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JORDAN

Health Planning and Services Development

67p.

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AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT PAPER FACESHEET

1. TRANSACTION CODE: A (A = ADD, C = CHANGE, D = DELETE)

PP

2. DOCUMENT CODE: 3

3. COUNTRY/ENTITY: JORDAN

4. DOCUMENT REVISION NUMBER: 0

5. PROJECT NUMBER (7 digits): 278-0208-

6. BUREAU/OFFICE: A. SYMBOL: NE; B. CODE: 03

7. PROJECT TITLE (Maximum 40 characters): Health Planning and Services Development

8. ESTIMATED FY OF PROJECT COMPLETION: FY 80

9. ESTIMATED DATE OF OBLIGATION: A. INITIAL FY 77; B. QUARTER 4 (Enter 1, 2, 3, or 4); C. FINAL FY 79

10. ESTIMATED COSTS ($000 OR EQUIVALENT $1 –)

A. FUNDING SOURCE	FIRST FY B. FX	FIRST FY C. L/C	FIRST FY D. TOTAL	LIFE OF PROJECT E. FX	LIFE OF PROJECT F. L/C	LIFE OF PROJECT G. TOTAL
AID APPROPRIATED TOTAL						
(GRANT)	(750)	( )	(750)	(1375)	( )	(1375)
(LOAN)	( )	( )	( )	( )	( )	( )
OTHER U.S. 1.						
OTHER U.S. 2.						
HOST COUNTRY		385	385		725	725
OTHER DONOR(S)						
TOTALS	750	385	1135	1375	725	2100

11. PROPOSED BUDGET APPROPRIATED FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE C. GRANT	PRIMARY TECH. CODE D. LOAN	E. 1ST FY 77 F. GRANT	E. 1ST FY 77 G. LOAN	H. 2ND FY 78 I. GRANT	H. 2ND FY 78 J. LOAN	K. 3RD FY 79 L. GRANT	K. 3RD FY 79 M. LOAN
(1) SA	534	510		750		500		125	
(2)									
(3)									
(4)									
TOTALS				750		500		125	

A. APPROPRIATION	N. 4TH FY — O. GRANT	N. 4TH FY — P. LOAN	Q. 5TH FY — R. GRANT	Q. 5TH FY — S. LOAN	LIFE OF PROJECT T. GRANT	LIFE OF PROJECT U. LOAN
(1) SA	--		--		1375	
(2)						
(3)						
(4)						
TOTALS					1375	

12. IN-DEPTH EVALUATION SCHEDULED: MM 04 YY 78

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PRP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET.

1 (1 = NO, 2 = YES)

14. ORIGINATING OFFICE CLEARANCE

SIGNATURE: [signature]

TITLE: Director, USAID/JORDAN

DATE SIGNED: MM 06 DD 02 YY 77

15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM 06 DD 06 YY 77

AID 1330-4 (3-76)

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT REVIEW PAPER FACESHEET

1. TRANSACTION CODE: A (A = ADD, C = CHANGE, D = DELETE)

PRP

2. DOCUMENT CODE: 2

3. COUNTRY ENTITY: JORDAN

4. DOCUMENT REVISION NUMBER: 0

5. PROJECT NUMBER (7 digits): 278-0208

6. BUREAU/OFFICE: A. SYMBOL: NE; B. CODE: 03

7. PROJECT TITLE (Maximum 40 characters): Health Planning and Services Development

8. PROPOSED NEXT DOCUMENT: 3 PP; B. DATE: MM 06 YY 77

9. ESTIMATED FY OF AUTHORIZATION/OBLIGATION: A. INITIAL FY 77; B. FINAL FY 79

10. ESTIMATED COSTS ($000 OR EQUIVALENT $1 -)

A. FUNDING SOURCE	FIRST FY B. FX	C. L/C	D. TOTAL	LIFE OF PROJECT E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL	750		750	1375		1375
(GRANT)	(750)	( )	(750)	(1375)	( )	(1375)
(LOAN)	( )	( )	( )	( )	( )	( )
OTHER U.S. 1.						
OTHER U.S. 2.						
HOST COUNTRY		385	385		725	725
OTHER DONOR(S)						
TOTALS	750	385	1135	1375	725	2100

11. PROPOSED BUDGET AID APPROPRIATED FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE C. GRANT	D. LOAN	E. FIRST FY 77 F. GRANT	G. LOAN	LIFE OF PROJECT H. GRANT	I. LOAN
(1) SA	534	510		750		1375	
(2)							
(3)							
(4)							
			TOTAL	750		1375	

12. PROJECT PURPOSE (Maximum 480 characters) ☐ "X" IF DIFFERENT FROM PID

1. To rationalize the training, assignment ,and functions of health manpower.
2. To establish an operational unit capable of planning for health improvement on a national basis.

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN PID FACESHEET DATA, BLOCKS 12, 13, 14, OR 15? IF YES, ATTACH CHANGED PID FACE SHEET.

1 (1 = NO, 2 = YES)

14. PLANNING RESOURCE REQUIREMENTS (Staff/Funds)

none

15. ORIGINATING OFFICE CLEARANCE

SIGNATURE: Christopher H. Rowe

TITLE: Director, USAID/JORDAN

DATE SIGNED: MM 06 DD 22 YY 77

16. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM 06 DD 06 YY 77

AID 1330-3 (3-76)

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT IDENTIFICATION DOCUMENT FACESHEET

TO BE COMPLETED BY ORIGINATING OFFICE

TRANSACTION CODE: C (A = ADD, C = CHANGE, D = DELETE)

PID

2. DOCUMENT CODE: 1

3. COUNTRY/ENTITY: JORDAN

4. DOCUMENT REVISION NUMBER: 1

5. PROJECT NUMBER (7 DIGITS): 278-0208

6. BUREAU/OFFICE: A. SYMBOL: NE; B. CODE: 03

7. PROJECT TITLE (MAXIMUM 40 CHARACTERS): Health Planning and Services Development

8. PROPOSED NEXT DOCUMENT: A. 2/3 (2 = PRP, 3 = PP); B. DATE: MM 06 YY 77

9. ESTIMATED FY OF AUTHORIZATION/OBLIGATION: a. INITIAL FY 77; b. FINAL FY 79

10. ESTIMATED COSTS ($000 OR EQUIVALENT, $1 = .331 JD)

FUNDING SOURCE		LIFE OF PROJECT
A. AID APPROPRIATED		
B. OTHER U.S.	1.	1375
	2.	
C. HOST COUNTRY		725
D. OTHER DONOR(S)		
	TOTAL	2100

11. PROPOSED BUDGET AID APPROPRIATED FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE C. GRANT	PRIMARY TECH. CODE D. LOAN	E. FIRST FY 77 F. GRANT	E. FIRST FY 77 G. LOAN	LIFE OF PROJECT H. GRANT	LIFE OF PROJECT I. LOAN
(1) SA	534	510		750		1375	
(2)							
(3)							
(4)							
			TOTAL	750		1375	

12. SECONDARY TECHNICAL CODES (maximum six codes of three positions each): 563, 520

13. SPECIAL CONCERNS CODES (MAXIMUM SIX CODES OF FOUR POSITIONS EACH): BR, BU, TNG

14. SECONDARY PURPOSE CODE: 589

15. PROJECT GOAL (MAXIMUM 240 CHARACTERS)

Improved health status

16. PROJECT PURPOSE (MAXIMUM 400 CHARACTERS)

1. To rationalize the training, assignment, and functions of health manpower.
2. To establish an operational unit capable of planning for health improvement on a national basis.

17. PLANNING RESOURCE REQUIREMENTS (staff/funds)

none

18. ORIGINATING OFFICE CLEARANCE

Signature: Christopher L. Rausch

Title: Director, USAID/Jordan

Date Signed: MM 06 DD 02 YY 77

19. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM 06 DD 06 YY 77

AID 1330-2 (3-76)

B. Recommendations

It is recommended that this project and funds be approved to finance the described foreign exchange and local currency costs of U.S. and Jordanian technical services, participant training, and commodities, for the purpose of improving health planning and upgrading the delivery of basic health services in Jordan. The total cost of the project is estimated at $2.1 million, of which the GOJ contribution is estimated at $725,000. The U.S. contribution of $1,375,000 thousand would be phased as follows: FY 77, $750 thousand; FY 78, $500 thousand; and FY 79, $125 thousand.

C. Description of the Project

1- Under this project, two major activities will take place:

a. Establishing a Health Planning Unit: This Unit, located in the MOH, will be the key element in charting the future course of the health sector in Jordan, and in the evaluation of all existing and projected programs. It will serve in two different capacities: as a component of the MOH, it will function as a back up, monitor and guide to other directorates of The Ministry; and as a staff unit responsible to The SHC, with a national perspective, it will respond to requests from that body, including addressing among its early activities, if so requested, completing the filling of the planning gaps identified in the Westinghouse report and detailed in pages IX - XII of that report. In the conduct of its activities, it will pay particular attention to (and Unit staff training will have to stress) examining cost effectiveness considerations in both new and continuing health sector investments for which consideration is recommended.

b. Upgrading of Basic Health Services: The second purpose of this project is to provide the population of Jordan now nominally or inefficiently being provided basic health services, especially underserved groups and areas, with an integrated, efficient and effective network of basic health services. These services, which include preventive, nutritional, curative, promotional and environmental services, and recording of vital events (birth, death etc.), should be provided at the first level of contact with the clients. This network will

be auxiliary operated and physician supervised. Both consumers and providers will be involved in the determinations of the reallocations of tasks to make the new system acceptable in the Jordanian context. It is anticipated that this approach is the most sensible and the fastest and most cost-effective way of redressing existing inequities in the distribution of services. st

2- AID/Washington will be asked to provide support services as appropriate leading to the award of an appropriate host country contract. The AID Mission in Jordan will be involved in monitoring the implementation of this project. The contractor, working with GOJ counterpart staff, will bear primary responsibility for implementation. The GOJ is expected to provide: counterpart staff, eligible trainees to be trained, office space, supportive staff, classrooms, equipment and supplies, in-country transportation and per diem for Jordanians on travel status. The HPRG will provide policy direction. st

3- Successful accomplishment of project purposes is expected to be achieved as follows:

a. The Health Planning Unit will be headed by a foreign expert while a Jordanian chief designate is being given post graduate training in the US. Other staff members will be trained in regional institutions and by expatriate experts on the job. The foreign experts will establish sound working procedures which are expected to be followed by the Unit in years to come.

b. Upgrading basic health services will be achieved by first, development of appropriate training plans and curricula, and then, training of Jordanian trainers who will train, under expert supervision, the existing, basic health workers. Trained personnel will then be supervised and evaluated in their actual field execution of new tasks. Counterparts, once the system is in place, are expected to be able to maintain the momentum of the newly established approach.

4. At the end of the project it is expected that (a) a health planningunit will be in place and capable of carrying out all assigned tasks; (b) all existing basic health services workers will have been returned to service, and (c) a proposal(s) will have been presented to the GOJ making recommendations for follow-on activities designed to extend improved services to groups and areas still not covered.

OUTPUTS

D. Summary Findings:

The Jordanian health sector is physician-based and curative oriented. This traditional structure, is providing services, but there is obvious maldistribution, both geographically and socially. With more than half of Jordan's population under 15 years, a great demand on basic health services especially for mothers and children is felt now and expected to increase in the coming years. It is felt that the current system is and will remain unable to respond to these urgent demands. Hence, it is recommended, that a system begin to be created which, though physician/dependent, but rather auxiliary operated. Maintaining a proper mix between professionals and auxiliaries is a condition necessary for its cultural acceptance and technical success. Moreover, a system totally based on auxiliaries, and heavily involved in curative services, is prohibited by current Jordanian law. The above proposed approach has been endorsed by the GOJ and the current project will implement it.

At all levels, there is recognition that national health services cannot be delivered in the absence of professional planning, and yet health planning is new in Jordan. The Directorate of Health Planning and Foreign Relations was created as a separate entity only in 1976. Its activities to date have been largely limited to statistical tabulation of data. This project has been agreed to as the vehicle through which it will be possible to institutionalize and develop a professional quality of national health planning capability in Jordan.

The Project meets all applicable statutory criteria.

E. Project Issues:

Given the continuation of prevailing economic and political stability, no serious hindrance is anticipated. It is assumed that the GOJ will continue its commitments to the conduct of health planning on a national level; and to the development and utilization of an auxiliary operated, physician supervised delivery system for basic health services. It is predicted that finding qualified Jordanian counterparts , availability and provision of support services, and availability of health workers to be retrained, will not present serious problems. No issues remain to be addressed with the GOJ.

* directed and supervised, is not totally physician

II. PROJECT BACKGROUND AND DETAILED DESCRIPTION

A. BACKGROUND

1. The Physical Environment

The Hashemite Kingdom of Jordan covers about 95,000 square kilometers in the upper northwestern part of the Arabian peninsula. Its main topographical divisions are an arid desert area to the east, and a series of lightly forested highlands to the west, which are cut by the deep Jordan River Valley. Rainfall is light, with an average of 400 millimeters per year in the highlands, 200 in the valley, and less than 50 in the desert. The climate in the highlands is a dry variant on the Mediterranean pattern; the Valley's climate is more like that of tropical countries; and the desert climate is similar to that of the surrounding Arabian and Syrian deserts.

The natural resource endownment discovered in Jordan to date is modest. No petroleum has been found, despite extensive exploration. There is some copper, manganese, and high-grade iron ore, but there is no commercial exploitation of these metals.

Exploitable phosphate reserves have been found, and are estimated to total over 300 million tons. Two million tons were extracted for export in 1975, and a 5.4 million ton annual output level is targeted for 1980. Revenues from increased phosphate exportation have played an increasingly important role in Jordan's finances during the mid-1970's.

A network of roads extends to most communities throughout the Kingdom. There are 5,000 kilometers of primary paved roads and 1,500 kilometers of secondary roads. There are some 34,000 registered Jordanian vehicles. A national airline and railway are also included in the transportation. infrastructure.

Information media include five daily newspapers, (four Arabic and one English), seven weekly newspapers, and national television and radio systems. In 1974, there was one radio for every two persons in the country. Spot surveys in urban and rural areas have estimated that between 60 and 80% of homes had a Television.

From a health standpoint, the most important aspect of Jordan's physical environment is the scarcity of water. Despite a slight excess of supply over demand, operating problems affecting the country's water distribution systems, as well as the long distances between source areas and areas of highest demand, have resulted in severe shortages of water, especially in the densely populated areas of Amman and Irbid. The national water consumption rate in 1975 was about 60 litres per capita per day, as compared with similar figures for Syria and Morocco of 163 and 90, respectively. In addition to the inadequacy of the quantities of water available to Jordanians, there are serious deficiencies in water quality. Analyses by the Ministry of Health of samples taken from water systems is eight major urban areas throughout the 1973-75 period showed that, by World Health Organization standards, none of the systems was delivering water safe for domestic use.

2. The Human Environment

The estimated East Bank population as of the end of 1976 was 2.014 million people.

Current demographic estimates indicate that a birth rate of 46.8 per 1,000 population has combined with a 14.5 per 1,000 death rate, to produce a 3.23 percent annual population growth rate during the 1970-74 period. If maintained, such a rate leads to a doubling of population in 22 years.

Gains in life expectancy were about one year per annum during the 1960's, and expectation of life at birth in 1972 stood at 59.1 for females and 57.4 for males.

The population of the East Bank is largely confined to a quarter of the land area, located along the western highlands and in the Jordan Valley. Population density in these areas is an estimated 273 persons per square mile. The desert areas, populated by scattered nomadic and semi-nomadic groups, have a density of three persons per square mile.

Rural-to-urban migration has been rapid and massive in Jordan. The Kingdom is now 70 percent urbanized, as opposed to 44 percent in 1961. The three largest urban areas, Amman, Zarqa and Irbid, account for about 54 percent of residents, and Amman alone accounts for some 34 percent. Amman has grown three times as fast as the balance of Jordan during the past two decades.

An estimated 51.2 percent of Jordan's population is under age 15, with 36.8 percent between 15 and 44 years of age, and the remaining 12 percent 45 and older. Such an age structure creates a heavy burden on the economically productive group. There are 114 persons of dependent age (under 15 and 65 and over) per 100 persons of economically productive age (15-64) in Jordan. Dependency ratios in developed countries are usually in the vicinity of 80 to 100.

3. The Economy

Prior to 1948, The East Bank was charaterized by rather primitive agriculture, extensive nomadism, and minimal industry. In the decade prior to 1967, however, economic growth was recorded at an annual level of about 10 percent in real terms, and by 1976, a $1.4 billion Gross National Product was being generated, with local investor and business confidence reported to be high, and over 100 foreign firms establishing offices in Amman.

Jordan's per capita income in 1976 was about $630, having reached pre 1967 levels only a few years ago. Given the events of 1967-1971 Jordan's maintenance of its standard of living reflects both the adoption of effective economic policies, and the effective mobilization of foreign resources. Jordan continues to need outside assistant however, The 1976 budget projects that 40 percent of recurring expenditures must be financed by foreign budgetsupport, principally from the U.S., Saudi Arabia, and Kuwait. A very sizeable balance of trade gop also exerts, offset in past by down grants.

Unlike many less develop countries, Jordan's agricultural sector is small, comprising about 12 percent of GOP and utilizing 23 percent of the labor force. The Jordan Valley area is the principal food-producing area, where the recent introduction of modern technology is expected to have significantly increase vegetable production.

Jordan's planners look to industrial growth and the generation of a substantial export surplus as their principal means of achieving overall economic self-sufficiency. In addition to increased exports of phosphate and fertilizer, potash & other minerals have considerable export potential. Increased cement output and expansion of a large oil refinery at Zarqa are also seen as key steps in the attainment of the country's economic objectives. About 30 percent of the investment envisioned in the new Five-Year Plan (1976-1980) is committed to these heavy industries.

Inflation became a serious problem in the mid-1970's. The Amman cost of livi g index registered 20 percent annual increases in 1974 and 1975. Largely due to the demand in neighboring countries, unemployment has been eliminated manpower shortages have led to rapidly rising wages in the private sector, and have fueled inflationary pressures.

The 1976 Jordan Development Conference study of the labor force in Jordan estimated that 382,000 persons, or 19.6 percent, of Jordan's (East Bank) population are participants in the labor force, with 3.8 percent of the female population in the labor force overall. The low participation rates for women and students, together with the youthfulness of the population, high enrollment rates in schools, and, finally, the large number s of professional and skilled Jordanian working abroad, combine and contribute to the low labor force participation rate.

While nearly 70 percent of the labor force is employed in the Amman Governorate, this figure represents a 15-percent decrease from 1970, when fully 85 percent of the labor force was in Amman. This reduction of labor foree concentration in the capital Amman may reflect a trend toward labor spillover into Jordan's regions, as well as migration to employment opportunities abroad.

Given the wars, massive imigrations and political upheaval in the last 30 years Jordans economic performance is truely remarkable structured problems however remain. Jordans need for budget support limits the pace at which it can expand services and provide strong justification for the proposed project which improve services by increasing the efficiency of an existing system, not adding significantly to budge expenditures.

4. Health Status

As in many countries of the Middle East and other parts of the developing world, precise evaluation of health conditions in Jordan is rather difficult. Statistical information is scanty and sometimes unreliable. Nevertheless, and despite all its shortcomings, available data can be used to construct a general view of these conditions and infer an order of magnitude of the most pressing problems.

a. Demographic Data

The Jordanian population is young, with over 51 percent below 15 years of age. For purpose of analysis, this group is usually divided between preschool age (0-4 years) and school age (5-14 years).

The first group constitutes about 22 percent and the second about 29 percent of the total population. The adult population, aged 15-44 years, represents about 37 percent of the population while the older generation aged 45 years and over represents the remaining 12 percent. Among the adult population, women in the childbearing age (15-44 years), represent about 19 percent or roughly one-fifth of the population. Women in the childbearing age and children under 5 years of age thus contitute about 41 percent of the population, while these potential mothers and their children under 15 years add up to over 70 percent of the population.

b. Mortality Data

Although officially reported deaths yields a crude death rate between 3 and 4 per 1,000 population, all international agencies and most workers in this field accept a crude death rate of about 14.5 per 1,000 population. Application of this rate suggest that about 75 percent of all deaths remain unreported. Results of all studies indicate that death rates have been declining since the early 1960's.

Again on the basis of officially reported deaths, infant mortality stands close to 11 per 1,000 live births. There is general acceptance that the actual rate is on the order of 90 - 100 per 1,000 live births.

Females appear to maintain higher mortality rates than males, especially in the age groups 1-4 and 15-34.

Classification of deaths by cause shows that enteritis, pneumonia, heart conditions other than Ischemic heart disease, and accidents are the four leading causes of death. The above-mentioned heart conditions are present in all age groups without exception, and this uniform distribution may incriminate agents other than the degenerative conditions usually encountered in industrialized countries. One such agent may be rheumatic disease and its cardiac complications.

Accidents are at the same level of importance as a cause of death in Jordan as they are in the U.S. Motor vehicle accidents account for about half of these deaths.

The high proportions of deaths attributed to symptoms of ill-defined conditions point to the fact that many deaths are not attended by a professional person, reflecting the degree or unavailability of health services to the total population.

Classified by age and cause, mortality data show that enteritis and respiratory diseases are the major killers of children under 5. Accidents emerge as the leading killer in school-age children (5-14), adults are dying of causes other than parasitic and infectious diseases (except pneumonia). Malaria has been eradicated, and very few deaths are attributed to tuberculosis. Women in the childbearing age frequently are dying of conditions relating to pregnancy and birth.

c. Morbidity data

Based on the official listing of reportable diseases, mumps, trachoma, measles and enteric diseases are the most important. Poliomyelitis, diptheria, pertussis and tetanus are still reported in relatively large numbers. Tuberculosis shows declining incidence rates (24/100,000 population in 1976). Preliminary statistics from the Division of School Health of the Ministry of Education indicate a high rate of dental defects, disorders of the ear, nose, and throat, the digestive system and the eye among school children examined.

The nutritional status of children, with its known impact on morbidity, has improved steadily in the past decade. Frank protein deficiency has decreased in importance, while merasmus is still frequently encountered.

5. The Health System

a. Providers

Jordan's health care system is characterized by a relatively large number of provider organizations operating to a significant degree independently of each other.

The public sector is represented by three major providers: The Ministry of Health (MOH), the Royal Medical Services (RMS), and the University of Jordan through the teaching hospital of the Faculties of Medicine and Nursing. Other public sector health service activities are carried out through the Ministry of Education (school health), Ministry of Labor and Social Affairs (health insurance schemes), Municipal Health Departments of Amman, Zarqa, and Irbid and still others.

Nongovernmental providers include modernprivate practitioners, the United Nations Relief and Works Agency (UNRWA), and various religious and charitable bodies. Traditional providers are mainly birth attendants ت-dayahs.

MOH institutions receive more than half of all hospital admissions (with less than 40 percent of all beds) and deal with two-thirds of all outpatient contacts. Aside from the UNRWA, the Ministry is virtually the only provider of preventive care. It also has legal responsibility for supervision of the private sector and development of national health policy. Only in the area of birth delivery is the Ministry not the most important provider of health care. Although there is a fee structure, services are most often provided without charge. Although anyone may use these services, the Ministry's major target population consists of those noteligible for RMS and UNRWA services.

The Royal Medical Services provide care to active military and security personnel and certain of their dependents, in all an estimated one-fifth of the population. The major facility of the RMS is the King Hussein Medical Center.

The University of Jordan has a single teaching hospital facility that operates primarily as an independent body. It serves referred MOH patients free but collects fees from private patients.

UNRWA carries some degree of responsibility for about 600,000 refugees and displaced persons. Perhaps one-third of these live in camps, but the rest are settled in other places and rely to a significant degree on the same health care services as the rest of the population of the country. UNRWA provides primary care only, including preventive activities. Hospital patients are referred to MOH facilities.

Private practitioners are primarily concentrated in Amman and Zarqa, although some small private hospitals are located elsewhere. More than half the hospital beds in the private sector are operated by the Red Crescent Society and similar charitable groups.

The major contribution of the traditional sector appears to be in the area of maternity care, where it is assumed that dayahs assist most of the 62 percent of all births that do not take place under the supervision of a trained health worker.

The Jordan Medical Association is a professional body whose membership consists of all non military physicians in the Kingdom. Its principal function is to insure that the medical training of physicians seeking to practice in Jordan meets recognized standards. This is necessary because of the diversity of foreign locations in which applicants receive medical training. The JMA examines the applicant's programs of study and certifies for the Ministry of Health that the programs are of acceptable quality. The Ministry issues medical licenses following receipt of this certification and passage of an examination by the applicant.

b. Health-Manpower

As of Mid 1976 there were 1,109 physicians in Jordan, or one physician for each 1,803 population. Of all physicians, about 26 percent are employed by the RMS and the remaining 74 percent equally divided between the MOH and University on one hand and the private sector and UNRWA on the other.

The MOH estimates the number of qualified nurses (RN's) in Jordan as 619, or one RN for each 3,231 population or 1 RN for each 1.7 MD. A reversal of this ratio is more desirable About 56 and 26 percent of nurses are working in the MOH and the RMS respectively. Most qualified nurses are trained for and working in hospital settings.

Practical or assistant nurses totalled 1,650 and more than 75 percent of them are in the MOH. Their level of entry is equivalent to the 9th or 10th grade. About half of them have received 18 months of hospital-based training. The other half were trained on the job. The number of nursing aides is close to two thousand. Their level of entry is equivalent to elementary school, after which they are supposed to complete between 6 and 18 months of training. This group has a high turnover due to a drain prompted by higher paying job opportunities outside the health sector.

The total number of midwives is 195, or one mid-wife for each 420 estimated live births. About 70 percent of midwives are in the MOH and 22 percent in the private sector.

The number of traditional birth attendant or Dayahs is not known, but may be estimated to be on the order of a few hundred and decreasing.

Over 50 percent of the 196 dentists are engaged in private practice. The other 50 percent are almost equally divided between the MOH and RMS. The total yields a ratio of 1 dentist for each 10,204 population.

Although the total number of Physician and the physician/population ratio appear to be not as deffective as they are in many other developing countries, their in-country distribution is more alarming.

About 91 percent of public and private MD's are located in the cities of Amman, Zarqa and Irbid, and 67 percent of them are in Amman alone. Private physicians amounts to 38 of 119 physicians in Irbid and only 3 of 25 in Ma'an. Almost all physicians are located in population centers of 5000 population and over. Outside the government of Amman, some where between 40 and 72 percent of the regional population live in villages and towns of less than 5000 population.

Like physicians, about 70 percent of Nurses are located in urban centers, especially Amman and are primarily employed in hospitals.

Midwives and practical nurses appear to be more equitably distributed, due to the location of public clinics and MCH centers. About 58 percent of midwives are outside Amman.

It is obvious that left to market forces physicians and nurses tend to aggregate in urban centers. Therefore, extending coverage by the Health System to underserved area has to rely, in the immediate future, on a physician supervised, auxiliary operated approach.

c. Health Facilities

Jordan has over 3000 hospital beds; approximately 1 bed for each 658 population. About 72 percent of these beds are in Amman.

The MOH operates a total of 358 outpatient facilities, of which 253 are village clinics.

It is estimated that slightly more than 41 persons per 1,000 were hospitalized in 1975. Hospitalization trends show that this figure leveling off after a few years of steady increase.

The highest rate of hospitalization was in the south (Karak: 78/1,000 and Ma'an: 51/1,000) and the lowest in Balqa: 30/1,000. The reasons for these discrepancies are not clear but may be attributed, among other reasons, to the lack in the south of effective health services responding to the basic health needs of the population.

More than 4 million visits to outpatient facilities were logged in 1975, for about 2 visits per person per year. In other developing countries, this ratio varies betwee 3 and 5 visits/ person/year. Given the short distances between populated areas and the availability of transportation, this low rate may be explained on the basis of factors relating to accessibility of health services as wel l as to the level of health education and the public's perception of Health and treatment.

Based on MOH statistics, maternal and child health services cover only about 20 percent of all pregnancies with at least one prenatal visit. The other 80 percent of pregnant women do not even receive this visit before delivery. Postnatal coverage is even lower, at 6 percent. Of all deliveries, only 38 percent are attended by a trained health worker (M.D. or midwife). The others are presumed to be attended by dayahs.

Immunization activities appear to be far below acceptable levels. For polio and DPT vaccination, the rates of coverage are: 1st dose: 35 percent, 2nd dose: 30 percent, 3rd dose: 28 percent, booster dose: 2 percent. Measles is another preventable disease for which immunization coverage is negligible. The level of BCG immunization among infants is about 75 percent, in preschool years about 35 percent, and about 75 percent for the whole population.

d. Health Planning

A planning Directorate was established within the MOH in 1976.

e. Other Donor Activity

For a number of years, foreign donors have been involved in health in Jordan, both directly and indirectly. In addition to the International Red Cross and UNRWA, who have been concerned primarily with refugees and displaced persons, charitable societies from Northern and Western Europe and the U.S. have had various involvment in health and nutrition in Jordan since the late 1940's. Among the few who are still active are CARE-MEDICO and the Swedish Organization for Individual Care. on the government level, some West European countries (France, England etc.) offer post-graduate scholarships for physicians. the UK has a direct technical assistance program with the University of Jordan. Of much deeper impact on the health field and prefession are the large number of scholarships for undergraduate medical studies offered by East European countries. The number of students studying medicine in these countries is not available, but is estimated to be on the order of several hundred. The UN and its agencies are starting to be involved in the health field, WHO is providing assistance to the university of Jordan and the MOH College of Nursing with UNICEF providing training material; UNFPA is providing for the establishment (construction) of 18 new MCH centers over the coming three years, and the World Food Program is providing food commodities for MCH facilities. No donor, however, is involved in activities which impact directly on this project, nor is any other donor engaged in a systematic, comprehensive effort to upgrade the basic health care system in Jordan.

f. The AID Role

In late summer of 1976 the GOJ requested USAID assistance in assessing the health sector and in development a comprehensive national plan to rationalize existing services. An ad hoc interministerial group - The Health Policy Reference Group. (HPRG) was formed to provide policy guidance to this effort. AID/W secured the services of a three consultants in September 1976 who prepared, in effect, a scope of work for a comprehensive examination of the problem. Under a contract with Westinghouse Health Systems, Inc., nine experts representing different disciplines in health arrived in Amman in early November to undertake this study. Their report, entitled "National Health Planning in Jordan, Phase Two: Health Policy Strategy" was submitted to the GOJ in Feb. 1977 (because of its bulk, more than 300 pages, the Report is not included as an annex to this paper. It is available as a reference in NE/TECH). It emphasised the following:

1. Institutionalization of the Health Policy Reference Group.

2. Creation in the MOH of a Health Planning Unit capable of assuming the full responsibility for Health Planning.

3. Invitation of manpower development activities aimed at improving the provision of Basic Health Services to the total population.

4. Invitation of activities to reduce Environmental Health hazards, especially drinking water and sewage disposal systems, which were found to be below accepted standards.

Government response to the Phase II report was delayed by the death of the Minister of Health and subsequent changes in key Ministry staff. It has now, however, been fully reviewed at both policy and staff levels, and accepted.

A regulation will soon be promulgated which will establish a Supreme Health Council (replacing the HPRG) empowered to coordinate and direct all health efforts in Jordan. It is anticipated that this new body will become operational in the summer of 1977. In the meantime the HPRG will retain its authorities. A decision has been taken to institutionalize a Health Planning Unit and a new 20-room building has been located to house it. The HPRG requested USAID to make more explicit the recommended next step to improve Jordan's planning capacity and the delivery of basic health services. Reflecting HPRG and MOH priorities, it was proposed that AID provide technical assistance to complete the following tasks:

1. To establish a Health Planning Unit in the MOH and to train Jordanian personnel to staff it and carry out required planning efforts;

2. To upgrade Basic Health Services. This task is idivided into:

   a. An inventory of Health manpower and tasks currently performed.

   b. Determination of tasks to be performed at the first level of contact.

   c. Determination of Training needs and curricula.

   d. Actual trainingg of Health workers.

   e. Evaluation of performance;

3. To help the GOJ initiate health promotion activities directed at the public at large and making full use of existing mass media especially ratio and television;

4. And, because of its importance, to examine and make recommendation concerning health insurance in Jordan.

This approach (detailed in Annex D) has been endorsed in full by the HPRG with the following changes in timing:

1. to phase health promotion within the activities of the Health planning unit.

2. to include the inventory of health manpower as an integral part of the activity to upgrade Basic Health Services;

3. to phase the insurance study with the activities of the Planning unit.

This proposed project does not directly address the water and sewage related environmental health hazards identified and stressed in the Phase II report. Separately, however, USAID is proposing several loan activities that will ameliorate the problem in two major areas - Amman and Aqaba. In Amman, where population growth has spiraled, poorer areas are not provided with only intermittent supplies because of an inadequate distribution system, and water quality samples obtained in a recent feasibility study showed the

the primary current source of Amman is water strongly effected by human pollution with nitrate concentrations often above WHO recommended levels. -- Serios supply, distribution and water quality problems. Working in concert with the World Bank, AID is proposing loans in FY 1978 and 79 to assist in the financing of several water supply and distribution and sewage collection and treatment facilities. In Aqaba, where similar problems obtain and where the labor force has doubled since mid-1975, a multilaterally financed water supply project is underway, and AID is proposing a loan in FY 1978 to finance an improved and expanded potable water distribution system and sewage disposal facilities.

B. DETAILED DESCRIPTION

The logical Framework Matrix is attached, Annex A.

1. Program Goal:

The Sector goal for this project is to improve the health status of Jordan's population, with special emphasis on the underserved groups in rural and urban poverty areas.

2. Project Purpose;

The purpose of this project is:

a. To establish in the Ministry of Health a planning Unit capable of planning for health improvement on a national basis.

b. To rationalize the training, assignment and functions of basic health manpower.

3. Planned Outputs:

For purpose 2.a above, the output will be a Planning Unit established and operational which will be capable of: (1) analyzing health problems and recommending health policies and actions to meet these problems, (2) managing a health information system; and (3) establishing and conducting ongoing evaluations of the health sector.

For purpose 2.b above planned outputs are: (1) existing Basic Health workers retrained and returned to service, (2) a health manpower information system developed and in place, (3) curricula currently used in existing facilities for training basic health workers revised; and (4) proposal(s) made for follow on training/ services activities designed to reach remainigg unserved or undeserved population groups.

The end product of this training effort will be basic health workers assigned at the first level of contact with the client who will be authorized and able to perform well defined tasks in the fields of health promotion, prevention, nutrition, environmental health, registration of vital events and curative services.

4. Planned Inputs:

For 2.a above, the US will provide a health planning expert who will direct the planning unit for the first thrity months. Incumbent will: (1) identify major planning gaps and propose consecutive six month plans of action, (2) assist in the selection of Jordanian counterpart and other staff of the unit, (3) recommend training schemes for selected counterpart and other staff members, (4) identify the need for short term technical assistance in the projected work load of the unit, and (5) identi the need for and type of commodities -- prepackaged computer programs etc. -- necessary for the proper running of the unit. The US will provide also for long and short term training of Jordanian staff. It is anticipated that the selected Jordanian chief of the Unit will receive 18 months of post graduate training in the US while other staff members will receive short term training in regional institutions.

The GOJ will provide: (1) counterpart professional and technical staff, (2) support services including office space, equipment and supplies, secretarial, clerical and translation staff, (3) in country transportation and (4) per diem for Jordanians in travel status.

For 2.b above, the US will provide three long term manpower development/curriculum/training experts for a total of sixty man/months, and about 29 man/months of short term consultant services. These experts will:)(1) conduct a national health manpower inventory aimed at identification of training received and tasks currently performed; (2) for basic health workers, identify tasks to be performed in order to upgrade basic health services at the first level of contract with the client, (3) identify training needs for existing basic health workers, (4) construct a training curriculum to meet these needs, (5) set up a training schedule for all existing basic health workers, with the least disruption of services and the maximum cost effectiveness, (6) train trainers, (7) supervise training of basic health workers, (8) evaluate training results, especially as to actual impact on services provided by trained personnel, (9) review curricula currently used by local facilities for training of basic health workers and propose changes necessary to bring the curricula in phase with proposed tasks, and (10) working with the health planning unit, and considering the continuing evaluation of the training experience, propose a detailed plan for geographic and population expansion of services to cover those areas and groups totally or partially still outside the system.

The US will also provide for training-related commodities, limited vehicle support, and two short term participant training programs for Jordanian staff.

The GOJ will provide (1) four counterparts: a coordinator who will be also responsible for manpower/curriculum, a health educator, an audio-visual technician and a training program editor, (2) support services including classrooms, office space, secretarial clerical and translation staff, equipment and supplies, (3) qualified trainees to become trainers, (4) trainees to be trained, (5) incountry transportation (6) per diem for Jordanians on travel status; and (7) per diem/housing, if necessary, for trainees.

5. Assumptions:

Several basic assumptions are made:

1. That the prevailing political and economic conditions are maintained or improved upon.

2. That the GOJ continues its current committment to: (a) improving the health status of the population and especially the underserved and poverty areas; (b) maintaining a national character in its health planning efforts. This drive has already generated a national coordinating and decision-making body which, although representing all provider segments, transcends in its outlook parochial and local interests; (c) maximizing the use of basic health workers in the provision of care at the first level of contact. Although planning in this field will be carried out on a national level, implementation is expected to start in facilities operated by the MOH. Anticipated success will facilitate the wider application; and (d) improving working conditions for health workers to promote stability and deter large turnover in staff.

3. That the GOJ and foreign experts will be able to devise task reallocations acceptable in the Jordanian context. Involvement of views of both consumers and providers is devising these tasks is a necessary condition for satisfactory outcome.

4. That qualified Jordanian candidates can be selected and made available.

5. That trained health workers are promptly returned to their jobs and allowed to practice what they were trained for.

6. That required foreign expertise is available and can be contracted for and located in Jordan within the time frame specified.

III - PROJECT ANALYSES

A. Technical Analysis

The Jordan health system, in all its governmental and private subsectors, is physician based and curative oriented. Such a system is per force self limiting in its expansion and coverage.

These limitations are exemplified by the low percentages of children who complete their immunization schedules, of eligible women who receive pre-natal or post-natal care and of deliveries attended by trained health workers (physician or midwife). The geographic maldistribution of health providers and facilities clearly illustrates the inequity which results from the current approach to the provision of health services. Although more than 90 percent of Jordan's villages are accessible by motor vehicles, health services provided in these areas are sporadic and never comprehensive. There are now over 250 village clinics in Jordan, mostly staffed by only one male nursing aide who is visited twice or three times a week by a physician from a nearby health center. These physician visits are mostly devoted to the episodic management of acute conditions presented by the clients. In between visits, the nurse aide is rarely involved in any meaningful health activity - except emergencies. Under this physician based system, extending comprehensive basic health services to the whole population of a village where a clinic is currently operational is a very difficult task, and geographic extension of services to other localities not currently served becomes an impossibility.

The Health Policy Reference Group has set as an immediate goal the improvement of basic health services extended at the first level of contact; over time to be extended to the whole population of Jordan. Drawing on experience with similar situations in other parts of the world, in Asia, Africa and Latin America, the Health Policy Reference Group accepted, as the only feasible alternative for reaching its goal, the concept of retraining existing basic health workers to perform the tasks necessary for providing adequate basic health services at the first level of contact. This approach appears to be the most suitable appropriate and cost-effective for the

Jordanian scene. The availability of eligible and appropriately located manpower, relatively low training costs, and the potential for widespread use of mass media especially television and radio in support of system changes to be introduced strongly recommend a health care system operated by trained auxiliaries and closely supervised and directed by physicians. USAID and the GOJ believe that the project design is culturally viable. In USAID opinion the project is within the capacity of the Jordanians to implement.

Jordan has long standing experience in national planning, but health planning is rather new. The Health Policy Reference Group and the MOH are eager to undertake national health planning on a rational and continuous basis. Training of Jordanian staff both on the job by the US experts and outside of Jordan in reputable institutions is the only way to assure the initial criterion and institutionalization of this effort. Once established, through continuous reappraisal and evaluation, the Health Planning Unit will direct all subsequent health efforts to avoid waste and duplication. The planning activity is believed to be culturally sound and within the Jordanian capacity to implement.

The Environmental impact of this project appears to be minimal at the onset. However, since the proposed training of health workers will include major components on environmental health and health promotion, the project should have a long term positive impact on the attitude and practices of the population regarding environment and related health conditions (improved sewage handling, potable water, etc.)

Finally, the technical design of the project is reasonable. U.S. cost estimates are believed to be reasonably firm, GOJ costs may (with respect to the training activity) increase, because wage scales are low, retrained workers wage expectations' may increase, and for either reason the GOJ may be forced at some point to make an across-the-board salary and benefits adjustment.

The project is believed to be technically sound.

B. Financial Analysis and Plan:

There are no cash flows associated with this project, and as such no rate of return has been projected. The budgetary implications which flow from initiation of the two proposed activities are considered slight and within the capacity of the GOJ to sustain following completion of AID's project involvement. The GOJ has demonstrated financial management competence adequate to the carrying out of their project implementation responsibilites.

The estimated per annum recurring costs of the two proposed activities, should they both be continued at roughly the same level of effort, are on the order of $225 thousand. This consists primarily of salaries, and would fall within the normal recurrent expenditures of the Ministry of Health which in 1976 were estimated at some $17.9 million. In addition it is estimated that only perhaps half of the GOJ counterpart personnel called for by this project will have to be recruited anew; the other half already being on Ministry of Health or other GOJ payrolls. Of the total estimated GOJ contribution of $ 725 thousand, $120 thousand is for one-time costs for setting up office space and facilities, and the MOH is already taking steps to do this. With respect to the Planning Unit, which is expected to continue as a permanent body, we see no budgetary or financial considerations of concern. With respect to the training activity, it is clearly understood within the GOJ that any followon effort to further extend or improve basic health services, beyond the scope of this project activity, (and for that matter, any other proposed followon activity in health) will only be begun after their related cost-effectiveness and budgetary implications.

Summary Cost Estimate and Financial Plan

($ 000s)

Source	AID		GOJ		Total
	FX	LC	FX	LC	
AID Inputs					
a. Tech. Services	1154				
b. Training	51				
c. Equipment	60				
d. Vehicles	50				
e. Other	60				
Total AID	1375				1375
GOJ Inputs					
a. Salaries				314	
b. Office Space & Equipment				270	
c. Vehicles				40	
d. Computer Services				45	
e. Other				56	
Total GOJ				725	
T O T A L	1375			725	2100

Costing of Project Outputs/Inputs

($ 000 or equivalent)

Project No. 278-0208 Title: Health Planning and Services Development

Project Inputs	Project Outputs		TOTAL
AID Appropriated			
Tech. Services	368	786	1154
Training	35	16	51
Equipment	-	60	60
Vehicles	-	50	50
Other	60	-	60
Total AID	463	912	1375
Other U.S.			
None	-	-	-
Government of Jordan			
Salaries	141	173	314
Office Space & Equip.	135	135	270
Vehicles	20	20	40
Computer Services	37	8	45
Other	19	37	56
Total GOJ	352	373	725
Other Donors			
None	-	-	-
Total	815	1285	2100

C. Social Analysis

This proposed project represents a Government of Jordan-desired effort to induce change. Other than by tacit recognition of public demand for improved health services the population to be served has not been consulted. The approach and project design involve several key assumptions and several key questions for which definitive answers are not available but which will be examined in the conduct of the project per se, along with such modifications to the approach as may be necessary to ensure the project's objectives are met, It is assumed that the GOJ commitment to improving basic health care will continue. It is believed that the institutional capaciy and will to carry out this project exists; that the approaches outlined are appropriate to the existing sociocultural matrix and that the behavioral changes and popular acceptance implicit in the design can be effected; and that adequate data can be assembled and appropriate qualitative and quantitative statistical and social indicators developed effectively measure progress and impact. The project design provides for both regular and periodic examination of these questions.

The above having been said, the following general comments obtain:

Beneficiaries:
The immediate beneficiaries of this project will be the population, largely poor, living in cachement areas (villages, towns and cities) where at the present time basic health facilities (village and urban clinics, health centers, MCH centers) exist and provide or have the potential for providing services (i.e. staff in place but undertrained or not authorized to provide certain services). Those that will benefit first and most directly are pregnant women and children. The nature of the benefit will be improved health status -- reduced morbidity and later mortality. Registration of vital events will lead to complete immunization of children and prenatal care to all pregnant women. Initiation of health promotion and preventative medicine activities (environmental education, etc), will impact quickly on morbidity. Curative services will be provided on a regular and not one or two day a week basis. Consumer perceptions will be examined to ensure that changes introduced are acceptable; and a health information campaign most probably utilizing existing and widespread mass media will facilitate behavioural change. Secondary

beneficiaries (or if you wish, primary beneficiaries of the proposed health planning activity) will be the whole of the population of Jordan.

Ultimate beneficiaries assuming a continued GOJ commitment to geographic expansion in basic health services to all of Jordan beginning in FY 1979, will be the balance of the population still not, at the completion of this project, receiving adequate or any services.

Congruence:
Moving from a physician based and curative oriented health system to one which is auxiliary-operated and physician supervised, with considerably more attention paid to preventive and promotive concerns, will involve some institutional behavioral and attitudinal change. A policy-level national commitment to induce this change has been made. Resistance will be encountered. As noted above, however, it is believed that by integrating provider and consumer perceptions into system design, and by paying careful attention to the health information system to be established and heeding motivational concerns and incentives which will may need to be established for upgraded health workers, that this resistance will be overcome. Particular attention will be paid to incresing womens' participation both numerically and by task in the basic health care system, particularly at the village level where male practical nurses predominate. This is not expected to be met with system resistance. It is expected to be met with consumer enthusiasm.

Impact:
The project design calls for the establishment of a national health information system which, when established, will be adequate to track both service statistics and welfare indicators.

D. Economic Analysis

The nature of this project is such that it does not lend itself easily to cost-benefit or other forms of quantitative economic analyses. An economic rate of return has not been estimate. Existing data is weak, and it will be some time before the planned health information system with retrained workers in place, will be able to measure impact on morbidity or consequent assumed impact on productivity. It is believed, however, that redefinition of tasks will permit increased poulation coverage and thus result in increased efficiency. Expanded and improved services at the primary care level are expected to both reduce referrals to the more costly secondary and tertiary levels of care and, as well, allow more rational use of those more sophisticated facilities. Generally it is believed that any activity which has the effect of reducing morbidity in the population at large will have the effect of decreasing lost-work time, increasing work effectiveness and, in general, increasing productivity. It is beleived that the two activities proposed are the most cost effective way of addressing the immediate problems identified, and that therefore the project may be considered economically sound.

IV. IMPLEMENTATION ARRANGEMENTS

A- Administrative Arrangements

1- Recipient:

Two entities will be primarily involved in the implementation of this project. The Health Policy Reference Group/Supreme Health Council and the Ministry of Health.

a- The Health Policy Reference Group: This Body, like its proposed replacement, the Supreme Health Council, is composed of representatives form all health subsectors, governmental and non-governmental, including pri- -e practitioners and the RMS. The HPRG has demonstrated its capacity to deal with planning and implementation issues from a national point of view and on a timely basis. It will continue to function until the new Supreme Health Council (SHC) becomes operational. This body will provide coordinated, national policy direction to both the Health Planning Unit and the manpower development activity.

b- The Ministry of Health:
The Minister and Undersecretary form the highest level of authority in the Ministry. They are supported in their work by ten department directors located in the central office and eight regional health directors located in the eight health regions of Jordan.

Besides the Minister and the Undersecretary, who are to be involved in all aspects of this project, different persons will be concerned more specifically with different aspects:

Health Planning Unit: This Unit will be located in The Directorate for Planning and Foreign Relations of the Ministry of Health. A Director and staff for the Unit will be appointed. Establishment of the Unit will not be a problem, but national health planning is relatively new to Jordan. The time and U.S. inputs called for by the project are believed adequate to institutionalize and make fully operational the Planning Unit.

Upgrading Basic Health Services: Ultimately all departments of the MOH will be involved in the implementation of this part of the project. Most involved will be the Directorates of Planning, Administration, Curative and

... Preventive services, and all eight regional directorates. The Ministry of Health has demonstrated its capacity to implement complex operational programs involving several of its components. The Undersecretary and the Director of Planning and Foreign Relations are expected to continue to play major roles in coordination and day to day project direction, and in associating fully the training and Planning Unit activities.

2- AID:

This project does not present unusual administrative problems. It is expected that Host Country contracting procedures will be followed. A single U.S. contractor university or consultant or some combination of the two is desired to provide the technical services described. Because of the fact that the HPRG and MOH are relatively unfamiliar with both AID regulations and contract management in general it is anticipated that USAID's monitoring role will at least at the outset be more time consuming that that which might be expected for other Host Country contracts underway in Jordan.

B- Implementation Plan:

A PPT Network is attached as Annex B.

This project is expected to be implemented through a host country contract where the primary responsibility for implementation will be on the contractor, who will work in close collaboration with GOJ-appointed counterpart staff. The HPRG will continue to provde policy level direction to project activities. The total duration of this project is less than three years, starting in July 1977 with the signing of the FY 77 Project Agreement, and ending in April 1980 with the departure of the last expatriate advisor.

It is hoped that this project will be approved in June 1977, and that a project agreement between the GOJ and USAID will be signed in July 1977.

Following completion of contracting procedures, it is proposed that the long term Health Planning expert and manpower inventory specialists will arrive in October 1977. Before their arrival, the GOJ will have prepared a list of qualified persons from which appropriate counterparts will be selected.

By November 1977, The Health Planning Unit's Jordanian Chief-Designate and five to six Technical Staff memebers will have been appointed and be ready to start. After several weeks of orientation with the Planning Unit advisor the Jordanian Chief Designate will depart for the US to be enrolled in a post-graduate health planning program starting January 1978. Before the Chief - Designate's departure, the Unit will have formulated its first six month work plan which is scheduled to be submitted to the Supreme Council in January 1978.

Between October 1977 and January 1978 manpower inventory specialists and Jordanian counterparts would have completed the inventory along the following broad lines: (1) design appropriate survey instrument(s); (2) apply instruments to all operational ahealth employees and facilities in the governmental and possibly non-governmental subsectors; (3) define for each employee places, dates and institution of training, skills acquired in training and elsewhere, tasks currently performed, time spent(by skills and tasks); (4) define for each facility: location, capacity, services provided, other operating data; (5) assess for each facility, especially hospitals, general quality of services delivered; (6) collect full curriculum information from current basic health training facilities as well as data on current enrollment, size of staff and credentials; and (7) design a basic computer system for storing and retrieving the above data.

In January 1978 the first long term training advisor is scheduled to arrive in Jordan and work with the Health Manpower inventory team to prepare for submission to the SHC in February 1978 the following: (1) analyses of health manpower data by breakouts which will contribute to subsequent development of training program; (2) recommended new task reallocations for MOH basic health workers (and possibly other subsectors); (3) dentification of skills needed to perform these tasks; and (4) identification of gaps between current and proposed tasks and skills.

During February and March 1978, the SHC will rule on the above recommendations and a final list of task allocations. Training curriculum will be developed and pre-tested between March and June 1978. Training of about 20 trainers will then start, to be completed by September 1978, when the training of trainees will start. It is felt that a simultaneous

training in at least three different geographic areas will be necessary, and that, in order to reduce service disruption to a minimum the selected geographic areas may have to be divided into subareas and training conducted on selected days of the week. Training of all existing basic health workers in the MOH is expected to be completed in one year. Continuous evaluation of the effectiveness and impact of the training will be conducted, however, and for this reason another three months are allowed to accomodate any retraining deemed then to be necessary.

After 18 months of post graduate education in the US, the Jordanian Chief-designate of the Health Planning Unit returns in June 1979. During his absence other staff members will have received short term training in appropriate regional institutions (Egypt, Iran, Jordan etc.). Upon his return, the Chief-Designate will review and assist in finalizing a fourth 6 month work plan, and, under guidance from the expatriate expert, will direct its implementation. Before the end of 1979, the Planning Unit, now directed by its Jordanian Chief, will fromulate the fifth and final 6 month work plan and by January 1980 start its implementation with residual supervision from foreign experts.

Also before the end of 1979 expatriate and counterpart training and planning staff will work on proposal(s) for geographic expansion of basic health services and other followon activities. These recommendation(s) will take into account training experiences evaluation results, and the results of planning activities completed, and are expected to be submitted to the GOJ by October 1979 for consideration and decision. A final project evaluation is scheduled for March 1980, with the final expatriate advisor to depart in April.

Evaluation in this project shall be continous. Nevertheless, three major evaluative efforts are to be undertaken jointly by representatives of the GOJ, AID and the contractor. The first evaluation is scheduled for April 1978. The second for April 1979 and the third for March 1980. Evaluation parameters for the Health Planning Unit's work relates to quality of design and end product. Manpower development will be evaluated on the basis of adherence to time frame, quality of design, training product, utilization of acquired skills, completeness in performing reallocated tasks, and client perception and acceptance of all above. An additional interim evaluation effort may become necessary before October 1979, directed primarily at training to assess already acquired experience before considering or

making further recommendations concerning expanded efforts in the basic health care system. Logistic support called for as project inputs, both AID-financed and in-kind by the GOJ, are not expected to be a problem. As noted elsewhere in this paper, the GOJ may be forced at some point, given the low wage scale for health workers and incentives that may have to be created for retrained health workers, to effect an across the board upward adjustment in compensation. It is believed that this, if demonstrated necessary, can be accomplished.

C. EVALUATION ARRANGEMENTS

Health statistics in Jordan, while more prevalent than in many developing countries, are spotty and not reliable. Inadequate information inputs are accomplished at the first level of contact with the population and such data as is reported is inconsistently assembled. Aggregated data retrievable at the central level do provide gross indices of Jordan's health status, but are not adequate to fully understanding trends in morbidity, mortality or nutritional status; or to permit redirecting of health sector resources to deal with geographic or other disparities in coverage. Institutionalization of a reliable national health information system for Jordan covering all levels of services is not within the scope of this proposed project. Several activities specifically intended herein, however, should quickly and materially improve existing baseline data and permit subsequent tracking of not only service statistics but also some aspects of morbidity and nutritional status. First, the health manpower inventory planned for the fall of 1977 will provide for the first time an accurate count of provider resources, retreivable by facility, district, services delivered, type of personnel, etc. Second, the health planning phase II report stressed on several occasions the need for a basic vital registration and health information reporting structure, and in subsequent discussins the Health Policy Reference Group and Ministry of Health have requested specific attention be given to the design of such a structure in this proposed project. Through task reallocations and retraining, effecting a consistently applied system of mandatory reporting at the system's first levels of contact with the population (to include birth and death registration; attendance, reason for contact and follow up data; records of immunizations; etc.) will result in significant improvements in the system's ability to monitor services deliveries and to begin the process of establishing a satisfactory data base for assessing measures of change in mortality, morbidity and nutritional status. Third, the Planning Unit, once established, is expected to begin quickly to undertake operational research in several areas important to an understanding of progress - or its lack in ameliorating existing problems. It is expected for example, that one of the early areas to be examined by the Health Planning Unit will be consumers' perceptions and expectations regarding health services. The results of this inquiry will directly impact on the design of training and retraining programs.

Because of the above, and recognizing that these are many unknowns which this project per se is attempting to answer, no attempt has been made to present a detailed evaluation plan in this paper. The project design includes provision for continuing "operational evaluation", and redesign as appropriate, of the training which is proposed to be conducted. In addition, three project level evaluations have been scheduled: after 6 months, with particular attention to be paid to the planning activity; after 1½ years, examining both planning and the training effort mid-way; and at the end of the project. It is intended that these evaluations, with whatever project management decisions they suggest, be jointly conducted by the consultant, USAID, and the GOJ.

D. Conditions, Covenants and Negotiating Status

USAID and the Government are in agreement as to the scope of the project. No critical host country actions remain to be accomplished prior to execution of the Project Agreement.

Project Design Summary

Logical Framework

ANNEX A

Program Goal	Measures of Goal Achievement	Means of Verification	Assumptions for Achieving Goal Targets
Improved health status of Jordan's population	Decreases in preventable morbidity and mortality	Morbidity and Mortality Statistics	Continued GOJ commitment to health status improvement Economic situation and political climate remain stable

Project Purpose	End of Project Status	Means of Verification	Assumptions for achieving purpose
1. To establish an operational planning unit capable of policy analysis, planning, evaluation, and programming for health improvement on an national basis.	Unit established and demonstrated capable of studying problems and recommending solutions.	Observation; expert evaluation of studies and planning activities completed.	Continued GOJ commitment to planning being conducted on a national, as opposed to subsectoral, basis.
2. To rationalize the training, assignment and functions of existing basic health manpower.	Existing basic health manpower retrained.	On the job observation and assessment of retrained health workers.	Continued GOJ commitment to maximizing use of basic health manpower; ability of experts/GOJ to devise task reallocations appropriate to cultural context.
	Existing basic health manpower training facilities' curricula revised.	Examination of curricula and expert evaluation of end product.	
	Basic national health manpower inventory information system established.	Health manpower information system records.	

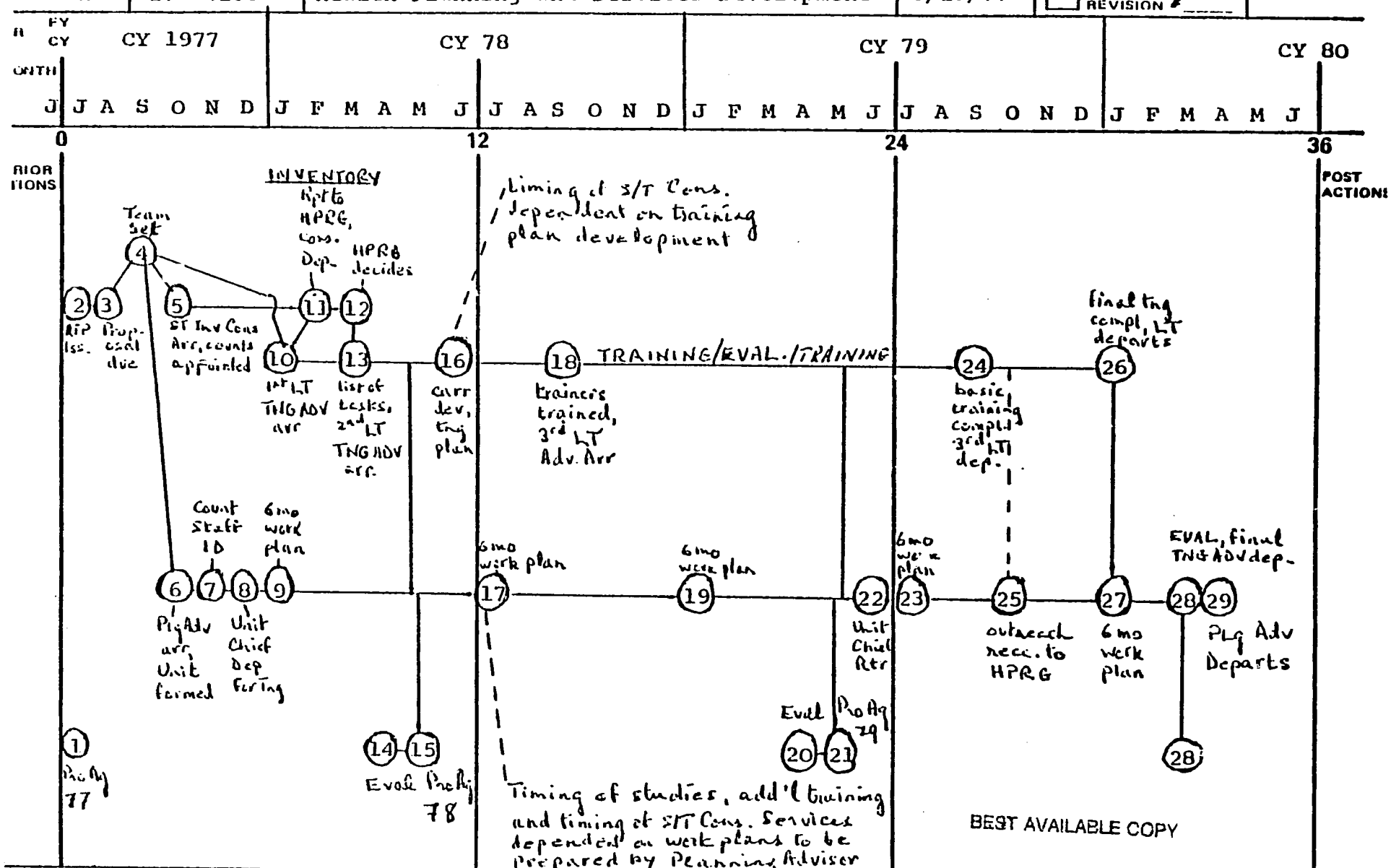
Outputs	Magnitude of Outputs	Means of Verification	Assumptions for achieving outputs
1. Planning Unit established.	One Unit	Legislation; observation.	
Unit Director and core staff trained and in place.	One graduate-level planner; 5 specialized.	Direct measurement	Candidates can be selected and made available.
Initial professional quality data acquisition/analysis/evaluation and studies completed.	To be determined by HPRG/experts	Expert Evaluation of end products	Provision of adequate GOJ support staff and facilities.
2. Existing basic health workers retrained and returned to service.	approximately 850 workers retrained	Health Manpower information system records; field inspection/evaluation.	Trainees can be made available and returned to appropriate positions.
Health manpower information system developed and in place.	Multi-purpose computer system	Direct measurement	Adequate and timely access to computer facilities and related support.
Existing basic health manpower training facilities' curricula revised.		Examination of curricula and evaluation of end product	
Proposal(s) made for follow-on training/services activities to reach population groups still not being at all or adequately served.	To be determined by HPRG/Experts	Proposal(s) submitted to HPRG/AID	Continued GOJ commitment to improvement of basic health services.

Inputs US Contribution	Implementation Target (Type & Quantity)	Means of Verification	Assumptions for Providing In puts
1. Technical assistance for Planning Unit.	30 mm planning advisor 10-12 mm short term consultant services.	AID records	Contract expertise available.
Participant training	One graduate level program in health planning and 5 short term participants.	"	Candidates can be selected and made available.
Commodities/other costs	Packaged computer programs if needed; local research costs.	"	
2. Technical assistance in upgrading of basic health services	3 long term manpower development/curriculum/training experts (total 60 mm); 29mm short term consultant services; one long term (local) contract administrative officer.	"	Contract expertise available.
Participant training	2 short term participant programs for GOJ counterpart staff	"	Candidates can be selected and made available.
Commodities/other costs	Reproduction and other training-related commodity support; local research costs; four carryall type vehicles.	"	Procurement can be effected on a timely basis.

Inputs GOJ Contribution	Implementation Target	Means of Verification	Assumptions for providing inputs
1. Counterpart professional/ technical staff for health planning activity Support services: Office space, equipment and supplies; secretarial/clerical/ translation support staff; transportation; computer services (time and staff); per diem for Jordanians in travel status	6, including Unit Director	Consultant Report	Qualified personnel available and GOJ provides support on timely basis
2. Counterpart professional/technical staff for training/ services activity	4-curriculum (coordinator), manpower, health education/audio visual, training program editor	Consultant report	Qualified personnel available and GOJ provides support on timely basis
Support services, as detailed above		"	"
Trainees to become trainers	Approximately 20	"	"
Trainees	Approximately 850	"	"
Perdiem/housing (if necessary)		"	"

Health ANNEX B

COUNTRY	PROJECT NO.	PROJECT TITLE	DATE		APPROVED
Jordan	278-0208	Health Planning and Services Development	5/29/77	[X] ORIGINAL REVISION # ____	



ANALYSIS SCHEDULE: PROGRESS VS FINANCIAL			
EVALUATION SCHEDULE	X	X	X

AID-1020-35 (6-76)

CRITICAL PERFORMANCE INDICATOR (CPI) NETWORK

CY	PROJECT NO.	PROJECT TITLE	DATE	ORIGINAL / REVISION #	APPROVED
80	278-0208	Health Planning and Services Development	5/29/77	[X] ORIGINAL	

PURPOSE (FROM PIP FACESHEET)

stablish an operational planning unit

ble of planning for health improvement on tional basis and to rationalize the train- assignment and functions of existing basic th manpower.

CRIPTION

07/77 - Project agreement for FY 77 signed (USAID and GOJ).
07/77 - RFP issued (AID/W)
08/77 - Proposals due to AID/W
09/77 - Consultant selected and contract negotiated (AID/W, GOJ)
10/77 - Manpower inventory specialists arrive, counterpart appointed (Consultant, GOJ).
10/77 - Planning advisor arrives, Planning Unit formed (Consultant, GOJ).
11/77 - Planning Unit Chief and staff appointed (Consultant, GOJ).
12/77 - Planning unit chief departs for LT training (Consultant).
01/78 - Planning unit advisor prepares first 6 month work plan (consultant)
01/78 - First long term training advisor arrives, works with CPI5team in report preparation (Consultant)
02/78 - Task reallocation recommendations presented to HPRG (Consultant)
03/78 - HPRG decides on new structure (GOJ)
03/78 - List of tasks finalized; 2nd LT training advisor arrives (Consultant).

14. 04/78 - First (6 months underway) project evaluation (USAID/consultant/GOJ)
15. 05/78 - Project Agreement for FY 78 signed (USAID and GOJ)
16. 06/78 - Training plan and curriculum developed (Consultant)
17. 07/78 - Second 6-month work plan for Planning Unit prepared (Consultant)
18. 09/78 - Training of trainers completed; 3rd Long Term training specialist arrives (Consultant).
19. 01/79 - Third 6-month work plan for Planning Unit prepared (Consultant).
20. 04/79 - Second (1½ years) project evaluation (USAID, consultant and GOJ)
21. 05/79 - Project Agreement for FY 79 signed (USAID and GOJ).
22. 06/79 - Planning Unit Chief returns from training (consultant).
23. 07/79 - With returned Chief, fourth 6-month work plan for Planning Unit prepared (Consultant and GOJ).
24. 09/79 - Basic training of health workers completed, 12-month LT specialist departs (consultant).
25. 10/79 - Planning Unit with participation of Planning Advisor and training advisors prepare and propose to HPRG proposal(s) for outreach/other followon activities (GOJ, consultant).
26. 01/80 - Final training completed, second LT training specialist departs (Consultant).
27. 01/80 - Remaining training specialist joins

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COUNTRY	PROJECT NO.	PROJECT TITLE	DATE		APPROVED
Jordan	278-0208	Health Planning and Services Development	5/29/77	[X] ORIGINAL REVISION # ___	

PROJECT PURPOSE (FROM PRP FACESHEET)

CPI DESCRIPTION

in preparation of final 6-month work plan for Planning Unit (Consultant, GOJ).

28. 03/80 - Remaining Training advisor and Planning advisor participate in final project evaluation; Training advisor departs (USAID, consultant, GOJ)
29. 04/80 - Planning advisor departs (Consultant)

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6C(2) - PROJECT CHECKLIST

Listed below are, first, statutory criteria applicable generally to projects with FAA funds, and then project criteria applicable to individual fund sources: Development Assistance (with a sub-category for criteria applicable only to loans); and Security Supporting Assistance funds.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? IDENTIFY. HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

GENERAL CRITERIA FOR PROJECT.

1. App. Unnumbered; FAA Sec. 653(b)

   (a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project; (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than $1 million over that figure plus 10%)?

   a) The Project is in the FY 78 Congressional Presentation but has changed in scope. The change will be notified to Congress.

   b) Yes

2. FAA Sec. 611(a)(1). Prior to obligation in excess of $100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

   NOT APPLICABLE

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

   No further action is required.

4. FAA Sec. 611(b); App. Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per Memorandum of the President dated Sept. 5, 1973 (replaces Memorandum of May 15, 1962; see Fed. Register, Vol 38, No. 174, Part III, Sept. 10, 1973)?

   NOT APPLICABLE

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed $1 million, has Mission Director certified the country's capability effectively to maintain and utilize the project?

   NOT APPLICABLE

A..

6. FAA Sec. 209, 619. Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. If assistance is for newly independent country, is it furnished through multilateral organizations or plans to the maximum extent appropriate?

The Project is not so susceptible. Jordan is not a newly independent country.

7. FAA Sec. 601(a); (and Sec. 201(f) for development loans). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

NOT APPLICABLE

8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

Private U.S. participation will be sought to implement this Project.

9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.

The Project Agreement will so provide.

0. FAA Sec. 612(d). Does the U.S. own excess foreign currency and, if so, what arrangements have been made for its release?

Jordan is not an excess currency country.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(c); Sec. 111; Sec. 281a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production, spreading investment out from cities to small towns and rural areas; and (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions?

NOT APPLICABLE

61

b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available: [include only applicable paragraph -- e.g., a, b, etc. -- which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.]

NOT APPLICABLE

(1) [103] for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, is full account taken of needs of small farmers;

(2) [104] for population planning or health; if so, extent to which activity extends low-cost, integrated delivery systems to provide health and family planning services, especially to rural areas and poor;

(3) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;

(4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:

(a) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

(b) to help alleviate energy problem;

(c) research into, and evaluation of, economic development processes and techniques;

(d) reconstruction after natural or manmade disaster;

(e) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;

(f) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

(5) [107] by grants for coordinated private effort to develop and disseminate intermediate technologies appropriate for developing countries.

c. FAA Sec. 110(a); Sec. 208(e). Is the recipient country willing to contribute funds to the project, and in what manner has or will it provide assurances that it will provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)?

d. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing?

e. FAA Sec. 207; Sec. 113. Extent to which assistance reflects appropriate emphasis on; (1) encouraging development of democratic, economic, political, and social institutions; (2) self-help in meeting the country's food needs; (3) improving availability of trained workerpower in the country; (4) programs designed to meet the country's health needs; (5) other important areas of economic, political, and social development, including industry; free labor unions, cooperatives, and Voluntary Agencies; transportation and communication; planning and public administration; urban development, and modernization of existing laws; or (6) integrating women into the recipient country's national economy.

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

B1

g. FAA Sec. 201(b)(2)-(4) and -(8); Sec. 201(e); Sec. 211(a)(1)-(3) and -(8). Does the activity give reasonable promise of contributing to the development: of economic resources, or to the increase of productive capacities and self-sustaining economic growth; or of educational or other institutions directed toward social progress? Is it related to and consistent with other development activities, and will it contribute to realizable long-range objectives? And does project paper provide information and conclusion on an activity's economic and technical soundness?

h. FAA Sec. 201(b)(6); Sec. 211(a)(5), (6). Information and conclusion on possible effects of the assistance on U.S. economy, with special reference to areas of substantial labor surplus, and extent to which U.S. commodities and assistance are furnished in a manner consistent with improving or safeguarding the U.S. balance-of-payments position.

2. Development Assistance Project Criteria (Loans only) — NOT APPLICABLE

a. FAA Sec. 201(b)(1). Information and conclusion on availability of financing from other free-world sources, including private sources within U.S.

b. FAA Sec. 201(b)(2); 201(d). Information and conclusion on (1) capacity of the country to repay the loan, including reasonableness of repayment prospects, and (2) reasonableness and legality (under laws of country and U.S.) of lending and relending terms of the loan.

c. FAA Sec. 201(e). If loan is not made pursuant to a multilateral plan, and the amount of the loan exceeds $100,000, has country submitted to AID an application for such funds together with assurances to indicate that funds will be used in an economically and technically sound manner?

d. FAA Sec. 201(f). Does project paper describe how project will promote the country's economic development taking into account the country's human and material resources requirements and relationship between ultimate objectives of the project and overall economic development?

e. FAA Sec. 202(a). Total amount of money under loan which is going directly to private enterprise, is going to intermediate credit institutions or other borrowers for use by private enterprise, is being used to finance imports from private sources, or is otherwise being used to finance procurements from private sources?

f. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete in the U.S. with U.S. enterprise, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

3. Project Criteria Solely for Security Supporting Assistance

FAA Sec. 531. How will this assistance support promote economic or political stability?

This Project will contribute to economic and political stability by ameliorating the health status of Jordan's rural and urban poor.

4. Additional Criteria for Alliance for Progress

[Note: Alliance for Progress projects should add the following two items to a project checklist.]

NOT APPLICABLE

a. FAA Sec. 251(b)(1), -(8). Does assistance take into account principles of the Act of Bogota and the Charter of Punta del Este; and to what extent will the activity contribute to the economic or political integration of Latin America?

b. FAA Sec. 251(b)(8); 251(h). For loans, has there been taken into account the effort made by recipient nation to repatriate capital invested in other countries by their own citizens? Is loan consistent with the findings and recommendations of the Inter-American Committee for the Alliance for Progress (now "CEPCIES," the Permanent Executive Committee of the OAS) in its annual review of national development activities?

6C(3) - STANDARD ITEM CHECKLIST

Listed below are statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by exclusion (as where certain uses of funds are permitted, but other uses not).

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of goods and services financed?	Procurement of goods and services will be pursuant to established AID regulations.
2. FAA Sec. 604(a). Will all commodity procurement financed be from the U.S. except as otherwise determined by the President or under delegation from him?	Yes.
3. FAA Sec. 604(d). If the cooperating country discriminates against U.S. marine insurance companies, will agreement require that marine insurance be placed in the U.S. on commodities financed?	Yes.
4. FAA Sec. 604(e). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity?	There will be no such procurement.
5. FAA Sec. 608(a). Will U.S. Government excess personal property be utilized wherever practicable in lieu of the procurement of new items?	Consideration will be given to the use of excess property when practical.
6. MMA Sec. 901(b). (a) Compliance with requirement that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S.-flag commercial vessels to the extent that such vessels are available at fair and reasonable rates.	Yes.
7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished to the fullest extent practicable as goods and professional and other services from private enterprise on a contract basis? If the facilities of other Federal agencies will be utilized,	Yes.

A7

are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

8. International Air Transport. Fair Competitive Practices Act, 1974

If air transportation of persons or property is financed on grant basis, will provision be made that U.S.-flag carriers will be utilized to the extent such service is available? — Yes.

B. Construction

1. FAA Sec. 601(d). If a capital (e.g., construction) project, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interest? — NOT APPLICABLE

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? — NOT APPLICABLE

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million? — NOT APPLICABLE

C. Other Restrictions

1. FAA Sec. 201(d). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter? — NOT APPLICABLE

2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? — NOT APPLICABLE

3. FAA Sec. 620(h). Do arrangements preclude promoting or assisting the foreign aid projects or activities of Communist-Bloc countries, contrary to the best interests of the U.S.? — Yes.

4. FAA Sec. 636(i). Is financing not permitted to be used, without waiver, for [illegible] — Financing is not permitted to be used for such purposes.

5. Will arrangements preclude use of financing:

a. FAA Sec. 114. to pay for performance of abortions or to motivate or coerce persons to practice abortions? Yes.

b. FAA Sec. 620(a). to compensate owners for expropriated nationalized property? Yes.

c. FAA Sec. 660. to finance police training or other law enforcement assistance, except for narcotics programs? Yes.

d. FAA Sec. 662. for CIA activities? Yes.

e. App. Sec. 103. to pay pensions, etc., for military personnel? Yes.

f. App. Sec. 106. to pay U.N. assessments? Yes.

g. App. Sec. 107. to carry out provisions of FAA Sections 209(d) and 251(h)? (transfer to multilateral organization for lending). Yes.

h. App. Sec. 501. to be used for publicity or propaganda purposes within U.S. not authorized by Congress? Yes.

بسم الله الرحمن الرحيم

ANNEX D

THE HASHEMITE KINGDOM
OF JORDAN
NATIONAL PLANNING
COUNCIL
AMMAN
Tel. 44466 - 44470
P. O. B. 555
Teleg. NPC — Amman

المملكة الأردنية الهاشمية
المجلس القومي للتخطيط
عمان
الهاتف : ٤٤٤٦٦ - ٤٤٤٧٠
ص.ب ٥٥٥

MAY 28 1975

No. [illegible]
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RETURN TO USAID C&R

Mr. Christopher Russell
Director
USAID/J
American Embassy
Amman

Dear Mr. Russell,

Further to my letter No. 127/22/1656 dated 16 April 1977, the Ministry of Health has approved your recommendations stated in your letter of 23 April 1977 with the following exception:

The Ministry of Health feels that the duration of the services of the Health Insurance Adviser is insufficient as stated in page 11 of the working document attached to your above-mentioned letter.

Therefore, you are kindly requested to recruit the required technical experts.

Yours sincerely,

President

cc. H.E. Minister of Health

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ANNEX D

PROPOSAL FOR FURTHER DEVELOPMENT OF HEALTH PLANNING AND HEALTH SERVICES IN JORDAN

(OCTOBER 1977 - OCTOBER 1980)

I. Health Planning

Assistance is proposed to develop a health planning unit within the MOH which will be capable of nationwide planning and which will also act as staff to the Health Policy Reference Group. During the unit's first two and a half years, a long-term U.S. advisor will act as chief while a Jordanian Chief-Designate is being trained abroad. Short term training for other staff members will also be necessary. Specifically, this activity will include the following:

A. Technical Services

1. A long-term planning advisor whose job will be to:

- assist in selection of planning unit head and other staff members.
- act as temporary head of the unit for the initial two and-a-half year period.
- plan suitable training programs for Unit Chief Designate and other staff members.
- identify short term expatriate advisor needs.
- supported by Jordanian and if necessary expatriate staff, design and conduct studies requested by Health Policy Reference Group.
- identify packaged computer programs which can be purchased to assist in data analysis where such programs are unavailable in Jordan.
- provide relevant materials on analytical techniques.
- provide consecutive six month work plans.
- return for two follow-up evaluation trips six months and one-year after departure from Jordan.

2. Short-term expatriate advisory services. These specialists will be brought to Jordan to assist the Unit's development and work as necessary.

B. Training

1. 12-18 man-months (mm) of training at a U.S. institution and a specially tailored observational program to give the Unit Chief-Designate solid grounding in planning techniques, modern health program directions, economic analysis, etc.

2. 3-4 man-months (mm) each of observation and training in other countries for selected staff members.

C. Commodities

- Packaged computer programs, if needed.

D. Other

- Jordanian students' services in the conduct of selected studies.

Proposed USAID Inputs/Tentative Budget

	1st year	2nd year	3rd year
Long-term advisor	$105,000	$ 95,000	$ 75,000
Short-term consultant services	40,000	40,000	-
Training Long-term	15,000		
Short term	10,000	10,000	
Student salaries, Commodities, other research costs	30,000	30,000	
	200,000	175,000	75,000

Proposed GOJ Inputs

Planning unit chief and professional technical staff of perhaps five individuals.

Office space, equipment and supplies

Secretarial/clerical/translation support staff

In-country transportation including vehicles/drivers

Computer time

Per diem for Jordanians in local travel status.

II. Upgrading at Basic Health Services, First Phase: Retraining of Existing Health Manpower (June 1977-October 1979).

A. First step - Health Manpower Inventory (June - September 1977)

In recognition of the GOJ's interest in improving the health sector and to avoid losing time it is proposed that a team of consultants make an inventory of available manpower and facilities which can serve as the data base for a manpower development/training project (described below), and which will also serve as the foundation of a permanent manpower information system for GOJ planning in health. Specifically, the consultants, and their Jordanian counterparts, will:

1. Design a questionnaire or set of questionnaires which will provide sufficient information to clearly identify, for each operational employee in the MOH and RMS systems, the
   a. places, dates and institutions where training has been received.
   b. specific skills acquired in training.
   c. specific skills acquired elsewhere.
   d. tasks currently performed and approximate time spent on such tasks, and,
   e. any other information relevent to developing a skill utilization profile.
2. Design a questionnaire or checklist which will provide for each facility: location, capacity, services provided and other operating data.

3. Develop and test a system for assessing general quality of services delivered in these facilities, especially Hospitals, such as record keeping, waiting time, patient followup,, surgery complication rates, laboratory services, etc.

4. Collect full curriculum information from current training facilities as well as data on current enrollment, size of staff and credentials, in sufficient detail to act as a catalog of available training resources.

5. Design a basic computer storage system for storing and retrieving the above data -- with access by facility, by district, by region, by type of personnel, etc.

6. Provide analyses of the data by type of personnel, by facility and by any other breakouts which will contribute to subsequent development of training and retraining programs.

7. Recommend to HPRG new task allocations for each category of service delivery unit in the MOH and possibly the RMS for improvements in the quality of services delivered and the extension of these services.

8. Identify skills needed to perform these tasks.

9. Identify and analyze the gaps between current and proposed tasks and skills.

Proposed USAID Inputs/Tentative Budget

4mm health manpower analyst, travel and per diem	31,000
4mm curriculum/training analyst, travel and per diem	32,000
3mm hospital personnel/services analyst, travel and per diem	24,000
12-18mm local student interviewers	4,000
	$91,000

Proposed GOJ Inputs

Two professional Jordanian counterparts (1 curriculum, 1 manpower).

Office space, equipment and supplies

Secretarial/clerical/translation support staff

In-country transportation including vehicles/drivers

Computer time, programmer, key puncher

Per diem for ocounterparts and students outside Amman.

B. Second Step - Manpower Development/Training of Existing Health Manpower (October 1977 - October 1979)

In order to assist in the retraining of current health personnel to improve the coverage, quality and efficiency of health service delivery and in order to determine the future training needs of basic health personnel in Jordan, AID proposes an initial two year project. Three long-term U.S. experts will work with their Jordanian counterparts to:

1. Review the findings from the manpower inventory.

2. Following the recommendations of the HPRG, draw up a comprehensive list of tasks to be performed by various health personnel.

3. Develop a set of curricula to train health personnel to carry out the new tasks.

4. Train trainers (teachers) to retrain (teach) the health personnel.

5. Supervise regional training conducted by trainers.

6. Design and implement an evaluation system to test whether the training is actually resulting in the application of new skills to new tasks.

7. Study existing curricula at Jordanian training institutions t o determine those changes required to improve the achievement of tasks defined for each category of health personnel.

8. Determine future training needs, beyond the training of existing health workers. Specifically:

   a. With the Health Planning Unit, describe tasks and optimal geographic distribution of facilities and personnel to ensure maximum coverage of the total population.

   b. With the Health Planning Unit, develop a proposal for whatever appropriate services and training program is required to meet the above objective.

Proposed USAID Inputs/Tentative Budget

	1st year	2nd year
Technical Services		
24mm Project Manager	106,000	106,000
24mm Trainer/curriculum designer	96,000	95,000
12mm Trainer/curriculum designer	96,000	
8mm Short term services - training	64,000	
10mm Short term services - curriculum design	88,000	
24mm Contract administrative support - local	24,000	24,000
4mm GOJ coordinator/counterpart (curriculum)	8,000	
4mm GOJ counterpart (health education/audio visual)	8,000	
Commodities/Other Costs	60,000	
Total	550,000	225,000

Proposed GOJ Inputs

Counterpart to coordinator

Health education/audio visual counterpart

Office space equipment and supplies

Secretarial/clerical/translation support staff

Editor (for training program preparation)

In-country transportation including vehicles/drivers

Trainees to become trainers

Per diem and housing arrangements for trainees.

III. Special Activities (Health Insurance and Health Education and Information - Summer 1977)

It is expected that with the creation of the planning unit, specific studies (see p.10 of the Westinghouse report) needed to complete the base for a ten-year health plan can be conducted by the planning unit with only limited outside specialist assistance. Two issues, though, seem of sufficient importance and of such a timely nature, that it is recommended that special technical assistance be provided during the next six month period.

A. Health Insurance

Because of the current proliferation (and fragmentation) of insurance plans, and the current reviews of this subject being planned or undertaken, it seems appropriate to provide some external analysis and advice. Specifically, two American health insurance experts, with GOJ counterpart consultants, woud:

1. inventory and describe those current insurance plans which companies have created for themselves.

2. to the extent possible, inventory and describe proposed private plans.

3. inventory and describe insurance plans covering government employees.

4. review Government policy/planning with respect to national plans; and

5. based on results of the above examination and on a knowledge of alternative financing and service methods, recommend a system, or systems, suitable in the Jordanian context.

Proposed USAID Inputs/Tentative Budget

1.5mm	health insurance advisor	$ 13,000
1.5mm	public administration/insurance management specialist	13,000
		$ 26,000

Proposed GOJ Inputs

Counterparts

Office space, equipment and supplies

Secretarial/clerical/translation support

Vehicle/driver as needed for out-of Amman

B. Health Information and Education

Jordan is fortunate to have a large percentage of its population who can be reached through television and radio. It is proposed that a mass media expert examine the possibilities for using existing mass media, television and radio, to carry a health/nutrition message that could significantly complement the other planned activities to improve the health status of Jordan's population.

Specifically, he would:

1. Review coverage and audience information

2. Investigate cost implications.

3. Examine any current public service message media efforts.

4. Determine organizational composition and skills which would be needed to translate ideas into action - including considering the participation of other Arab countries.

5. Recommend a program which would, over time, develop Jordan's capacity to utilize available media for health education.

Proposed USAID Inputs

1.5mm media/health advisor $13,000

Proposed GOJ Inputs

1 Counterpart

Office space, equipment and supplies

Secretarial, clerical and translation support.

April, 1977