above, 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 makes it clear that countries choosing to 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 a consensus was reached on 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 is in agreement with this definition or not, the resolution of this issue paved the way to 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.

Once the definition was agreed upon, districts were able to frame their CS strategies within the context of Indonesia's definition of CS. Agreement on the definition did not imply agreement with the government's decision to limit FP services to married couples; in fact, in their assessment of their district-level FP program and in identifying the policies that needed to be changed, CS team members in both Boyolali and Malang identified these as issues in their strategy and action plan.



District Level Results: Learning by Doing

Though Boyolali District began its CS process in early 2004, and Malang in mid-2004, both districts have achieved impressive results as of March 2005. The following list reflects achievements from both districts:

Advocating for Policy Change: Advocating for policy change at the local government level resulted in an official recognition that family planning services should an integral part of the district's basic health package. District governments now allocate annual budgets for the purchase of 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 is charged affordable prices based on socio-economic factors. With the government able to procure about 30% of contraceptive needs for the poor, the stakeholders advocated to the local government for a specific line item to procure contraceptives and medicines. With approximately

US$16,000 budgeted for contraceptive procurement from the local government in 2004, the group has requested nearly US$60,000 for contraceptive procurement in 2005.

Easing licensing process for new pharmacies: Prior to decentralization, a lengthy bureaucratic process was required at the central level to open pharmacies. After decentralization this authority was given to the local district health office. 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 to open new pharmacies through this streamlined process included an agreement that the new pharmacies would be located at the sub-district level and must provide contraceptives. By March 2005 there are ten new pharmacies at the sub-district level as a result of this process.

Partnering with pharmacies: The CS team facilitated an agreement with pharmacies that allow 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 and by March 2005 three pharmacies are part of this arrangement.

Segmenting the market: In an effort to wean that portion of the population that can afford to buy their contraceptives off the publicly-provided free contraceptives reserved for the poor, the CS team initiated discussions on local radio stations. These talk shows, which air four times weekly, reinforce the idea of "free contraceptives for the poor", pointing out, among other things, that the cost of pills – about Rp.100 per day (approximately US$0.12) – is affordable to most of the population. These 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 like to 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 to all clients regardless of economic situation through public health centers. After decentralization public supplies could only be used for the poor. This left the non-poor with 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 own 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 as a particular reputation a private midwife might have. The district board of IBI, the professional midwives association, facilitated a consensus agreement among their members within the district that a standard price structure would be applied to all contraceptives available through private midwives. This IBI policy change has improved access to affordable contraceptives since 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 was the common theme that brought these groups together. They also commented that one of the greatest benefits from this process was "learning by doing", and in their first formal presentations of their progress on CS made to the province and to BKKBN, they highlighted this as a one of the major benefits.

Provincial Level Results: Building Capacity

he 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 became involved in 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. And realizing the importance of the provincial level in CS, BKKBN has decided to focus significant activities at building provincial capacity in CS.

Central Level Results: Reaching Policy-Makers and Donors

This paper has described how the STARH program initially targeted local district governments with a CS process and planning tool, while at the same time ensuring that provincial and central level decision-makers were aware of and involved whenever possible in district level CS activities. This "bottom-up" approach comes with some potential risks, one of which could be the development of a sense of threat on the part of the central level to the central authority position they had always played. With such an attitude 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 as these personnel saw a clear and critical role for central regarding CS. This helped these personnel advocate for BKKBN's central CS role, and for the ultimate formation of a National CS Team.

The National CS Team has also initiated other important policy changes at the central level, all which have helped local governments in their struggle to achieve contraceptive security. In 2005 the MOH, a member of the National CS Team, decreed that FP is a basic health service and that contraceptives are included on the National Essential Drugs List (NEDL).

Presently national level is advocating to include all contraceptives in the NEDL. Once the national list includes all contraceptives, local governments can revise their local regulations which then makes budgeting and procurement of contraceptives easier. Though local governments are not required to provide these contraceptives and budget for them, the list is often a powerful guideline in helping local governments plan and budget for contraceptives.

The positive role BKKBN has taken on 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 will require 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 have recognized the value of this district-level approach and have begun applying the process and tool in their project areas.

The Indonesia office of UNFPA was first introduced to the STARH CS approach at a regional UNFPA workshop on commodity security held in Laos in mid-2004 when Dr. Wandri Mochtar of BKKBN, and a member of the CS team, presented the experience and results of 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 not only present the experiences of Boyolali and Malang Districts, but also to support CS by presenting statistical data prepared by BKKBN and Dr. John Ross.

5. CONCLUSION

Bringing together public and private sector stakeholders at the district level and providing them with an opportunity to develop an appropriate process to jointly address contraceptive security is a significant contribution other districts and provinces, and indeed other countries facing decentralization, can learn from. When public and private sector stakeholders jointly assessed their family planning program, developed a joint strategy to address their findings, and jointly implement the strategy, a new paradigm emerges. The commitment local governments developed to the CS process and tools evolved out of their direct involvement in it and the realization that their future truly is in their own hands. Ultimately, the process has resulted in the empowerment of the public and private sectors at the local district level. And 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.

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
FP	Family Planning
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome
IBI	Ikatan Bidan Indonesia (Indonesia Midwives Association)
IDI	Ikatan Dokter Indonesia (Indonesia Medical Association)
ISFI	Ikatan Sarjana Farmasi Indonesia (Indonesia Pharmacists Association)
JKK	Jaminan Ketersidiaan Kontrasepsi (the behasa-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	Nongovernment 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	United States Agency for International Development
WB	World Bank

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At BKKBN: Sudibyo Alimoeso; Dr. Wandri Mochtar; DR Dasep Budi Abadi; Pak Darlis Darwis; Pak Subakir; Ibu Ida Muhasyim

In Boyolali District: Dr. Syamsudin H.; Ibu Sri Adiningsih; Dr. Naniek Ambika; Pak Budi; Ibu Sri Sukitin; Ibu Sri Sugiatmi; (IDI); (Kesra); (Bappeda)

In Malang District: Pak Payakun; Ibu Cholis; Drs. Immanudin Apt; Dr. Fauzi; (Bappeda); (Kesra); (IBI); (IDI); (RSUD)

In East Java: Dra. Sri Supiaty Apt, MM; Pak Yuswantoro; Dr. Tris Anggraini; (Bappeda); (Kesra); (IDI); (IBI); (ISFI)

USAID/Washington: Alan Bornbusch, who realized early on that the CS process and tools being developed and tested were a model that other countries facing decentralization of their family planning program could benefit from.

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