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CONTRACEPTIVE SECURITY AND DECENTRALIZATION

Lessons on Improving Reproductive Health Commodity Security in a Decentralized Setting

Technical advisor visiting a municipal warehouse in Bolivia to discuss decentralization.

During the last decade, reproductive health commodity security (RHCS) advocates, funded by multiple donor agencies—for example, the U.S. Agency for International Development (USAID) and the United Nations Population Fund (UNFPA)—have worked in more than 50 countries to successfully strengthen supply chains and improve access to essential RH commodities.

During this time, advocates for RH have increasingly recognized that certain commodity security issues occur more often in decentralized settings. They have also learned the value of engaging lower-level stakeholders (regional-, district-, and facility-managers and health providers, as well community members) throughout the commodity security strengthening process.

RHCS champions in El Salvador, Ethiopia, Indonesia, Mexico, Nigeria, Philippines, and Tanzania—among others—have devised their own RHCS strategies in their decentralized settings.

Ensuring RHCS in a decentralized system takes time and commitment. RHCS advocates need to continuously monitor commodity availability throughout the supply chain and make adjustments.

Although there is no perfect model for ensuring RHCS under decentralization, analyzing country experiences can help identify common pitfalls, lost opportunities, and successes. Other countries can apply these lessons as they encounter similar challenges and opportunities.

What Is RHCS and Why Is It So Important?

Reproductive health commodity security (RHCS) exists when clients are able to choose, obtain, and use quality contraceptives and other essential RH products whenever they need them.

By achieving commodity security, countries can guarantee their population access to reliable family planning services and supplies. These services leave families less vulnerable to unintended pregnancies and births; and reduce abortion rates, maternal and infant deaths, and sexually transmitted infections, including HIV. These health benefits ultimately make a powerful contribution toward a country's economic growth, poverty reduction, and achieving its Millennium Development Goals.

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Reproductive Health Commodity Security and Decentralization

The goal of health sector reform initiatives, like decentralization, is to improve the quality, equity, and efficiency of health care services. Part of this process includes guaranteeing the availability of preventative services—including RH and family planning (FP) and their related supplies—to everyone who needs them. Managers at all levels must refine the system during and after decentralization to achieve these health reform objectives.

RHCS advocates, in particular, need to ensure that managers at all levels are working to build an enabling environment for RHCS in a decentralized system. To do this, they will need to show decisionmakers at all levels of the health system how RHCS can help achieve health goals. In addition, focusing on the client and communities can help reformers make tough decisions about how to set up the new health system and supply chain in more equitable ways.

Decentralization can improve or weaken quality health service and commodity delivery. With careful planning, implementation, and oversight, countries can ensure that decentralization protects the supply chain for essential medicines while simultaneously benefiting clients.

Decentralization aims to balance authority and responsibility between the central- and local-levels to achieve gains in national health priorities while, at the same time, responding to local health needs. RHCS advocates, in particular, will need to help ensure that RH commodities are sufficiently protected without discouraging the ability of lower-level managers to identify and resolve their RHCS problems.

Advocates may need to assist when—

- *Regions limit FP provision because of a lack of commitment.* The central level can establish clear policies and guidance to mandate RH service provision and financing for contraceptives.
- *Lower-level staff are unclear about their new roles and responsibilities.* Central- and regional-level RHCS advocates can use good coordination mechanisms to clarify these roles and correct for overlaps and duplication between levels.
- *Lower-level staff are not ready to assume their new RHCS responsibilities.* RHCS advocates, at all levels, can implement strategies to build institutional capacity and orient staff to their new roles.
- *Managers are not aware of work being done at higher- or lower-levels, or within neighboring regions.* RHCS advocates, at lower levels, can help set up communication links between levels and among regions.
- *Lower-level managers mobilized their own financing for RHCS.* Central-level RHCS stewards can monitor any funding gaps; supplement these resources with central-level financing, if needed; and advocate for the lower level to mobilize additional resources on their own.
- *Certain supply chain functions work better with central-level oversight.* RHCS champions can advocate to the highest levels of government to design and manage these functions with significant central-level oversight.
- *Certain supply chain functions work better when managed by the lower levels.* RHCS champions can advocate throughout the decentralization process for regional- or district-level staff to manage these functions, as needed.
- *Health workers and community members have good ideas for increasing access and demand for RH commodities.* Central-, regional-, and district-level staff can actively provide support for their implementation by monitoring progress and making resources available, when needed.

Country Examples

Under decentralization, advocates can set the groundwork for RHCS by helping managers at the various health system–levels work together to achieve a common goal—increasing better coordinated and balanced access to RH and FP services and supplies.

Various country experiences have created a wealth of valuable lessons on how to manage these risks and benefits to promote RHCS under decentralization (see table 1).

Table 1. Country-Level RHCS Issues and Lessons in Decentralized Systems

Area	Opportunities/Challenges	Lessons
Fostering commitment	♦ RHCS strategies may be more attuned to local level needs and thus have more support. ♦ Support for RHCS at the lower levels may be inconsistent if central-level oversight role is greatly weakened. ♦ May reduce priority of preventive services, such as RH and FP.	***All levels*** ♦ Raise awareness about the importance of RH/FP and contraceptive availability among all health authorities, at all levels. ♦ Track key RHCS indicators at central- and lower-levels. ***Central level*** ♦ Preserve central level oversight role for setting regulations and protecting priority services and supplies (like FP), if necessary. ♦ Set regulations that require lower-level facilities to provide priority RH/FP services and supplies. ***Lower level*** ♦ Identify and empower lower-level RHCS champions to develop their own strategies early in the decentralization process.

Case examples: Ethiopia, Indonesia, Mexico, and Philippines (See all four briefs in this series for the full range of country examples.)

Under the devolved system in the **Philippines**, the central level continued to distribute primarily donor-funded contraceptives from the central- to the local-level (Lakshminarayanan 2003). However, the municipal governments determine how to provide these RH and FP services. In some areas, clients were denied access to services because local municipal managers were opposed to providing FP for religious reasons. In recent years, the central-level government has tried to strengthen its stewardship role, even though the supply of contraceptives from the central level has ended. They have defined a basic package of essential services that must be provided at lower levels, including RH and FP, and they provided grants to municipalities to support the services. They are currently strengthening central-level supervision mechanisms to help monitor RH service provision and commodity availability.

In **Mexico**, state-level managers did not usually view FP service provision and contraceptives as a priority (Beith et al. 2006). Thus, many states did not fund FP sufficiently, because of the lack of commitment to contraceptive security at the central level. Furthermore, states had little experience planning, budgeting, and procuring contraceptives; and the central level did not provide a regulatory framework within which to work. As a result, many states had contraceptive stockouts shortly after decentralization. To remedy this situation, the MOH required states to provide these services and include contraceptive funds in their budgets. The central level also set up a mechanism for procuring quality, low-priced contraceptives at the central level.

Area	Opportunities/Challenges	Lessons
Clarifying roles and responsibilities	♦ Lower levels can take the lead for the RHCS process, dividing responsibility across levels. ♦ Managers may be confused about roles, responsibilities, and what level is responsible for which aspects of RHCS. ♦ Tasks may be left undone because of duplication of efforts and lack of coordination among levels. ♦ RHCS efforts may not be harmonized between the central, regional, and district levels; and among regions and districts. ♦ In a highly decentralized setting, the central level may not receive regular reports from lower levels, which they need to monitor the RHCS process.	***All levels*** ♦ Advocate for RHCS champions to be assigned to appropriate levels and management teams. ♦ Set up RHCS reporting system between levels and neighboring regions, when appropriate. ♦ Set up formal communication channels between and among levels to report on policy and operational changes that may affect RHCS. ♦ Involve, support, and encourage regional- or district-level advocates to align their RHCS goals. ***Lower levels*** ♦ Set up RHCS coordination mechanisms at lower levels of the health system. ♦ Engage private-sector service providers and other partners at lower levels, when appropriate.

Case examples: Bolivia, Ethiopia, Indonesia, and Tanzania (See all four briefs for the full range of country examples.)

In **Tanzania**, district council health management teams were set up to manage the health system, in coordination with the central level (Patykewich et al. 2007). These teams, however, did not, by law, include the existing RH coordinators. This omission limited the teams' ability to promote RHCS and to serve as a communication link on behalf of the RH and FP programs under the new decentralized system.

In **Ethiopia**, members of the central-level contraceptive security (CS) committee are becoming good stewards under decentralization. Because the country is so large and regions are increasingly responsible for managing the health system, central-level RHCS advocates must now step back and oversee the process. First steps have included building awareness at the regional level and supporting regional CS committees to develop their own strategies for making contraceptives more available to the people who need them. The central-level CS committee will use these regional strategies to improve their understanding of lower-level needs and to determine where to provide future supplementary support and resources for RHCS.

In **Indonesia**, the decentralized CS process tapped into existing partnerships between the public and private sector, raising a sense of community responsibility (Thompson 2005). One reason for this could be that members of the district and provincial CS teams from both sectors already knew each other. Also, many of them had close relationships with policymakers at their level. For example, in the Boyolai district, CS champions coordinated their CS strategies with local private service providers. Members of the Boyolai district CS team noted 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.

Area	Opportunities/Challenges	Lessons
Ensuring sufficient financing	♦ May create opportunities for leveraging additional resources or even a budget line item at the lower levels. ♦ Lower-level staff may be able to help manage data more closely to track and map overall financing—commodity needs, allocations, and expenditures. ♦ RHCS financing may be lost if multiple levels are financing commodities. ♦ May result in less financing for FP and RHCS, especially if budgets have been fully devolved and lower-level managers oppose or are unable to support RHCS. ♦ May be difficult to estimate funding gaps or available resources to complement central-level funding.	***All levels*** ♦ Define and implement clear policies and standard operating procedures when various levels provide financing so they can accurately estimate the funds needed and coordinate allocation and execution of these funds from multiple sources. ♦ Consider how cost recovery systems may impact special commodities like contraceptives and how to administer these systems in a decentralized setting in the design stage. ***Central level*** ♦ Protect RH commodity financing at the central level using laws and budget line items, or continued receipt of central-level donations. ♦ Include RH and FP in social and health insurance packages, when appropriate. ♦ Mandate financing and equitable redistribution of funding or RH supplies, when needed. ***Lower levels*** ♦ Begin advocating for regional- or district-level funding to complement central-level financing that will cover the cost of procurement and supply chain management.

Case examples: Bolivia, Ecuador, Ethiopia, Malawi, Peru, Philippines, and Uganda (See all 4 briefs for the range of case examples.)

In **Uganda**, district administrators, believing that health services were already well funded under decentralization, allocated money to other services (Dmytraczenko et al. 2003). The central ministry of health responded to the problem by establishing district grants to ensure that priority programs were adequately funded; donors supplemented the grants with funding for key RH programs, including FP services and supplies.

In 1999, **Bolivia's** maternal and infant health insurance program (SUMI) was expanded to include RH and FP services (Beith et al. 2006). However, because contraceptives were still donated centrally, municipalities were not reimbursed for providing these services. In anticipation of donor phaseout, RH advocates lobbied to expand SUMI to include RH supplies. As a result, in 2006, SUMI was expanded to cover all its beneficiaries' RH needs, including contraceptives.

Regions in **Ethiopia** do not always know how much funding to make available at their level for contraceptives and other RH commodities. Regions carry out commodity forecasts to determine their financing needs. This information is relayed to the central level where stakeholders decide how much of the regional forecasts to finance. These decisions, however, are not always communicated to the lower levels. Thus, regions often are unaware whether there is a funding gap until late in the process. This prevents regional managers from mobilizing funds or putting contingency plans into place to avoid a shortfall.

In **Malawi**, a cost recovery system was set up for health commodities (USAID|DELIVER PROJECT and USAID | HEALTH POLICY PROJECT 2010). The central medical store charges a mark-up fee to cover the cost of the product and supply chain management (5 percent for donated product and 112.5 percent for procured product) and districts draw down from a predetermined budget allocation. Prior to decentralization, the ministry paid the central medical stores for medical supplies it delivered to the districts. In 2005, for the first time, districts were expected to pay for the product plus a handling fee. After this policy change, districts would not always order the quantities of contraceptives needed to satisfy demand, claiming their medicine budget was not sufficient and they had allocated resources to other priorities.

Area	Opportunities/Challenges	Lessons
Building capacity	♦ May create opportunities to build lower-level staff's capacity to manage certain logistics functions. ♦ Regional managers or district managers may lack time, resources, and/or capacity to focus on RHCS. ♦ Local governments may not have the same level of technical and managerial capacity to effectively deliver health services. ♦ Local resources may not be available to effectively manage the supply chain.	***All levels*** ♦ Train lower-level staff to collect, monitor, and use RHCS indicators for making decisions at their level. ♦ Build lower-level capacity to estimate their commodity needs and secure and manage funds and resources at their level. ***Central level*** ♦ Ensure that logistics functions, responsibility, and authority are explicitly delegated and fully funded. ♦ Invest in elevating the importance of logistics staff at all levels.

Case examples: Bolivia, Ecuador, Guatemala, Nigeria, and Philippines (See all four briefs for the full range of country examples.)

In the **Philippines**, limited institutional capacity at local levels led to inadequate health services after devolution (Lakshminarayanan 2003). In addition, not all local governments had the same level of technical and managerial capacity to effectively deliver health services and supplies. As a result, the larger and economically better-off local governments could manage better with the increased responsibilities imposed by devolution. Meanwhile, poorer local governments with low institutional capacity were overwhelmed by the new additional demands. The differing levels of health service delivery and supply chain management capacity between local governments adversely affected health equity.

Nigeria faces a severe shortage of skilled health personnel, such as community health extension workers, nurses, midwives, and doctors, a situation exacerbated by decentralization (Tien 2009). Some states are reluctant to bring personnel in from other states because of a preference for hiring local staff, or because they think outside personnel will not be accepted. Furthermore, some states are unable to recruit and train enough health workers and logisticians.

In **Ecuador**, following devolution, most lower-level staff did not receive the necessary logistics training. Very few health facilities had procedures manuals or received supervisory visits that specifically addressed logistics issues. Because of a lack of trained staff at lower levels, although there was sufficient funding to provide the necessary contraceptive supplies at all levels, both oversupply and stockouts were common.

Area	Opportunities/Challenges	Lessons
Setting up central-level oversight for supply chain management	♦ May increase local control over reordering decisions and stock and help avoid overstocks and undersupply. ♦ May increase local control of shipping schedules and transportation and better adapt these functions to local conditions. ♦ May create opportunities to better align incentives for managing an effective supply chain across levels. ♦ The logistics management information system (LMIS) may become less important if there is no lower-level commitment. ♦ May lead to a lack of standardized forms and national flow of information. ♦ Information, used as a feedback mechanism, may no longer flow from the lower- to the central-level. ♦ May create challenges for rationally allocating scarce products across regions. ♦ Procurements may be less cost-effective if divided into smaller volumes.	***Central level*** ♦ Retain some degree of central-level oversight for the logistics functions that are most likely to function well if managed or, at least, designed mainly by the central level, including— o LMIS o design of the inventory control system o pooled procurement or centrally negotiated prices to ensure competitive prices o quality assurance (John Snow, Inc. / DELIVER 2001). ♦ Plan carefully when delegating supply chain management responsibilities to lower levels to ensure they have the skills and authority to accept these new roles and responsibilities. ♦ Set up a logistics management unit at the central level to help oversee management, and monitoring and distributing of all essential health commodities even when lower levels are managing many logistics functions.

Case examples: Chile, El Salvador, Guatemala, Peru, Philippines, and Tanzania (See all four briefs for all country examples.)

In **Chile**, the central logistics manageme unit (CENABAST), a semiautonomous public agency, oversees procurement and supply chain management for all essential medicines at the central level (Beith et al. 2006). CENABAST procures and distributes contraceptives to 26 regional health authorities; which, in turn, distribute the commodities to public-sector facilities. In Chile's decentralized health system, district health offices can purchase from the source that offers the best service or price. The fact that all the districts continue to use CENABAST is a testimony to the quality of its service.

In **El Salvador**, purchasing essential drugs was deconcentrated to regional levels (Beith et al. 2006). Despite deconcentration, central-level logistics managers advocated that contraceptive supplies continue to be procured centrally. Each district manages its own contraceptive budget and prepares a forecast. The Essential Drug Unit then consolidates the district's forecasts and pools funds, ensuring lower prices through bulk negotiations. Central-level stewards developed a more cost-efficient solution at the central level, yet it enables the lower level to manage their own forecasting and financing.

In **Tanzania**, after decentralization, skilled staff were not always available at the district level to manage the contraceptive supply chain, as expected. In addition, levels of authority and the roles and responsibilities for supply chain management were not clarified between the different management structures at the district level. For example, lower-level managers and local health management teams/committees (mix of community leaders, political leaders, and technical staff) did not know who was responsible for overseeing the various logistics functions.

Area	Opportunities/Challenges	Lessons
Setting up central-level oversight for supply chain management	♦ May create opportunity to better adapt service delivery to local needs. ♦ Health managers and service providers may help resolve human resources issues to provide better services. ♦ Community members may be able to have a monitoring and oversight role to ensure that commodities are available for clients.	***Lower levels*** ♦ Assign sufficient authority to facility-level staff to develop innovative solutions to meet the needs of their clients. ♦ Define a role for community groups, medical associations, user groups, and nongovernmental organizations (NGOs) to help create pressure from outside the government to ensure that quality RH services and commodities are available for clients

Case examples: Bolivia, Ecuador, Indonesia, Philippines, Tanzania, and Nigeria (See all four briefs for the full range of country examples.)

In **Ecuador**, community management and user committees have increasingly worked to strengthen the role of the municipal government in local health care management by identifying public health priorities, incorporating citizens' perspective into health management, identifying potential resources, assessing the local health situation, and monitoring the quality of health services delivered at the lower level (Hermida et al. 2005). These groups help monitor and ensure that RH services and supplies, including contraceptives, are available at service delivery points.

In the **Philippines**, local health boards were established at the local government unit (LGU) levels (Lakshminarayanan 2003). Several LGUs used this mechanism to successfully involve the community in local health matters. A study comparing LGUs with functioning health boards to those with non-functioning health boards found more community consultations, more fundraising activities, additional health initiatives, and higher per capita health expenditures in the LGUs with functioning boards. Also, local women leaders often helped manage the boards, allowing them to contribute to local health decisionmaking and to advocate for RH service provision.

In **Bolivia**, after authority for service provision was devolved to lower levels, municipalities explored new ways to reach clients. In coordination with local NGOs and other private providers, municipalities added pharmacies, initiated outreach programs, provided subsidies for primary health services to the poor, and developed new organizational arrangements for coordination and payment exchange between and within municipalities (Beith et al. 2006).

Prior to establishing the district CS team in Indonesia, private midwives set their own fees for FP services and contraceptives (Thompson 2005). The price was based on what clients were willing to pay, given the midwife's reputation. The district board and the professional midwives association developed consensus among their members that a standard price structure would be applied to all contraceptives available through private midwives. This policy change improved access to affordable FP services.

Some Final Words

Decentralization can dramatically affect the structure of the public health system, which can disrupt quality service and commodity provision. Managers and service providers throughout the health system may not be prepared for the dramatic changes in their roles. For example—

- Lower-level managers may not be ready to assume responsibility for new health system functions, programs, and RHCS strategies.
- Central-level RHCS advocates may not be ready to transition from doing to overseeing and, therefore, may not know how to manage lower levels to provide quality services and supplies.

Nonetheless, decentralization also creates opportunities to better engage front-line health system personnel.

For example—

- Lower levels often understand their clients' needs and often have useful ideas for strengthening the health system. They should be more easily heard after authority has devolved to lower health system levels.

For example—

- Decentralization can help facilitate public participation and encourage collaboration among coalitions of stakeholders at the local level, including clients. Civil society groups, community leaders, and user groups can create pressure from outside the government to ensure that essential RH commodities are available to those who need them.

Central-level stewards can also monitor whether quality services are distributed equitably throughout the health system. These stewards can work to balance different regions' priorities with the need to meet clients' needs nationally, especially for the poor or more vulnerable populations.

Ensuring RHCS under decentralization takes time and commitment. RHCS advocates, at all levels, must continuously monitor commodity availability throughout decentralization and make adjustments based on lessons from their own and other countries' experiences.

References

Beith, Alix, Nora Quesada, Wendy Abramson, Anabella Sánchez, and Nadia Olson. 2006. *Decentralizing and Integrating Contraceptive Logistics Systems in Latin America and the Caribbean, with Lessons Learned from Asia and Africa.* Arlington, VA: DELIVER, for the U.S. Agency for International Development.

Dmytraczenko, Tania, Vijay Rao, and Lori Ashford. 2003**.** *Health Sector Reform: How It Affects Reproductive Health.* POPULATION REFERENCE BUREAU MEASURE Communication Washington, DC and Partners for Health Reformplus, Abt Associates Inc, Abt Associates Inc., Bethesda, MD

Hermida, J., Romero, P., Abarca, X. Vaca, L., Robalino, M.E., and Vieira, L. 2005. *The Law for the Provision of Free Maternity and Child Care in Ecuador.* LACHSR Report Number 62. Published for the U.S. Agency for International Development (USAID) by the Quality Assurance Project.

John Snow Inc./DELIVER. 2001. *Strategic Decentralization: Centralizing Logistics.* Arlington, Va.: John Snow Inc/DELIVER, for the U.S. Agency for International Development.

Lakshminarayanan, Rama. 2003. Decentralisation and its Implications for Reproductive Health: The Philippines Experience. *Reproductive Health Matters* 2003; 11(21):96–107.

Patykewich, Leslie, Marie Tien, Erin Mielke, and Tim Rosche. 2007. *Tanzania: Contraceptive Security Assessment*. Arlington, Va.: USAID | DELIVER PROJECT, Task Order 1 and New York, NY: The ACQUIRE Project.

Thompson, H. Daniel. 2005. *Shifting the Contraceptive Security Paradigm toward a Model tor Decentralized Environments: Lessons from Indonesia.* Arlington, Va.: USAID | DELIVER PROJECT, Task Order 1.

Tien, Marie, Sylvia Ness, Ugochukwu Amanyeiwe, Echendu Adinma, Uzo Ebenebe, and Azubike Nweje. 2009. *Nigeria: Reproductive Health Commodity Security Situation Analysis.* Arlington, Va.: USAID | DELIVER PROJECT, Task Order 1.

USAID | DELIVER PROJECT and USAID| HEALTH POLICY PROJECT. 2010. *Assessing Contraceptive Financing and Procurement Policies in Malawi.* Arlington, Va.: USAID | DELIVER PROJECT, Task Order 1 and Washington, DC USAID | Health Policy Initiative, Task Order 1.

Additional Sources

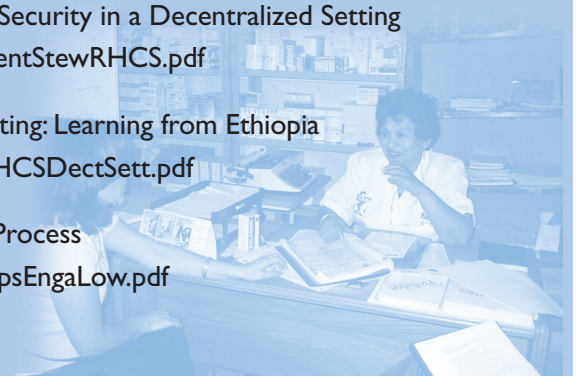
Abramson, Wendy, Anabella Sánchez, y Nadia Olson. 2006. *Diagnóstico de la Disponibilidad Asegurada de Insumos Anticonceptivos en Guatemala: Fortalezas y Retos de los Servicios de Planificación Familiar en Guatemala.* Guatemala: DELIVER, para la Agencia de los Estados Unidos para el Desarrollo Internacional (USAID).

Bates, J., Y. Chandani, K. Crowley, J. Durgavich, and S. Rao. 2000. *Implications of Health Sector Reform for Contraceptive Logistics: A Preliminary Assessment for Sub-Saharan Africa.* Arlington, Va.: Family Planning Logistics Management/John Snow, Inc., for the U.S. Agency for International Development (USAID).

USAID | Health Policy Initiative, Task Order 1 and USAID | DELIVER PROJECT, Task Order 1. August 2010. *Assessing Contraceptive Financing and Procurement Policies in Malawi.* Washington, DC and Arlington, Va.: USAID | Health Policy Initiative, Task Order 1 and USAID | DELIVER PROJECT, Task Order 1.

To complement this brief, the USAID | DELIVER PROJECT developed the following tools to help countries ensure RHCS in a decentralized setting:

- Central-Level Stewardship for Reproductive Health Commodity Security in a Decentralized Setting
  http://deliver.jsi.com/dlvr_content/resources/allpubs/guidelines/CentStewRHCS.pdf
- Reproductive Health Commodity Security in a Decentralized Setting: Learning from Ethiopia
  http://deliver.jsi.com/dlvr_content/resources/allpubs/guidelines/RHCSDectSett.pdf
- Tips on Engaging Lower-level Health Managers in the SPARHCS Process
  http://deliver.jsi.com/dlvr_content/resources/allpubs/guidelines/TipsEngaLow.pdf



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