

U.S Agency for International Development

PROJECT PAPER

Comprehensive Post Partum (CPP) Project

Amman, Jordan

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT PAPER

COMPREHENSIVE POST PARTUM (CPP)

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APPENDIX 3A, Attachment 1
Chapter 3, Handbook 3 (TM 3:43)

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE A = Add
 C = Change
 D = Delete

Amendment Number _____ DOCUMENT CODE 3

COUNTRY/ENTITY Jordan

3. PROJECT NUMBER 278-0293

4. BUREAU/OFFICE ANE/PD

5. PROJECT TITLE (maximum 40 characters) COMPREHENSIVE POST PARTUM

6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 04 3 10 9 9

7. ESTIMATED DATE OF OBLIGATION (Under "B" below, enter 1, 2, 3, or 4)
A. Initial FY 94 B. Quarter 2 C. Final FY

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY 94			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AD Appropriated Total	4,000	-	4,000	11,000	-	11,000
(Grant)	(4,000)	(-)	(4,000)	(11,000)	(-)	(11,000)
(Loan)	(-)	(-)	(-)	(-)	(-)	(-)
Other						
U.S.						
Host Country	-	500	500	-	5,458	5,458
Other Donors)	-	100	100	-	1,378	1,378
TOTALS	4,000	600	4,600	11,000	6,836	17,836

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) DA/POP	N/A	N/A	-	-	-	4,000	-	11,000	-
(2)									
(3)									
(4)									
TOTALS						4,000	-	11,000	-

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each) N/A

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)
A. Code N/A
B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

TO INCREASE THE NUMBER OF WOMEN INITIATING AND SUSTAINING USE OF EFFECTIVE CONTRACEPTIVE METHODS DURING AND AFTER POSTPARTUM PERIOD.

14. SCHEDULED EVALUATIONS

Interim	MM 04	YY 97	MM	YY	Final	MM 04	YY 99
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15. SOURCE/ORIGIN OF GOODS AND SERVICES
 000 941 Local Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP amendment)

The methods of financing to be used in this project are in conformity with USAID's policy statement on financial and administrative management and USAID's comprehensive general assessment.

Mohammad Tanandy
Mohammad Tanandy, CONT.

17. APPROVED BY

Signature *William T. Oliver*

Title William T. Oliver
Mission Director

Date Signed MM DD YY 6 JUN 1994

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM DD YY

B

6

PROJECT AUTHORIZATION

Name of Country: Jordan
Name of Project: Comprehensive Postpartum
Number of Project: 278-0293

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Comprehensive Postpartum Project for Jordan involving planned obligations of not to exceed \$11,000,000 in grant funds over a five (5) year period from the date of Authorization subject to the availability of funds in accordance with the USAID OYB/allotment process, to help in financing foreign exchange and local currency costs for the Project. The planned life of the Project is five (5) years from the date of initial obligation.

2. The Project will assist the Government of Jordan in reducing unwanted fertility in Jordan by increasing the number of women adopting effective contraceptive methods during and after the postpartum period by establishing hospital-based comprehensive postpartum centers where women will come for postpartum care and family planning services (as well as for a check up for their babies).

3. The Project Agreement(s) which may be negotiated and executed by the officer(s) to whom such authority is delegated in accordance with USAID regulations and Delegations of Authority shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as USAID may deem appropriate.

a. Source and Origin of Commodities, Nationality of Services

(1) Commodities financed by USAID under the Project shall, except as provided below in subsection (2) or as USAID may otherwise agree in writing, have their source and origin in the United States (USAID Geographic Code 000). Except for ocean shipping and, in matters not pertaining to ocean shipping, except as provided below in subsection (2) or as USAID may otherwise agree in writing, the suppliers of commodities or services shall have the United States as their place of nationality. Ocean shipping financed under the Grant shall, except as USAID may otherwise agree in writing, be financed only on flag vessels of the United States.

(2) The following goods and services required for the Project may have their source, and except as provided below or as USAID may otherwise agree to in writing, their origin in Jordan:

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(a) commodities of U.S. origin purchased in Jordan if the transaction value is equal to or less than \$100,000 or the local currency equivalent (exclusive of transportation costs);

(b) commodities of USAID Geographic Code 935 origin if the transaction value is equal to or less than \$5,000 or local currency equivalent (exclusive of transportation costs);

(c) professional services contracts estimated not to exceed \$250,000 or local currency equivalent;

(d) construction services contracts estimated not to exceed \$5,000,000 or local currency equivalent;

(e) the following commodities and services which are available only locally: (i) utilities including fuel for heating and cooking, water disposal and trash collection; (ii) communications (telephone, telex, fax, postal and courier services); (iii) rental costs for housing and office space; (iv) petroleum, oils and lubricants for operating vehicles and equipment; and (v) newspapers, periodicals and books published in Jordan; and

(f) other commodities and services (and related expenses) that, by their nature or as a practical matter, can only be acquired, performed or incurred in Jordan, provided, however, that without the prior written consent of A.I.D., such other commodities and other services must fall into one of the following categories: (i) vehicle maintenance, and (ii) hotel accommodations.

b. Conditions Precedent to Initial Disbursement

Prior to the first disbursement under the Grant, or to the issuance by USAID of documentation pursuant to which disbursement will be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to USAID in form and substance satisfactory to USAID:

(1) An opinion of counsel acceptable to USAID that the Project Agreement has been duly authorized and/or ratified by, and executed on behalf of the Grantee, and that it constitutes a legally binding obligation of the Grantee in accordance with all its terms.

(2) A statement of the name of the person holding or acting in the office of the Grantee specified in the

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Project Agreement, and of any additional representatives, together with a specimen signature of each person.

(3) A statement of the name of the full time Project Director, who will serve as counterpart to the Project Contractor staff and who will be designated by the Grantee as an additional representative as provided for in the Project Agreement.

c. Covenants

(1) The Parties shall agree in the Project Agreement to establish an evaluation program as part of the Project. Except as the Parties otherwise agree in writing, the program will include, during the implementation of the Project and at one or more points thereafter:

(a) evaluation of progress toward attainment of the objectives of the Project;

(b) identification and evaluation of problem areas or constraints which may inhibit such attainment;

(c) assessment of how each such information may be used to help overcome such problems; and

(d) evaluation, to the degree feasible, of the overall development impact of the Project.

(2) The Grantee shall agree in the Project Agreement to provide all core staff essential for the CPP centers and for the implementation of this Project, on a timely basis, and to make candidates selected for training promptly available with full pay and benefits upon notification of training courses and dates.

(3) The Grantee shall agree in the Project Agreement to ensure that, upon completion of training, all staff will be retained in positions for which they were trained.



William T. Oliver
Director, USAID/Jordan

6 JUN 1994

Date

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TABLE OF CONTENTS

	Page
Project Data Sheet	i
Project Authorization	iii
Table of Contents	iv
List of Tables and Figures	v
List of Acronyms	vi
Executive Summary	1
1. Project Background	1
1.1 Demographic Trends in Jordan	1
1.2 Government of Jordan Policy on Population and Birth Spacing	1
1.3 USAID Strategic Objective	2
2. Perceived Problem and Project Rationale	3
2.1 Perceived Problem	3
2.2 Project Rationale	4
2.2.1 A.I.D. Population Assistance	6
2.2.2 Other Donor Assistance	7
3. Project Goal, Purpose, Achievements and Impact	9
3.1 Goal and Purpose	9
3.2 Achievements	9
3.3 Impact	10
4. CPP Project Description	10
4.1 Project Overview	11
4.2 Service Delivery Component	13
4.2.1 CPP Service Delivery System	13
4.2.2 Facilities Upgrade	14
4.2.3 CPP Center Staffing	16
4.2.4 Programmatic Research	17
4.2.5 Service Delivery Component Management	17
4.2.6 Service Delivery Budget	18
4.3 Training	19
4.3.1 In-country Training	19
4.3.2 Out-of-country Training	22

4.3.3	Training Component Management	22
4.3.4	Training Budget	23
4.4	Information, Education and Communications Component	23
4.4.1	Health Education	24
4.4.2	Mass Media	25
4.4.3	Outreach	25
4.4.4	IEC Component Management	26
4.4.5	IEC Budget	26
5.	Management Plan	26
5.1	Prime Contractor	27
5.2	Ministry of Health	28
5.2.1	MCH Directorate	28
5.2.2	Health Education Department	29
5.3	Royal Medical Service	30
5.4	Jordan University Hospital	30
5.5	Islamic Hospital	30
5.6	USAID's Capacity to Manage, Monitor and Evaluate	31
6.	Implementation Plan	31
6.1	Project Implementation Schedule	32
6.2	Procurement Plan	36
7.	Cost Estimate and Financial Plan	37
7.1	Cost Estimate	37
7.1.1	USAID Contribution	37
7.1.2	Host Country Contribution	38
7.1.3	Other Contributions	38
7.2	Financial Plan	38
8.	Monitoring and Evaluation Plan	39
9.	Summaries of Project Analyses	44
9.1	Technical Analysis Summary	44
9.2	Financial Analysis Summary	45
9.3	Economic Analysis Summary	46
9.4	Social Soundness and Gender Analysis Summary	47

9.5	Administrative Analysis Summary	48
9.6	Environmental Determination	50
Annex I	Legal Exhibits	
	A. Request for Assistance	
	B. Delegation of Authority for PID and PP	
	C. Statutory Checklist	
	D. Environmental Determination	
	E. Conditions Precedent and Covenants	
	F. RMS Rationale	
Annex II	Technical Exhibits	
	A. Logical Framework Matrix	
	B. Implementation Action Plan	
	C. Service Delivery Component	
	D. Training Component	
	E. IEC Component	
	F. Mini-Survey Report	
	G. Impact Calculations	
	H. PID Issues	
Annex III	Project Analyses	
	A. Technical Analysis	
	B. Financial Analysis	
	C. Economic Analysis	
	D. Social Soundness and Gender Analysis	
	E. Administrative Analysis	

List of Tables

<u>Table</u>	<u>Description</u>	<u>Page</u>
Table 1.	CPP Project Summary Budget	
Table 2.	CPP Project Sites by start-up Phase	16
Table 3.	Summary Service Delivery Budget	19
Table 4.	CPP Project Training Plan	20
Table 5.	Training for Hospital Staff: Estimated Number of Courses	21
Table 6.	Training for Hospital Staff by Professional Level and Service Channel	21
Table 7.	Training for Hospital Staff by Professional Level and Project Year	21
Table 8.	Summary Training Budget	23
Table 9.	Summary IEC Budget	27
Table 10	Summary Implementation Plan	33
Table 11.	Technical Assistance Summary	36
Table 12.	CPP Project Summary Budget - Donor Contributions	37
Table 13.	Methods of Implementation and Financing for CPP Project	39
Table 14.	CPP Project Summary Cost Estimate and Financial Plan (\$US)	40
Table 15.	Implementation Plan - General Management	Annex II.B.
Table 16.	Service Delivery Component	Annex II.B.
Table 17.	Information System	Annex II.B.
Table 18.	Programmatic Research	Annex II.B.
Table 19.	Training Component	Annex II.B.
Table 20.	IEC Component	Annex II.B.
Table 20.B.	Technical Assistance Person Months	Annex II.B.
Table 21.	Implementation Plan - Monitoring and Evaluation	Annex II.B.
Table 22.	Projected Number of Beneficiaries of CPP Project	Annex II.G.
Table 23.	Projected Number of Immediate Postpartum Family Planning Acceptors	Annex II.G.
Table 24.	Projected Number of Women Returning to CPP Centers	Annex II.G.
Table 25.	Projected Number of Women Accepting Family Planning at CPP Centers	Annex II.G.
Table 26.	CPP Project Expenditures by Fiscal Year (\$US)	Annex II.G.
Table 27.	CPP Project Summary Budget - GOJ Estimated Contributions	Annex III.B.
Table 28.	CPP Project Summary Cost Estimate - Local and Foreign Exchange Costs	Annex III.B.
Table 29.	Procurement Plan	

List of Figures

<u>Figure</u>	<u>Description</u>	
Figure 1.	Diagram of Jordanian Maternal and Child Health Service System	12
Figure 2.	Map of Jordan and CPP Sites	15A
Figure 3.	Ministry of Health Organizational Chart	Annex III.E.

List of Acronyms

A.I.D.	U.S. Agency for International Development, Washington, D.C.
CA	Cooperating Agency
CHC	Comprehensive Health Centers
CPP	Comprehensive Postpartum Project
CPPC	Comprehensive Postpartum Center
CTO	Cognizant Technical Officer
DPT	Diphtheria, Polio and Tetanus
FHS	Family Health Services Project - USAID/Jordan funded
GOJ	Government of Jordan
GUVS	General Union of Voluntary Services
IEC	Information, Education, Communication
IFB	Invitation for Bids
IPPF	International Planned Parenthood Federation
IPPI	Immediate Postplacental Insertion
IUD	Interuterine Device
JPFHS	Jordan Population and Family Health Survey, 1990
JAFPP	Jordan Association for Family Planning and Protection
JUH	Jordan University Hospital
LAM	Lactational Amenorrhea Method
MBS	Marketing of Birth Spacing Project
MCHs	Maternal and Child Health Clinic
MIS	Management Information System
MOH	Ministry of Health
MWRA	Married Women of Reproductive Age
NGO	Non-Governmental Organization
NPC	National Population Commission
Ob/Gyn	Obstetric and Gynecology Specialist
OR	Operations Research
PHC	Primary Health Center
PID	Pelvic Inflammatory Disease
RFP	Request for Proposals
RMS	Royal Medical Services
TFR	Total Fertility Rate
TOT	Training of Trainers
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development, overseas mission
WHO	World Health Organization

EXECUTIVE SUMMARY

JORDAN COMPREHENSIVE POSTPARTUM PROJECT

Background and Rationale for the Project

The population of the Hashemite Kingdom of Jordan is increasing rapidly. Between 1979 and 1990 it grew from 2.13 million to 3.45 million--an average increase of 4.3 percent annually. At this rate, the population can be expected to double in just 16 years. The adverse effects of this situation include a disturbing decline in per capita income, increasing unemployment and pressure on the country's finite natural resources, most particularly water for which demand already outstrips supply. The recent return of an estimated 300,000 Jordanians since the Gulf War has only exacerbated these problems.

In light of this situation, USAID/Jordan has adopted the reduction of fertility as one of its three strategic objectives. The goal of the Comprehensive Postpartum (CPP) Project is to reduce the prevailing high rate of fertility in Jordan and its purpose is to increase the number of women adopting effective contraceptive methods during and after the postpartum period. The total cost to USAID is \$11 million in DA/POP grant funds over five years. The project will be implemented through the Ministry of Health (MOH), Royal Medical Services (RMS), Jordan University Hospital, Islamic Hospital and selected nongovernmental organizations (NGOs).

The Government of Jordan (GOJ) has no formal population policy but supports birth spacing activities as a means of improving maternal and child health. This Project proposes to integrate family planning into maternal and infant health care for a "comprehensive postpartum approach." Not only is this an optimal approach in the Jordanian context but it reflects the lessons learned in AID-funded projects around the world that have implemented postpartum family planning.

The Project proposes to establish hospital-based Comprehensive Postpartum Centers where women will come for postpartum care and family planning services as well as for a check-up for the baby. These Centers will operate at 12 selected sites that, between them, cover about 48 percent of all births in Jordan (or 55 percent of assisted deliveries). Most of the sites will be in the public, rather than the private sector, because the bulk of deliveries occur there, the potential to increase contraceptive use is greater, and these hospitals need assistance more than most of those in the private sector. A hospital-based system was chosen because it promises to be effective in increasing contraceptive use by targeting women of proven fertility who, without contraception, are likely to become pregnant soon again. It should also be a cost-effective approach, after the relatively high initial start-up costs. This is because it reaches a large number of women at a small number of sites--namely the hospital where they deliver--avoiding the expense of integrating family planning into a large number of clinics around the country.

Anticipated Impact of the Project

It is estimated that, over the life of the Project, approximately 67,100 women will accept a modern contraceptive method and, by the end of the Project, at least 27,800 women per year will be doing so. Using The Futures Group's Target-Cost Model, an estimated 40,200 births could be averted over the five-year life-span of the Project. Contraceptive prevalence (modern methods only) can also be expected to increase--from 26.9 percent to an estimated 33.9 percent among currently married women. By the end of the Project, when services are fully operational, approximately 18,800 births per year could be averted through the 12 Project sites, i.e. over 15 percent of the 120,000 reported births in 1991. The total fertility rate is anticipated to decline from 5.6 to 4.9 children per woman.

The overall impact of the Project could be much greater than the aforementioned figures indicate. Both the training and information, education and communications (IEC) activities of the Project are designed to foster the integration of the comprehensive postpartum approach, especially family planning, into the Jordanian medical system beyond the Project sites. Moreover, these statistics do not take into account the potentially significant impact of the Project on maternal and infant health. For example, scientists project that if all Jordanian births were at least 24 months apart, the infant mortality rate would fall by 40 percent (or 4,000 infant deaths/year) and maternal mortality would drop by 29 percent.

Project Objectives and Project Description

The Project has two overriding objectives: to increase the availability of family planning services and to improve knowledge of effective contraception. However, the comprehensive postpartum approach dictates that family planning be offered as part of a constellation of selected maternal and child health services such as breastfeeding, infant care, and maternal health education, monitoring of the infant's growth and development, etc.

The CPP Project will have three core components: (1) service delivery; (2) training; and (3) information, education and communications. The first two components support the objective of making family planning services more available, while the IEC component emphasizes improving knowledge of contraception.

Under the **service delivery component**, facilities will be upgraded at 12 selected sites (6 MOH hospitals, 3 RMS hospitals, 1 university hospital, 1 NGO/charity hospital and 1 NGO clinic) to provide the appropriate space and equipment for comprehensive postpartum services and to make the CPP Centers attractive to users. Antenatal care at the participating facilities will be expanded to include routine information, education and counseling in family planning and the importance of postpartum follow-up care for both the mother and infant. Every woman delivering at the hospital will receive information to reinforce the antenatal educational messages and two appointments to return for postpartum care at the CPP Center. Women who received no antenatal care or who were not exposed to the CPP approach, will be targeted to receive more extensive information prior to

8

discharge. The CPP Centers will provide a constellation of postnatal care and family planning services to women and well-baby check-ups for their infants at the same time and in the same place, so that services are as convenient as possible to the user. There will also be a strong emphasis on counseling and education to make women aware of the benefits of family planning, to reduce the high rates of contraceptive discontinuation, to improve breastfeeding practices (both as a means of protecting women against pregnancy and as a means of improving infant health), and to address a variety of concerns that women have during the postpartum period.

The CPP Centers will be staffed by obstetricians-gynecologists (Ob/Gyns) and pediatricians--specialist care is highly prized in Jordan--nurses, midwives and health educators. The CPP Project will emphasize continuity of care from the maternal and child health (MCH) Center to the hospital, the Comprehensive Postpartum Center and back to the MCH center. This will be achieved through the development of a referral system which will have as its centerpiece an attractive medical record that will serve both as the medical record of the mother and child for health care providers and as an educational tool for the mother.

Programmatic research will be conducted to improve the quality and efficiency of service delivery and to assess the impact of the Project by measuring the knowledge, attitudes and practices of health care providers at the beginning and end of the Project. To this end, a number of studies will be undertaken on such selected topics as continuation, cost effectiveness and provider attitudes.

In general, the beneficiaries targeted by the Project include the 350,000 married women of reproductive age and the 125,000 children under one year of age in Jordan. It is not foreseen that any group will be adversely affected by the Project.

The Project's training component will not only train the obstetric and pediatric staffs of the 12 CPP Center hospitals in family planning, but will reach beyond them in an effort to ensure that the CPP concept is thoroughly integrated into the Jordanian medical system. The Project's training sites will be located in the country's major teaching hospitals so that residents will be rotated through the program, assuring that the CPP concept is carried on into the future. Training will cover medical family planning issues, as well as, management, counseling, education and a team approach to the provision of services. It is anticipated that 74 training courses will be provided for almost 1,200 persons over the life of the Project.

The IEC component will seek to inform the general public of the benefits of the new comprehensive postpartum approach and encourage effective contraceptive use. It will use the mass media backed up by interpersonal communications through community-based NGOs and other systems to make the public aware of the new services and to encourage utilization. It will also develop innovative materials that encourage women, in subtle ways, to seek regular care throughout pregnancy and into the postpartum period. The targeted beneficiaries of IEC activities are the 806,000 women and 856,000 men aged 15 - 49.

Project Implementation

The CPP Project will be implemented by a U.S. Prime Contractor, selected on a competitive basis, in collaboration with the Jordanian Ministry of Health, Royal Medical Services, Jordan University Hospital, Islamic Hospital and selected nongovernmental organizations. Project funds will cover technical assistance, training, IEC and research activities, equipment and materials, vehicles, the upgrading of facilities and contraceptive supplies.

The prime contractor will provide one long-term advisor, as well as medium- and short-term technical assistance and a Jordanian professional and support staff. It is anticipated that the Senior Jordanian Advisor will take over the management of the Project at the end of the fourth year. The Maternal and Child Health Directorate of the Ministry of Health and other participating Jordanian institutions will have major responsibility for the project implementation and will provide staff to the Project.

The CPP Project is the first to be developed under USAID/Jordan's new strategic objective of fertility reduction. It complements the existing Family Health Services and Marketing of Birth Spacing Projects' activities by targeting, at the hospital-level, pregnant women with family planning information and newly-delivered mothers with family planning information and services in order to reduce fertility.

Project Funding

Total costs of the CPP Project are expected to be \$11.0 million US dollars in DA/POP funds over the five year life of the Project. The following table provides a breakdown of project costs by activity.

TABLE 1.
CPP Project Summary Budget

Project Input	Amount
Service Delivery	4,175,448
Equipment	2,847,239
Training	1,091,558
IEC	1,010,915
Evaluation	200,000
Audit	250,000
Project Management	874,840
Contingency	550,000
Total	11,000,000

1. PROJECT BACKGROUND

1.1 Demographic Trends in Jordan

The Hashemite Kingdom of Jordan is experiencing rapid population growth. In 1979, the total population of Jordan was 2.13 million¹. By 1990, the population had increased to 3.45 million, an average increase of 4.3 percent annually.² At the current rate of growth, the population can be expected to double in just 16 years³. More than 80 percent of the population are concentrated in one-eighth of the total land area, due to rainfall patterns, methods of cultivation and the concentration of business and manufacturing in urban areas. The Jordanian population is highly urbanized with more than 70 percent of the population living in localities of more than 5,000 inhabitants. The cities of Amman, Zarqa and Irbid alone account for a full 40 percent of the country's total population.

The negative effects of rapid population growth and a high total fertility rate in Jordan (5.6 in 1990) have been heightened by the massive international migration which resulted from the Gulf War. Since 1991, an estimated 300,000 Jordanians (nearly 10 percent of the total population) have been repatriated from the Gulf States. This unexpected and large-scale return migration has exacerbated the already high unemployment rate caused by a weakened economy and has placed a heavy burden on public infrastructure and services.

1.2 Government of Jordan Policy on Population and Birth Spacing

The Government of Jordan currently has no formal national population policy. However, various activities and statements indicate increasing support for family planning services. His Majesty King Hussein has made several references to the relationship between population and development. At the Safe Motherhood Conference, the King explicitly referred to family planning and said, "We placed emphasis on education and training. Through them we sought to realize two things: First to enhance national awareness of family planning through education. Secondly, to help raise the rate of productivity in many areas by means of education and training." King Hussein further noted "... these achievements in education, health and family planning are not due to government efforts alone, the private sector had a supplementary role to play here."

In view of the present economic and demographic situation, the Government has made the reduction of population growth an important health program objective and a MOH statement issued in February 1992 identifies promotion of birth-spacing activities as one of

¹Department of Statistics, 1982.

²National Population Commission, 1991.

³Jordan Population and Family Health Survey (JPFHS), 1990.

10

its priorities. The first steps to provide birth spacing within the MOH system were taken in late 1987 and early 1988 with the training of a limited number of physicians and the equipping of some clinics.

In 1988, the GOJ reactivated the National Population Commission (NPC) and regularized the Commission's work by creating a General-Secretariat at the Queen Alia Fund under the patronage of HRH Princess Basma. Princess Basma has a keen interest and enthusiasm for viewing population as an integral part of the development process and particularly, the development of women. The NPC's reactivation substantiated the Government's commitment to demonstrating the impact of rapid population growth on national development goals to decision-makers and planners at all levels.

In 1990, the GOJ commissioned the Jordanian Population and Family Health Survey. The survey results demonstrated to skeptics that the families of Jordan want to plan their families; indeed, more than 50 percent of married women had already used a modern method of contraception. A national-level Directorate for Maternal Child Health, which includes family planning as a major activity, was created within the MOH in 1993. The Government also supports the family planning activities of NGOs, some of which have strong links with the Crown, such as the Queen Alia Fund, the Noor Al-Hussein Foundation and the Jordan Association for Family Planning and Protection (JAFPP), the local International Planned Parenthood Federation (IPPF) affiliate.

In April 1993, the cabinet formally endorsed a plan by the NPC to make birth spacing services available as an integral part of health services provided by government and NGO clinics.

1.3 USAID Strategic Objective

Fertility reduction has been selected by USAID/Jordan as one of its three strategic objectives because of the long term constraint on development posed by the current rapid population growth rate. Specifically, a reduced rate of population increase would directly reduce consumption demands including the growing burden on public infrastructure and services. In addition, fertility reduction affects the goal of broad-based and sustainable economic growth indirectly through its association with improvements in the health of the population, and consequently their productivity.

In order to reduce fertility, USAID is focusing on a single program outcome: the increased use of effective contraceptive methods. Three sub-program outcomes have been identified which will lead to this overall outcome. They are: (1) improved knowledge of effective contraceptive methods; (2) increased availability of higher quality family planning services; and (3) widened selection and range of prices of contraceptives in pharmacies. Collectively, these conditions are expected to bring about an increased use of effective contraceptive methods.

The CPP Project's three core components (service delivery, training, and IEC) will contribute directly to the Mission's fertility reduction Program Outcome by supporting two of three Sub-Program Outcomes. While the IEC component will support the Sub-Program Outcome of improved knowledge of effective contraceptive methods, the service delivery and training components will address Sub-Program Outcome No. 2, namely, of increasing the availability of higher quality family planning services. The third Sub-Program Outcome of widened selection and range of prices of contraceptives in pharmacies will not be addressed by the CPP Project. This will be addressed by the Marketing of Birth Spacing (MBS) Project. The Family Health Services (FHS) Project will complement the CPP Project efforts aimed at Sub-Program Outcome No. 2 by improving the quality and availability of higher quality family planning services at primary health care (PHC) centers.

2. PERCEIVED PROBLEM AND PROJECT RATIONALE

2.1 Perceived Problem

The central problem that the CPP Project is designed to address is the high fertility rate in Jordan. More specifically, the Project seeks to narrow the gap between women's actual and desired fertility preferences and raise the current low level of modern contraceptive use by increasing access to family planning information and services in hospitals during the postpartum period.

For a variety of sociocultural and economic factors, large families and short birth intervals have been the norm in Jordan. In 1990, the majority of Jordanian women (52 percent) considered the ideal family size to be at least 4 children. Of concern to family planning programs is the fact that 40 percent of the Jordanian women with five or more children exceeded their ideal family sizes, many by two or more children. Currently, the total fertility rate in Jordan is 5.6. However, desired fertility is estimated to be 3.9, if all unwanted births were prevented⁴. Half of all children are born less than 2 years apart. Such rapid succession of births is a serious health constraint to both mother and child; Jordan's high risk birth ratio exceeds 50 percent.

In part due to current domestic trends including the declining economic situation and rising unemployment, rapid urbanization and shortages of social services and natural resources (including water), many Jordanians are becoming more aware of the need to reassess their desired family size and to be more proactive with regard to the promotion and utilization of birth spacing. In fact, about half (47 percent) of currently married women in Jordan state that they do not want any more children; another quarter (25 percent) state they want to space their next pregnancy by at least two years.

⁴JPFHS, 1990, p. 74.

17

Virtually all (99 percent) of currently married women know about at least one modern method of contraception. Ninety-four percent also know a source for a modern method. Over half (51.7 percent) of all currently married women already have used one of the modern contraceptive methods. However, in spite of high levels of knowledge and ever use and the fact that three-fourths of all Jordanian women are interested in either spacing or limiting, only 26.9 percent of currently married women are using a form of modern contraception at the present time. Even in Amman, only 33.8 percent of women use a modern method. This gap may well be explained by two important factors. First, there are clearly widespread concerns about contraceptives. The MBS consumer survey found that 48 percent of Jordanian men and women thought that contraceptives have negative side effects and 25 percent thought they cause infertility. Second, many men oppose the use of family planning. The MBS survey indicated that 60 percent of women said that their partner would not allow them to practice contraception. The Jordan Husband's Fertility Survey (1985) found that nearly 40 percent of husbands stated that they did not believe in practicing contraception.

Yet, unmet need for family planning services is high in Jordan. Of currently married women, 23 percent are in need of a family planning method, either for spacing (8 percent) or for limiting (15 percent). Of the 40 percent of women using contraception (including the 5 percent who are using prolonged breastfeeding), 12 percent use it to delay their next birth, while 28 percent want to stop childbearing. An additional 4 percent of women have need of a better method, since the one they were using failed to protect them from pregnancy. Overall, the total demand for family planning among currently married women in Jordan is 66 percent. Jordan's unmet need (23 percent) is one of the highest in the world. By way of comparison, Tunisia's unmet need is 19 percent. Thailand's is only 6 percent.

In light of the high fertility rate, the desire of three-quarters of currently married women to either space or limit their families and the high levels of unmet need for family planning services, USAID/Jordan is committed to working with the Government of Jordan and the private sector to increase access to high quality family planning services at hospitals to enable Jordanian couples to achieve their desired family size through the use of effective family planning.

2.2 Project Rationale

Current family planning efforts in Jordan do not actively target pregnant and postpartum women to provide information, education, counseling and services in family planning at the hospital level. Consequently, such interval family planning service delivery programs repeatedly find women "currently pregnant" and therefore "ineligible". While recently delivered women are not deliberately ignored, for lack of prompt attention, they are repeatedly missed. In light of Jordan's high fertility rate, the lack of emphasis on family planning at hospitals during pregnancy, delivery and the postpartum period represents a significant lost opportunity.

In 1990, the majority of pregnant women (80 percent) received at least one antenatal checkup from trained health personnel. The median number of antenatal visits was 7.5. However, family planning information and counseling is not provided routinely to all pregnant women during antenatal visits, thus limiting informed and voluntary choice of an appropriate method during the postpartum period.

For 1991, MOH statistics show that of the 120,000 live births in Jordan, nearly 80 percent were delivered in hospitals: 69 percent in the 27 public sector hospitals (MOH-47 percent; Royal Medical Service-19 percent; Jordan University Hospital-3 percent) and 31 percent in the 27 private sector hospitals. In spite of high numbers of women delivering at hospitals, Jordan lacks a comprehensive obstetrical program; antenatal, delivery and postpartum care occur at multiple sites, do not follow standardized protocols and are not systematically linked within the public health system to insure continuity and quality of care throughout the maternal health continuum. Also, there is no routine discussion of the importance of birth spacing and family planning methods at the time of delivery to determine the woman's family planning intentions and needs. Education and guidance concerning postpartum maternal health care and exclusive breastfeeding also rarely occur at this time.

In spite of the high percentages of antenatal care and hospital deliveries, only a small number of women, roughly 6 percent, receive any postpartum care within MOH facilities. The main reasons for low utilization of postpartum care are the lack of comprehensiveness of postpartum services currently available at times, in places or in ways which suit women's needs and preferences and the minimal emphasis placed by health personnel on the need for women to seek follow-up care. Postpartum follow-up is important for general maternal and child health and is an optimal time to provide family planning education and counseling and to initiate the use of modern contraception. However, in Jordan, postpartum services are not standardized and do not routinely include information and counseling on family planning methods appropriate during the postpartum period including the natural contraceptive effects of exclusive breastfeeding for the first six months, i.e. the lactational amenorrhea method (LAM).

It is important to note that while women generally do not return for postpartum care for themselves, they do return with their children for well-baby care. For example, virtually all children (over 98 percent) receive vaccinations against DPT and polio and 9 in 10 children receive a measles vaccination during the first year of life⁵. The gap between the low utilization levels of postpartum services and the high use of infant follow-up care represents a major lost opportunity on the part of service providers to provide family planning and to monitor maternal health.

⁵JPFHS, 1990.

12

The CPP Project recognizes that mothers of newborns are interested in the well-being of the current baby, often at the sacrifice of their own health needs. Therefore, the Project is designed to capitalize on mothers' concerns for their children by simultaneously providing care for both the newborn and mother. Thus, monitoring of the growth and development of the infant, currently not routine in Jordan, will be stressed in the Project. Diarrheal disease remains an important problem in some governorates, such as Balqa and Karak, and in the urban squatter areas of Amman and Zarqa, and will also be stressed.

Hospital-based antenatal care will be upgraded through the CPP Project to routinely include education and counseling in family planning and modern contraception. Hospital delivery services also will be upgraded to reinforce the educational information provided during antenatal visits and to include the provision of postpartum family planning prior to discharge. The importance of postpartum care will be actively promoted and hospital services will be upgraded and expanded to routinely provide family planning education, counseling and services to postpartum women within the framework of health for both mother and child at the CPP Centers.

The CPP Project will include assistance to three Royal Medical Services military hospitals. Assistance is not of a military or paramilitary nature and only will consist of hospital facilities upgrading, CPP training, medical equipment and contraceptives; no salaries or other personnel support will be provided. General Counsel opinions have concluded that family planning activities which provide benefits to military personnel and their dependents are legally permissible and may be financed from DA/POP accounts (see Annex I.F. Royal Medical Service Rationale for Legal Determination.)

2.2.1 A.I.D. Population Assistance

The overall goal of A.I.D.'s foreign assistance program is sustainable development. Towards this goal, A.I.D. Administrator Brian Atwood has identified four areas of strategic focus for A.I.D. in the coming years: Population and Health, Economic Growth, Environment and Democracy.

According to the draft strategy paper on Population and Health, released by the Administrator in October 1993, A.I.D.'s "global population policy aims at the stabilization of the world's population at the earliest date at the lowest possible level. Specifically, USAID's goal is to contribute to a global effort that results in a total world population between 8 billion and 9 billion people by the year 2025, and less than 10 billion by the year 2050, with very low growth thereafter. Health policy aims at a halving of current maternal and child mortality rates and a 15 percent decrease in new HIV infections by the year 2000."

To achieve these goals, the strategy papers state that A.I.D. will concentrate its population and health programs on two types of countries:

- countries that contribute the most to global population and health problems;

- countries where population and health conditions impede sustainable development;

Countries in the latter category are characterized by high fertility and population growth rates that outstrip the country's ability to provide adequate food and social services; threaten the environment; and impede the ability of adults, particularly women, to produce and participate in the sustainable development effort.

Jordan, clearly, falls in the latter category of countries with a total fertility rate of 5.6 per cent and an average annual increase in population of 4.3 per cent between 1979 and 1990 - - one of the highest rates in the world. At this rate, Jordan's population will double in 16 years -- a prospect with perilous consequences for economic, social, and political stability of the country and the Region, considering that the current population is already pushing the country's resources to the breaking point.

The CPP project will contribute directly to the A.I.D.'s global population objective of reducing world population growth rates and stabilizing world population at the lowest possible level. Not only will the CPP project reduce substantially the present high rate of fertility and population growth in Jordan, its focus on providing women family planning education and services during pregnancy and the post partum period, and on integrating mother and child care services at CPP centers, also will contribute to significant reductions in maternal and child mortality. Additionally, by encouraging women to practice birth spacing and by preventing unwanted pregnancies, the CPP project will free women to participate in the economic development and democratic processes -- a major objective of A.I.D. in the Economic Growth and Democracy strategic areas.

2.2.2 Other Donor Assistance

The World Bank, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and the International Planned Parenthood Federation (IPPF) are the other donors active in Jordan at the present time in population and family planning assistance.

The World Bank is currently working with the Government of Jordan and Ministry of Health on a project designed to enhance the health status of the population through a comprehensive health sector reform program that includes a massive reorganization of the Ministry of Health, including management, finances and planning departments, and a public sector hospital "rehabilitation" program to strengthen MOH hospitals and to reduce recurring costs. The project has five components: service upgrading of both hospitals and PHC services; facilities improvement (MOH hospitals); reorganization and management; financing and cost recovery; and long-term planning. Under the Bank Loan Agreement, improvement of PHC services, including the integration of FP/MCH services is to be funded by other donor agencies, such as USAID. Thus, the Bank program in Jordan concentrates on health sector reform and improvement of hospital and emergency services.

13

UNFPA, active in Jordan since 1976, seeks to enhance national efforts towards self-reliance based on a well-established balance between population and resources within the context of sustainable development. Notable examples of UNFPA activities include: full scale support to the 1979 population and housing census, the establishment of the Population Studies Program at the University of Jordan, projects to support regional planning and women in development. Currently, UNFPA plans to provide direct support to medical and paramedical training (revision of curricula and introduction of safe motherhood and family planning elements into the curricula) with some technical assistance, support to the MOH in introducing injectables and Norplant in selected hospitals, expansion of NGO involvement and support to IEC.

UNICEF programs are heavily focused on broad-based maternal and child support. As part of this focus, UNICEF has set the following as priorities for its safe motherhood activities in Jordan:

- Upgrading quality of care at MCH centers through the provision of continued training to medical and para-medical staff;
- Raising the awareness of mothers regarding the importance of proper antenatal and delivery care, so as to encourage them to make better use of existing facilities;
- Raising awareness of the strong link between high fertility, short birth intervals and infant and maternal mortality, so that the already high level of contraceptive knowledge is translated into higher rates of contraceptive usage.
- Promoting the family planning services which are available in MCH centers.

In 1992, UNICEF sponsored the Safe Motherhood Campaign to create demand for use of MCH centers by informing the public of the services available there. One spot on birth spacing was developed and aired. UNICEF is also working to promote "Baby Friendly Hospitals" and exclusive breastfeeding.

The International Planned Parenthood Federation (IPPF) provides support to the Jordanian Association for Family Planning and Protection (JAFPP), their local affiliate, to extend and expand services to meet the increasing demand for family planning while improving the quality of care. Currently, JAFPP provides one-third of the modern contraception in Jordan through their family planning clinics, which are staffed completely with female service providers. JAFPP also receives assistance from USAID to expand the number of clinics and to improve the quality of existing services.

The CPP Project thus complements the activities of the other major donors in Jordan. The CPP Project will work collaboratively with other donors on areas of mutual interest concerning breastfeeding, family planning and maternal health, as appropriate.

3. PROJECT GOAL, PURPOSE, ACHIEVEMENTS AND IMPACT

3.1 Goal and Purpose

The **goal** of the CPP Project is to reduce the prevailing high rate of fertility in Jordan. The Project **purpose** is to increase the number of women initiating and sustaining use of effective contraceptive methods during and after the postpartum period. To achieve this purpose, the CPP Project will establish comprehensive postpartum service delivery sites at selected hospitals; provide technical assistance to train service providers at the identified hospitals in family planning information, education, counseling during the antenatal and postpartum periods and in postpartum family planning service delivery; and develop information, education and communication material emphasizing maternal health and child spacing.

3.2 Achievements

The following end-of-project achievements for the CPP Project have been identified by the PP design team:

- Comprehensive Postpartum Centers will be established in up to 9 government hospitals (including MOH and RMS), 1 university hospital and up to 2 in the NGO sector to provide comprehensive postpartum and family planning services.
- Standardized guidelines, checklists and IEC materials for antenatal, delivery and postpartum education, counseling and service delivery will be developed.
- A standardized system of communication/feedback between primary, secondary and tertiary health care units will be developed to allow for increased continuity of care during the antenatal, delivery and postpartum periods.
- Up to 300 OB/GYNs, at least 240 pediatricians, 320 nurses, 280 midwives, 20 health educators and at least 1 manager per Center will be trained in family planning service delivery, counseling, health education and management.
- Standardized messages and informational brochures to be given to women concerning breastfeeding/LAM, maternal nutrition, family planning and maternal health care will be developed. Twenty-five mass media messages concerning the interrelationship of maternal and child health and nutrition, with emphasis on the value of birth spacing will also be developed

It is estimated that, over the life of the Project, approximately 224,600 women will have benefited directly from its services, at a minimum by having received information, education and materials about family planning at the 12 project sites. It is anticipated that, at each site, 35 percent of women delivering will return for postpartum care in the first year, rising to 60 percent by the fourth year. Applying this formula, approximately 115,500 women could be expected to return for postpartum and infant care over the life of the project. Furthermore, it is estimated that about 67,100 women will accept a modern contraceptive method at the project sites, either while they are in the hospital for delivery or when they return for a postpartum check-up. This figure is based on five percent of women who deliver at these sites accepting a modern method immediately postpartum in the first year of operation at each site, rising to 20 percent in the fourth year; and 30 percent accepting a method at the CPP center in the first year, rising to 50 percent in the fourth year.

Using the Target-Cost Model and the above estimates of utilization and contraceptive acceptance, it is estimated that a total of 40,200 births could be averted over the life of the project. By the end of the project, approximately 18,800 births per year would be averted through the 12 project sites alone, amounting to over 15 percent of the 120,000 reported births in 1991. Contraceptive prevalence (modern methods only) could be expected to increase--from 26.9 percent to an estimated 33.9 percent among currently married women--and the total fertility rate could decline from 5.6 to 4.9 per woman. This would be a major step toward Jordanian women's desired fertility of 3.9 children per woman.

The figures above reflect only the impact of services provided at the 12 Project sites. However, through the Project's training and IEC activities, it is anticipated that the concept of comprehensive postpartum care will be integrated into the standard medical practices of the Jordanian health system, thus significantly increasing the project's overall impact.

A more in-depth discussion of impact and the methodology used for the calculations on postpartum visits and contraceptive acceptance are included as Annex II.G.

4. CPP PROJECT DESCRIPTION

The maternal health care system in Jordan is highly fragmented. Antenatal, delivery and postpartum services are provided by multiple parties and women frequently utilize services from more than one provider and from both the public and private sectors during any given pregnancy and for subsequent pregnancies. During the antenatal period, there are three possible sources of care for pregnant women: public and private sector hospital Ob/Gyn outpatient clinics for women who live in the hospital's catchment area or who were referred due to high risk status; MCH/PHC Centers; and independent private sector physicians and clinics. A number of women receive no antenatal care. For delivery, the majority of women deliver in a public or private hospital. Little postpartum care is available anywhere within the health system. Referral, linkages between service delivery units and information flow

are not systematic making continuity of care impossible. The CPP Project with its hospital focus seeks to improve the continuity, quality and comprehensiveness of maternal care, with special emphasis on family planning and postpartum care. See Figure 1 for a diagram showing the existing system for ante-natal care, delivery assistance, and post partum care. While 80 percent of all deliveries take place in hospitals only six percent of the women receive any post partum care.

4.1 Project Overview

While the emphasis of the CPP Project is on postpartum family planning, the Project's hospital-based activities are designed to incorporate comprehensive pregnancy care, counseling and services into all three phases of medical care associated with women's reproductive health during childbearing: 1) antenatal care; 2) delivery; and 3) postpartum follow-up.

Antenatal care at the medical facilities with CPP Centers will be strengthened to provide information, education and counseling on pregnancy care, birth spacing and postpartum follow-up care for both the mother and infant. Prior to delivery, all women will be referred from the antenatal clinic to the CPP Center for one or two appointments in order to meet the staff, to receive an overview of the family planning services available at delivery and during postpartum check-ups and to register ("book") the upcoming birth with the Delivery Ward.

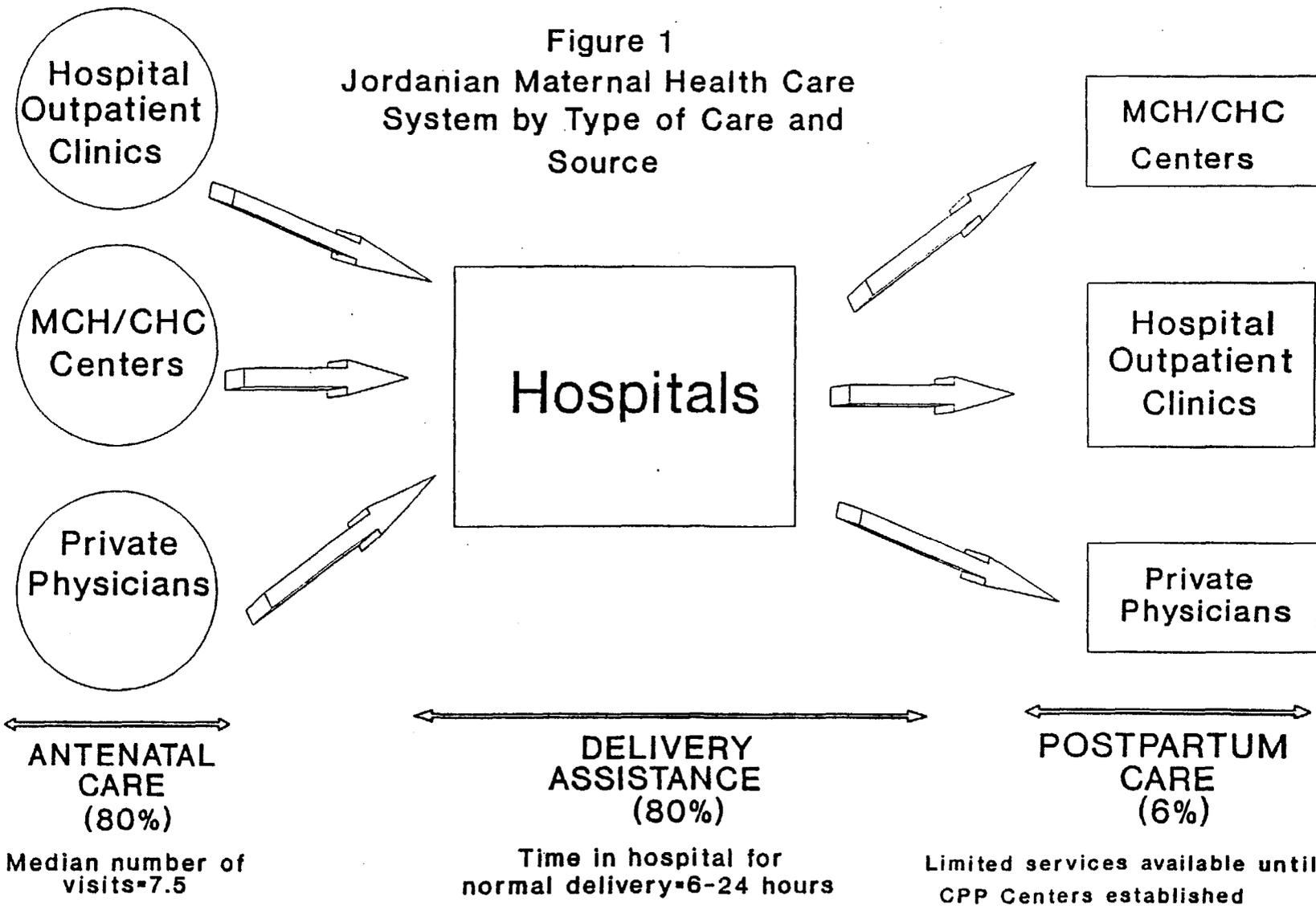
Every woman delivering at CPP Project hospitals will receive information while in the hospital to reinforce the antenatal educational messages. Two appointments to return to the CPP Center for postpartum care will be scheduled and their importance emphasized to the woman and her family. Women who received no antenatal care and thus were not exposed to the CPP approach, will be targeted to receive more extensive information prior to discharge.

During the two postpartum check-ups, the CPP Centers will provide a constellation of postnatal care and family planning services to women and well-baby check-ups for their infants, so that services are as convenient as possible to the user. All women will receive health education both on an individual basis and in group sessions on such topics as the benefits of birth spacing, modern contraceptive methods, breastfeeding, postpartum depression, breast-self examination, infant care, etc.

During the postpartum visit, both the mother and infant will be examined by the Center medical specialists. For example, mothers will receive episiotomy checks, pap smears and breast exams. A range of family planning methods that do not interfere with lactation will be available to meet the individual woman's needs (IUDs, combined and progestin-only pills, injectables and condoms). Infants will be monitored for growth and development and perhaps receive a zero-dose of polio. Mothers will receive instruction in the prevention and management of common childhood diseases such as diarrhea.

51

Figure 1
Jordanian Maternal Health Care
System by Type of Care and
Source



NOTE: Percentages indicate women currently receiving health care by type of service.

The need for regular follow-up care for both mother and child will be emphasized (i.e. yearly check up for the IUD and pill, etc.). After the second postpartum appointment, the CPP Center will refer women back into the mainstream health system where such care is offered (MCHs, CHCs, JAFPP, outpatient clinics, etc.).

The CPP Project consists of three main components:

- **Service delivery** - to upgrade facilities and establish Comprehensive Postpartum Centers, to integrate postnatal care, family planning, infant health care and health education into the services provided at the selected sites, and to conduct limited programmatic research to incrementally improve the quality and efficiency of services.
- **Training** - to train the staffs at the selected sites in family planning service delivery, counseling, management techniques, health education and other topics.
- **Information, education and communications (IEC)** - to develop materials for distribution to service providers and clients and to educate the public about the benefits and the availability of the new postpartum services.

4.2 Service Delivery Component (\$5,006,694)

The service delivery component of the Project will develop and implement a comprehensive postpartum service delivery system, establish CPP Centers, and conduct programmatic research.

4.2.1 Service Delivery Subcomponent 1: CPP Service Delivery System

Among the first tasks of the CPP Project will be the establishment of comprehensive postpartum service delivery guidelines and a records/information system for the CPP Centers, as well as a system of referral to link the CPP Center services with the existing health care system.

As no universal standards or approved guidelines exist in Jordan for antenatal, delivery and postpartum care, the CPP Project will, in close cooperation with the Ministry of Health, develop minimum standards for maternal and infant health services and family planning education, counseling and service delivery. To this end, the Project will sponsor a consensus conference for key medical personnel from the MOH, RMS, NGO and private sector. The conference will outline the general concepts associated with the CPP approach, address a range of topics including medical barriers to family planning services in Jordan, contraceptive technology updates, management and programmatic issues, as well as the results of focus group research with women concerning their needs and satisfaction with antenatal, delivery and postpartum care. Working groups will discuss protocols and standardization of guidelines for antenatal visits (including timing and frequency of visits, medical examination procedures and laboratory tests, education and counseling, etc.),

14

delivery procedures (duration of stay, rooming-in, breastfeeding information, provision of immediate postpartum family planning, etc.) and postpartum visits (timing and frequency, medical examination components for mother and infant, education and counseling and family planning, etc.).

To ensure quality and continuity of care between the various sources of maternal health care, the CPP Project will develop and implement a referral system to link women from their source of antenatal care to the hospital for delivery, then onto the CPP Center for postpartum care and finally back to their usual source of medical care. To facilitate the flow of information concerning the client's medical history between service sites, a unique maternal and child health booklet will be developed. The health booklet will contain information concerning the woman's reproductive history, family planning use and her children's growth and development. The health booklet will also serve as a reminder of the care that the woman and her infant need and when/where to receive it.

A standardized computer information system (IS) system will be designed for the CPP Centers to serve three purposes:

- 1) to schedule and track future CPP Center appointments and to provide lists both of women who do not return for their appointment for follow-up purposes and of women referred back out to the various MCH Centers;
- 2) to store selected information on client medical and family planning histories for use by the Center health educator and medical staff in providing education and services tailored to an individual woman's needs;
- 3) to compile Center usage and family planning acceptance data into summary tables useful both for decision-making and planning by Center managers and hospital administrators, as well as meeting the reporting requirements of the Project.

It is recommended that the computerized system currently in use at Al-Sareeh Comprehensive Health Center in Irbid be adapted for use at the CPP Centers.

4.2.2 Service Delivery Subcomponent 2: Facilities Upgrade

Twelve sites have been selected to develop Comprehensive Postpartum Centers as part of their outpatient clinics, including 9 public sector hospitals, 1 university hospital, 1 charity/NGO hospital and 1 NGO clinic. Approximately half of the 120,000 births per year will benefit from the CPP Project through the twelve Centers. Criteria for selection of sites was as follows: 1) number of deliveries per year; 2) currently existing outpatient clinics; 3) potential to provide on-site training to medical and nursing students and residents; 4) political will and commitment to voluntary and informed birth spacing; 5) feasibility, particularly as it relates to hospital resources (i.e. staffing and space) and client demand; and 6) potential "multiplier" effect. Table 2 provides a list of the sites selected for

participation in the CPP Project. See Figure 2 for a map of Jordan indicating the geographic location of the selected sites.

The sites participating in the CPP Project will receive assistance to modify their existing outpatient clinic facilities and delivery ward procedures to focus on the special needs of postpartum women and their infants. The upgrading of the eleven hospitals and one clinic will be phased over a three to six month periods. The hosting facility will provide the space and staffing for the Center. The CPP Project will provide partitions, paint, plaster, clinical and other equipment necessary to upgrade the space. For more detailed information concerning facility upgrading, see Annex II.C.

Each CPP Center will consist of two or more examining rooms in which both mother and baby will receive their care as an Ob/Gyn and a pediatrician rotate in to see their respective patients. Examining rooms will be outfitted with the basic medical equipment necessary to provide preventive maternal and child health care. For detailed information concerning equipment see the Procurement Plan, also in Annex II.C.

TABLE 2
CPP Project Sites by Start-up Phase

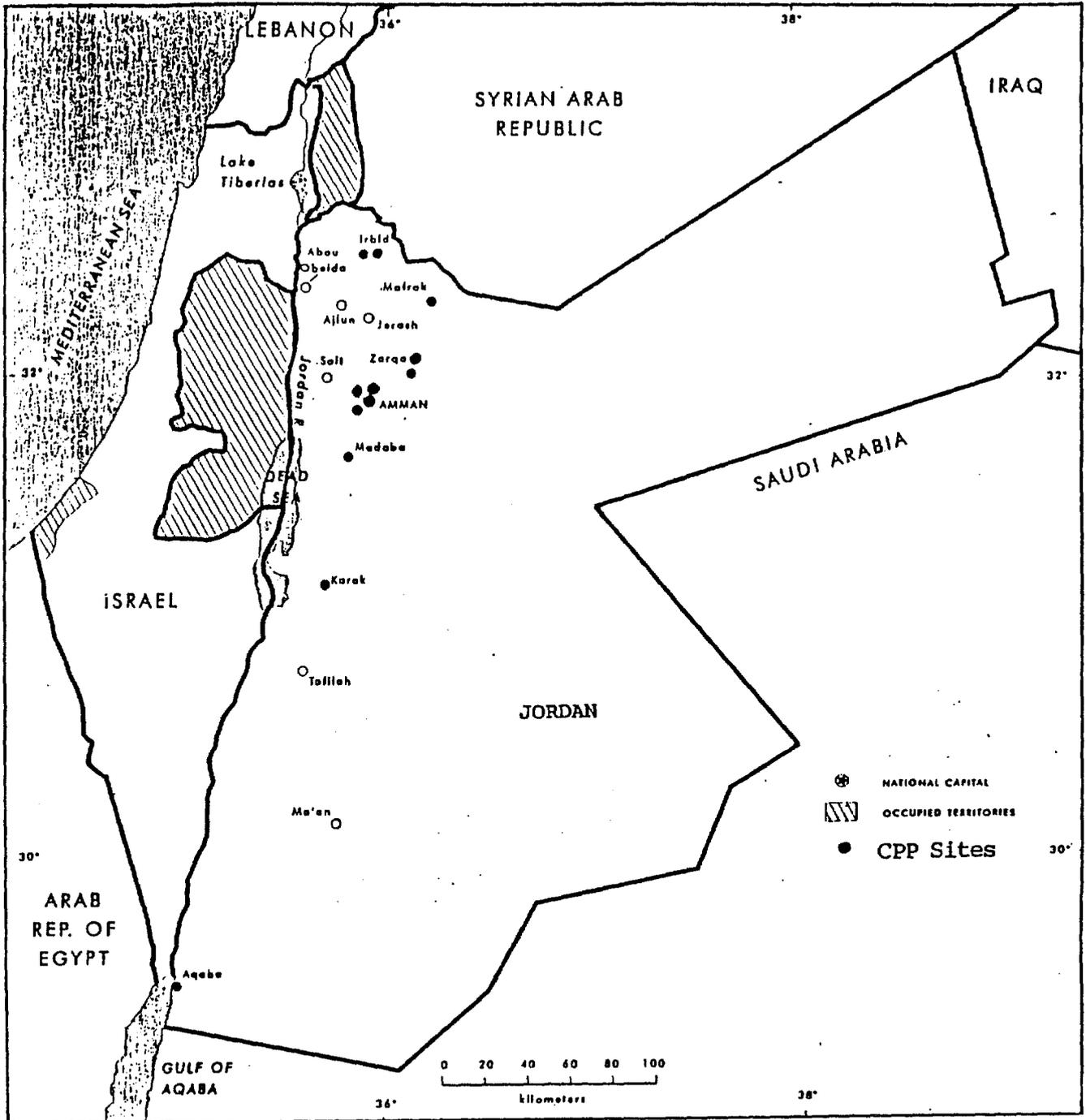
Start-up Phase	Service Channel	Hospital Name and Location	Number of Deliveries**
Phase I	MOH	Al-Bashir Hospital - Amman	10,521
	RMS	King Hussein Medical Center - Amman	4,158
	UNIV	Jordan University Hospital - Amman	2,732
	NGO	Islamic Hospital - Amman	9,600
Phase II	MOH	Princess Basma Hospital - Irbid	8,733
	RMS	Military Hospital - Irbid	6,607
	MOH	Karak Hospital - Karak	1,656
	RMS	Princess Hayya Hospital - Aqaba	1,972
Phase III	NGO	Soldier's Welfare Society - Zarqa	0
	MOH	Zarqa Hospital - Zarqa	3,937
	MOH	Mafraq Hospital - Mafraq	3,311
	MOH	Madaba Hospital - Madaba	2,335

**Based on 1992 MOH Statistics.

17

Figure 2.
Map of Jordan and CPP Sites

IBRD 24383



DECEMBER 1992

For hospitals without adequate space for a separate CPP Center, the outpatient pediatric and gynecology clinics will work closely together to ensure that mother and baby can be seen on the same day, thereby increasing access for mothers who would not normally take the time to return on a different day for their own care. This close coordination between the two clinics will create a CPP Center "in spirit."

4.2.3 Service Delivery Subcomponent 3: CPP Center Staffing

The staffing of the CPP Centers will be critical to ensure effective provision of the comprehensive postpartum services. Without regular, full-time staff in each of the identified categories, the Centers' capacity to provide the full range of education, services and individualized attention to the woman and her child will be compromised. At a minimum, each CPP Center should at least have the following six types and quantities of full-time staff:

- 1) One Ob/Gyn to examine postpartum women and provide family planning. Where possible, the Ob/Gyn specialist should be a woman, as women clients are more comfortable discussing family planning and women's health issues with women service providers.
- 2) One pediatrician to examine the infant and monitor its growth and development.
- 3) Two nurses (one per specialist) to assist in the examining room, to assist in the day to day activities of the Center and to answer any questions the client may have.
- 4) One health educator to work exclusively to educate and counsel clients, either individually or in groups. The health educator will also spend a portion of her time planning and coordinating educational outreach activities and follow-up for clients who miss their appointments.
- 5) One receptionist/secretary to greet clients and provide appointments, make follow-up phone calls to women with telephone service who miss their appointments, manage the medical records system and use the Center computer.
- 6) One manager to coordinate the Center's day to day activities, including training and education, with other units within the hospital, schedules and supervises staff, oversees that Center standards are met and procedures followed, completes project reports, and reorders contraceptives and other supplies.

All Center staff members will be expected to work in close collaboration with each other and operate as a team. Regular staff meetings will be held to discuss issues, monitor progress, discuss problematic cases and any other pertinent issues. Staff for the Center should be carefully selected not only for their professional credentials but also for their personality. The specialists and the health educator should all be committed to the concept of unitary care for the mother and child, be outgoing, have excellent interpersonal skills and

be able to provide client-focused care. A quality assurance system will be developed and implemented all the CPP Centers.

Prior to the grand opening of the CPP Center, all staff members will participate in the training courses necessary to function in their new roles within the Center. See Training Component Section 4.3 for further details.

4.2.4 Service Delivery Subcomponent 4: Programmatic Research

The Project will support approximately seven programmatic research or research-related subprojects to assist the various CPP Centers implement their activities. In the form of studies and technical assistance, the programmatic research subcomponent will strive to increase access to and improve the quality of information and services delivered through the Project. Studies that address relative cost issues and assist in the evaluation of the overall Project may also be undertaken.

Because the research component must be flexible to aptly meet the CPP's service delivery, training and IEC needs, the exact nature and approach of the studies will be determined later. Research topics will be chosen based on their relevance and potential impact on the CPP's access, quality, and cost-effectiveness. For discussion of possible topics, See Annex II.G. All research activities will be undertaken by the Prime Contractor or Sub-contracted to qualified U.S. and Jordanian institutions.

Both quantitative and qualitative research methodologies will be used in carrying out research activities, including diagnostic studies; baseline studies; knowledge, attitudes and practice (KAP) surveys; and service facility surveys; focus groups, in-depth interviews, and observational studies; time-series analyses; and quasi-experiments.

The dissemination and utilization of research results by program managers, service providers, policy-makers, and USAID/Jordan will be emphasized throughout the Project.

4.2.5 Service Delivery Component Management

Five different service channels will be involved in the implementation of the CPP Project. The MOH will establish CPP Centers at 6 hospitals and the RMS at 3 hospitals. Jordan University Hospital, Islamic Hospital and the Soldier's Welfare Society will establish 1 Center each at their respective facilities. The service channel and the hospital/clinic will contribute the physical space required to establish a Center. The Prime Contractor will coordinate directly with the service channel and hospital administration on a site by site basis to design and renovate the facilities and provide any necessary medical equipment to upgrade the site to meet the Project standard.

The primary responsibility for the actual delivery of comprehensive postpartum services lies with the hospital or clinic where the CPP Center is located and ultimately with the service channel operating the hospital/clinic. Each service channel will appoint a Project Director responsible for Project implementation and coordination with the Prime Contractor. The service channel and the hospital/clinic are responsible for selecting, assigning and funding the salaries of the appropriate types and numbers of full-time staff for the CPP Center. Contraceptives will be provided by USAID through the Prime Contractor. The Center Manager appointed by the hospital/clinic will have responsibility for the day-to-day operations of the Center. Ongoing monitoring and supervision of the Center, its staff and activities will be the joint-responsibility of the Prime Contractor's Project staff and the Director appointed by the respective channel (MOH, RMS, JUH, Islamic Hospital or Soldier's Welfare Society).

The Prime Contractor will coordinate closely with the MOH to plan and conduct the consensus conference and to develop and approve the CPP guidelines, protocols and referral system. The Prime Contractor will work with the Jordan University of Science and Technology (JUST) to adapt their computerized medical system from Al Sareer Comprehensive Health Center for use in the CPP Centers. The Prime Contractor will be responsible for coordinating with each service channel the planning and implementing of any programmatic research activities. Dissemination of results will rest jointly with MOH and the Prime Contractor's Project staff.

4.2.6 Service Delivery Budget

The following table provides information concerning the budget for the service delivery component of the CPP Project. For a more complete breakdown of service delivery costs, see the tables in the Financial Analysis, Annex III.B.

**Table 3.
Summary Service Delivery Budget**

Item	Amount
Technical Assistance	2,776,282
Contraceptive Commodities	591,020
Equipment and Supplies	744,682
Facilities Upgrade	288,931
Programmatic Research	568,108
Other	37,671
TOTAL	5,006,694

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4.3 Training Component (\$1,597,096)

Training is an essential component of the CPP project. In general, the specialized medical staff at Jordanian hospitals have good clinical skills. However, few of them have received any in-depth training in family planning, especially methods appropriate for the postpartum period. Additionally, counseling skills and a client-centered perspective are not widespread. The training component is thus designed to provide medical staff with the knowledge and skills to add postpartum family planning to the services they currently provide and discuss with their patients. Table 4 provides an overview of the CPP Project training plan, including the types and numbers of staff to be trained, the areas in which they will receive training, the number of days per trainee and the total number of person months necessary to train all targeted training recipients. Table 4 also provides a breakdown of training by subcomponent: 1) in-country; and 2) out-of-country.

At the sites where CPP Centers will be established, training will be provided for all obstetrical and pediatric staffs and their residents, as well as, for the nursing and midwifery staffs who support antenatal, delivery, postpartum and newborn services. In all, approximately 75 CPP training courses for 1200 hospital staff members will be provided through the Project. Table 5 provides a breakdown of the estimated number of training courses over the life of the project by service channel. Due to the high level of staff turnover at MOH facilities, the exact numbers of people to be trained cannot be specified precisely. Table 6 gives an overview of the estimated number of hospital staff to be trained by staff type and service channel. Table 7 provides training estimates by project year and staff type. The level of turnover at MOH facilities will be reduced through necessary agreements with heads of facilities to keep staff in place for a specified period of time after their training.

In addition to the training described above, the Project will work also with medical and nursing schools to ensure the CPP approach is integrated into the curricula for medical and nursing students. The Project will also arrange opportunities for students to receive on-site orientations to the comprehensive postpartum approach at the CPP training sites during years 3, 4 and 5.

4.3.1 Subcomponent 1: In-Country Training

Five sites for in-country CPP training have been identified: Al-Bashir and Princess Basma Hospitals for the Ministry of Health, King Hussein Medical Center for the Royal Medical Services, Jordan University Hospital and the Islamic Hospital. Each will provide training on-site at the CPP Center in order to demonstrate the effectiveness of comprehensive postpartum services and the concurrent care of mother and infant and to provide practical hands-on experience.

TABLE 4.
CPP Project Training Plan

Staff Category	NO.	Field of Training	# Days	P/M
In-Country Training				
CPP Trainers	30	1. Family Planning Trainers Training	6	5.00
Ob/Gyns	312	1. CPP Concept 2. Family Planning - Theory 3. Family Planning - Clinical 4. Counseling/Client-centered Approach	18	234.00
Pediatricians	246	1. CPP Concept 2. Family Planning - Theory 3. Infant Check-up Refresher 4. Communications/Client-centered Approach	18	184.50
Midwives	286	1. CPP Concept 2. Family Planning - Theory 3. Counseling/Client-centered Approach	12	143.00
Nurses	320	1. CPP Concept 2. Family Planning - Theory 3. Counseling/Client-centered Approach	12	160.00
CPP Health Educators	24	1. CPP Concept 2. Family Planning - Theory 3. Counseling/Client-centered Approach 4. Health Education Techniques	12	12.00
CPP Managers	12	1. CPP Concept 2. Management/Team Building 3. Family Planning Records Management 4. Computerized CPP Information System	6	3.00
Records Managers (Receptionist)	12	1. Family Planning Records Management 2. Computerized CPP Information System 3. Communications/Client-centered Approach	6	3.00
NGO Staff	85	1. CPP Concept 2. Family Planning Outreach Techniques	1	3.50
MOH Project Staff	4	1. CPP Concept 2. Management/Team Building 3. Computerized CPP Information System	12	2.00
MOH Health Educators	40	1. CPP Concept 2. Family Planning Outreach Techniques	9	15.00
MOH/HED	2	1. Advanced IEC Materials Development	6	.50
Out-of-Country Training				
Ob/Gyns	10	1. IPPI IUD Insertion Techniques (Turkey)	10	4.00
	4	2. NORPLANT (Tunisia/Indonesia)	15	3.00
	15	3. CPP Study Tour (Tunisia/Mexico/Thailand)	7-14	5.00
MOH/HED Director	1	1. IEC Program Management (USA)	25	1.00
TOTAL				778.50

TABLE 5.
CPP Project Training for Hospital Staff
Estimated Number of Training Courses

Service Channel	Year 2	Year 3	Year 4	Year 5	TOTAL
MOH	10	13	4	4	31
RMS	10	6	3	3	22
University	5	3	3	2	13
Islamic	5	1	1	1	8
Totals	30	23	11	11	74

TABLE 6.
CPP Project Training for Hospital Staff
By Staff Type and Service Channel

Service Channel	Ob/Gyn	Pediatrician	Nurse	Midwife	Health Educator	TOTAL
RMS	85	58	102	99	8	352
MOH	144	104	125	115	12	502
University	52	56	58	40	2	208
Islamic	31	28	35	32	2	128
Totals	312	246	320	286	24	1188

TABLE 7.
CPP Project Training for Hospital Staff
By Staff Type and Project Year

Year	Ob/Gyn	Pediatrician	Nurse	Midwife	Health Educator	TOTAL
2	124	111	123	102	24	484
3	102	63	98	105	-	360
4	43	36	52	45	-	176
5	43	36	47	34	-	160
Totals	312	246	320	286	24	1188

The first training program provided by the project will be in management for the MOH Project Director and staff and the medical and nursing directors from each of the five training sites. The CPP approach, constellation of services, curriculum and training methodology will be reviewed and finalized. This will then become the basis for the subsequent training courses.

At each training site, selected senior hospital staff will participate in a training of trainers course. The training of trainers course will use new approaches to health and family planning education, and emphasize quality of care as measured by the information given to clients, range of choice, professional competence, interpersonal relations, the constellation of available services and follow-up. Adult learning theory and modern teaching methodologies, such as experiential learning, group exercises and role plays, will be used. Special emphasis will be placed on setting goals and measurable learning and behavioral objectives.

After completion of the TOT course, the trainers will begin offering in-service training at their respective training site to small groups of hospital staff including those assigned to the CPP Center, the pediatric and Ob/Gyn outpatient clinics, and the Delivery Ward. The first phase of in-service training will be for staff based at the facility where the training site is located. Staff from other hospitals where CPP Centers will be established in the same channel (MOH, RMS, etc) will receive training during subsequent phases.

4.3.2 Subcomponent 2: Out-of-Country Training

In addition, the Project includes limited out-of-country training of three types: 1) clinical training for selected Ob/Gyn Trainers in new contraceptive techniques, i.e. Norplant in Tunisia or Indonesia and Immediate Postplacental IUD Insertions in Turkey; 2) IEC program management training for the MOH Head of Health Education in the USA; 3) study tours of successful postpartum projects for selected Project Staff and Ob/Gyns in Tunisia, Mexico or Thailand. Third country training is designed to provide Jordanian medical personnel exposure to selected highly successful USAID-funded family planning projects and clinical training centers in other parts of the world.

4.3.3 Training Component Management

In order to train and provide follow-up for the hundreds of doctors, nurses, midwives and health educators identified to participate in the CPP training, the Prime Contractor will engage a team of training consultants to assess training needs, develop the training curricula and course materials, train the trainers, and monitor/evaluate subsequent training. The training team should include a senior internationally known obstetrician skilled in the provision of modern contraceptives, counseling, quality of care standards and training methodology, a senior Jordanian obstetrician familiar with Jordanian medical training institutions and an expatriate or Jordanian nurse skilled in counseling and conversant with modern educational techniques. The team will work in close collaboration with CPP

21

Technical Advisor, the MOH Directorates of MCH and Education and Training and the 5 training sites.

The TOT courses will be scheduled by the prime contractor and the training team, in consultation with the Ministry of Health and the various service channels. Responsibility for subsequent training at the 5 training sites will rest with the service channel and its trainers. The training team will monitor the progress of each site and report directly to the CPP Technical Advisor.

4.3.4 Training Budget

The following table provides information concerning the budget for the training component of the CPP Project. For a more complete breakdown of training costs see the tables in the Financial Analysis, Annex III.B.

Table 8.
Summary Training Budget

Item	Amount
Technical Assistance	543,770
In-country Training	550,101
Out-of-country Training	265,680
Equipment and Supplies	237,545
TOTAL	1,597,096

4.4 Information, Education and Communications Component (\$2,146,537)

The IEC component is the CPP Project's primary means of achieving the Mission's goal of reducing fertility by improving knowledge of effective contraception (Country Program Statement, Sub-Program Outcome 3.1.1). IEC is also an essential element of successful postpartum projects elsewhere in the world. Experience in Lebanon, Peru and Mexico, for example, has shown that contraceptive acceptance increases dramatically when strong IEC programs are implemented, particularly programs with a solid interpersonal communications component.

The three primary objectives of the IEC component are:

- To educate pregnant women and new mothers about the benefits of birth spacing and the safety and efficacy of contraception;

- To encourage pregnant women and new mothers to adopt an effective contraceptive method at the time of delivery or postpartum; and
- To promote effective contraceptive use by couples who adopt a method.

The IEC component of the CPP Project has three subcomponents: health education; mass media; and outreach as outlined below and described in more detail in Annex II.E.

4.4.1 IEC Subcomponent 1: Health Education

Health education currently is not a routine component of the Jordanian health system, especially at the hospital level although a growing number of providers now recognize its importance. Therefore, a core subcomponent of Project will be to strengthen and upgrade the health education provided at the 12 Project sites so as to encourage women to seek regular health care during pregnancy and the postpartum period and to improve understanding of the benefits of birth spacing and correct use of contraceptive methods. Each CPP Center will have a full-time health educator on staff to educate and counsel women when they come for postpartum services and to ensure that health education is conducted also in the delivery ward and the obstetrical and pediatric outpatient clinics. Each CPP Center will be provided with a range of printed and audio-visual materials and audio visual equipment, so that everyone coming to the Center will have access to the information.

The CPP Project will design and produce a number of materials to be used to educate women and their families and also to encourage them to seek regular care during pregnancy and the postpartum period and to gently reinforce the family planning message. For example, a two-part booklet covering topics of major interest to women during pregnancy and afterwards, including family planning is planned. It will be appealing, easy to read and clearly illustrated, along the lines of a very brief "Dr. Spock." The first part would be given to women during antenatal care and, at the end, it would lead the reader to seek out the second part for advice on topics of concern after delivery. This part would be available in the hospital maternity wards and CPP Centers. Other materials to be produced include videos on family planning-related topics, promotional materials, leaflets, posters, etc. Special attention will be placed on developing materials and messages targeting men and grandparents.

The Project will work cooperatively with the FHS Project to ensure that MCH and PHC Centers use the same educational approaches, messages and materials as the hospital CPP Centers. The Project does not plan to produce materials on contraceptive methods, but rather to use those produced under the MBS Project. Many of the CPP Project's materials will be distributed beyond the 12 Project sites to public and private hospitals, health centers, physicians' offices, pharmacies, NGOs and elsewhere.

4.4.2 IEC Subcomponent 2: Mass Media

Television and radio reach virtually every household in Jordan and can be used effectively to educate a wide audience about the benefits of birth spacing, the need to seek care during pregnancy and the postpartum period and the availability of CPP services. The Project will produce short TV and radio spots to be aired frequently during prime time. With the MOH's access to free air time for health messages, this strategy promises to be highly cost-effective. Print advertisements will also be produced and placed in major newspapers and magazines.

An important adjunct to these activities will be the coverage of family planning-related topics in the regular programming of radio and TV and articles in the press. There is the possibility, for example, for a soap opera series to be produced around the Project's topics--such a series could reach about three quarters of the adults in Jordan each evening. There is also willingness on the part of the creator of Jordan's popular "political theater", who also works with television, to cooperate with the Project on the development of a humorous program with educational messages. Other opportunities, on a more modest scale, abound: a physician who responds to questions from the public, programs dealing with family concerns, news programs, features and articles. To strengthen links with the mass media and facilitate media coverage, the Project will conduct a seminar for journalists.

4.4.3 IEC Subcomponent 3: Outreach

While the mass media can be extremely effective in raising awareness, in order to have an impact on behavior, mass media messages need to be reinforced through other channels of communication that are more personal and conducive to discussion. In Jordan, where family and friends are of paramount importance, interpersonal communication should be a persuasive method of reaching people more directly and in greater depth on family planning topics.

The implementing agency will enter into agreements with selected NGOs that already have strong roots in communities where the CPP Centers are to be established to use the NGO staff and volunteers to reach community members directly. The Project will provide training for the NGOs on family planning-related topics and innovative outreach techniques, such as story-telling and improvised drama, along with needed materials.

Additionally, the MOH network of 40 health educators also will be used for outreach activities. This group will receive much the same training as the NGOs and will work closely with the MOH/HED and their local CPP Center to reach out to local community groups with messages on family planning-related topics, in addition to their other ongoing activities.

It is anticipated that outreach activities will reach at least 5,000 people in the "catchment" area of each CPP Center over the life of the Project. Since knowledge of contraception is already close to universal in Jordan, the impact of the IEC component will be measured less by the traditional KAP approach and more by utilization of family planning and postpartum services.

4.4.4 Management of the IEC Component

The Health Education Department of the Ministry of Health (MOH/HED) will be responsible for the overall strategy and execution of the IEC component along with an experienced expatriate IEC technical consultant. The MOH will make available 40 percent of the time of the Chief of Health Education, two full-time professional staff and a full-time secretary. The use of a qualified IEC consultant is viewed by the MOH, as well as outside experts in IEC, as a high priority in order to strengthen the Health Education's capabilities. Only two additional person-months of short-term technical assistance are planned.

The MOH/HED staff working on the Project will receive training appropriate to their functions, including IEC component management training in the U.S. for the Chief of Health Education. The department will also receive equipment needed for the execution of the Project.

The implementing agency will enter into an agreement with a local advertising agency to advise on campaign development, to carry out the mass media activities, to assist with audience research and the development of materials and execute other appropriate functions under the direction of the MOH/HED and the IEC technical consultant. A working group will be established to implement the IEC component of the Project and will include not only the MOH/HED but also NGO representatives, the advertising agency and other interested parties.

4.4.5 IEC Budget

Table 9 provides information concerning the budget for the IEC component of the CPP Project. For a more complete breakdown of IEC costs see the tables in the Financial Analysis, Annex III.B.

5. MANAGEMENT PLAN

The management of the CPP Project is vitally important because of its numerous diverse activities and because of the number of implementing agencies involved and their different management styles. The following addresses mechanisms for ensuring sound management practices that enhance the project's implementation.

Table 9.
Summary IEC Budget

Item	Amount
Technical Assistance	596,768
Materials Development	794,033
Mass Media	414,147
Seminars, Training, Meetings	275,777
Equipment and Materials	65,812
TOTAL	2,146,537

5.1 Prime Contractor

The Prime Contractor will place a Senior Resident Advisor (RA) in Amman as soon after the signing of the contract as possible. This person will have principal responsibility for managing and coordinating the entire Project and for being the primary liaison between the various Project channels and USAID/Jordan. S/he will also be expected to have sound evaluation skills, be knowledgeable of family planning and maternal and child health care practices, and be familiar with USAID regulations and audit requirements.

The Prime Contractor also will hire a full-time Senior Jordanian Advisor in the first year. S/he will act as the "Deputy" to the RA and provide assistance in the implementation of the Project. During this time, the RA will also train her/him in the management of the Project so as to institutionalize this capacity within Jordan. At the end of fourth year, the RA will leave the country, and the Senior Jordanian Advisor will continue in her/his stead until the end of the Project.

The Prime Contractor will hire an expatriate IEC Senior Technical consultant to provide technical assistance to the Department of Health Education to upgrade their skills and manage the IEC activities of the project. The Contractor will also secure the services an expatriate training consultant to coordinate and manage the extensive training activities of the Project. These consultants will make periodic visits, but will not reside in Jordan.

The Prime Contractor will also hire locally the following additional staff to assist in the management and implementation of the Project:

- a data specialist who will be responsible for the management of the information system that is being designed as an integral part of the referral mechanism. This person must be knowledgeable of computers and information systems but can be more junior in experience;

- an accountant/administrative assistant to assist with the subcontractual disbursements and AID audit requirements;
- a secretary; and
- a driver.

One vehicle will be imported for the joint use of the Resident Advisor and the Project staff. Office space will be provided by the Project through the Prime Contractor for all CPP Project staff. If feasible, this office space will be at the same location as the space for the FHS Resident Advisor in order to assure ease in planning and communicating and to reduce any redundancy.

The Prime Contractor and its Resident Advisor will be responsible for planning and coordinating by all Project activities with participating institutions (MOH, Royal Medical Service, Jordan University Hospital and the Islamic Hospital.

5.2 Ministry of Health (MOH)

The role of the MOH in the successful implementation of this Project cannot be overemphasized. Except for the Southern Region, the bulk of Project activities will be handled by the MOH. Although the MOH has not followed a pro-active program in family planning, it has mounted a number of other highly successful preventive health activities in the past, thereby suggesting its ability to effectively handle the management of the CPP Project.

The MOH's successful management of the Project will require some reallocation of staff responsibilities. The MOH has agreed to re-assign top-level specialists to administer and implement this Project. More specifically, the Project will primarily fall within the responsibilities of the recently created Directorate of Mother Child Health (MCH), which is also responsible for the implementation of USAID's companion project, FHS. However, the MOH's Health Education Department will also supply a significant amount of technical and managerial expertise in the Project's Information, Education, and Communication (IEC) component.

5.2.1 MCH Directorate

Within the MCH Directorate, the Project will be directed by two full time physicians. One will serve as Project Director with major responsibility for assuring that each CPP Center at an MOH hospital is adequately staffed and running smoothly. This person will serve as the principal MOH liaison with the Prime Contractor's Senior Resident Advisor.

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The second physician will be primarily responsible for overseeing the training component of the Project. In the first and second year of the Project, s/he will collaborate with the training consultants in the design of training curriculum, the setting up of the training sites, and the training of trainers. In the second year, s/he will work with the Prime Contractor to begin to develop a supervisory system that assures quality in CPP Centers. Every effort will be made to coordinate these activities with the MOH's Directorates of Training and Human Resource Development and of Quality Assurance.

A third physician will be provided only for one year of the Project. Her/his responsibilities will be to manage the standardization of protocols for health care in the antenatal, delivery and postpartum periods. S/he will work with a short-term expatriate consultant who has experience in the development of maternal and child health care norms. The MOH physician will assist in the design of the focus groups leading up to the consensus conference and will arrange the consensus meeting at which proposed norms will be discussed. S/he would also be responsible for following-up on the consensus meeting's recommendations.

These second two physicians will report to the MOH Project Director.

During the hospitals' renovations to expand or upgrade existing space to house the CPP Center, the Ministry's architects will be actively involved in the Project and will report to the MOH Project Director for issues concerning CPP sites.

5.2.2 Health Education Department

The Health Education Department in the Ministry of Health (MOH/HED) will be responsible for the overall strategy and execution of the IEC component along with an experienced expatriate technical consultant. The MOH will make available 40 percent of the time of the Chief of Health Education, two full-time professional staff and a full-time secretary. The IEC consultant is viewed by the MOH, as well as outside experts in IEC, as a high priority in order to strengthen the Health Education Department's capabilities and it is envisioned that the advisor will spend the first three years of the Project in country. Only two person-months of short-term technical assistance are planned.

The MOH/HED staff working on the Project will receive training appropriate to their functions, including IEC program management training in the U.S. for the Chief of the Health Education Department. HED will also receive equipment necessary for the execution of the Project.

The Prime contractor will enter into an agreement with a local advertising agency to advise on campaign development, to carry out the mass media activities, to assist with audience research and the development of materials and execute other appropriate functions under the direction of the MOH/HED and the IEC advisor. A working group will be established to implement the IEC component of the Project and will include not only the MOH/HED but also NGO representatives, the advertising agency and other interested parties.

To support these nationwide activities, the Project will import two vehicles for the use of the MOH. The vehicles are intended to be used by the Project Director/Coordinator and Training staff in carrying out their responsibilities under the Project. The MOH will provide petrol, oil, regular maintenance and a driver for each vehicle. Also, the MOH will provide comprehensive automobile insurance for the vehicles.

5.3 Royal Medical Services (Public)

The administrative arrangements for the RMS channel of health services under the Project is much less complex than that for the MOH. This is due partly to the fact that the RMS is a much more highly centralized organization than the MOH and, also, that the MOH has much greater administrative responsibilities under this Project than does RMS.

The RMS will select a Senior Project Director to be based at the King Hussein Medical Center. The Senior Project Director will be responsible for all CPP Centers at RMS facilities ensuring training takes place in a timely manner and that the centers are functioning well. The Senior Project Director will represent the RMS at various meetings and will be in regular contact with the RA and other Project staff. USAID's Prime Contractor will enter into an agreement with the RMS to provide for the necessary staff training, equipment, IEC materials and space renovation required in order to establish and operate CPP Centers in RMS hospitals as described in detail in the Project Description section. Residents, medical, nursing, midwifery students will rotate through RMS' King Hussein CPP Center. All agreements between the Prime Contractor and RMS will conform to A.I.D. regulations.

5.4 Jordan University Hospital (Independent)

Like the administrative management of the RMS, JUH is less complex than the MOH. Basically, the JUH is an autonomous organization with no subordinate hospitals to administer. JUH has agreed to appoint a Senior Specialist as Project Director to oversee the provision of CPP services and to coordinate the training of students and residents. It is anticipated that USAID's Prime Contractor will enter into an agreement with the JUH to provide staff training, IEC materials, and research costs required in order to establish and operate a CPP Center. As part of their clinical training, residents, medical and nursing students will be rotated through the JUH CPP Center. In addition to its training/services responsibilities, JUH is an attractive channel for project activities because of its pre-eminence in research. All agreements between the Prime Contractor and JUH will conform to A.I.D. regulations.

5.5 The Islamic Hospital (Charity/NGO)

The Islamic Hospital is governed and partially funded by a private foundation. However, it coordinates closely with the MOH and JUH in training residents. The Islamic Hospital has agreed to establish a CPP Center in the near future when space becomes available for

2
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integrated Ob/Gyn and pediatric services. The Islamic Hospital will appoint a Senior Physician as Project Director to oversee the provision of CPP services. Because its training program is limited to female Ob/Gyn residents, its high number of deliveries (second only to Al-Bashir) and its highly qualified staff with deep ties to the scientific and Islamic communities, the Islamic Hospital is a very attractive site for a CPP Center.

The Prime Contractor will reach an agreement with Islamic Hospital to provide staff training, equipment, IEC materials and minor renovations for establishing and operating a CPP Center. All agreements between the Prime Contractor and the Islamic Hospital will conform to A.I.D. regulations.

5.6 USAID's Capacity to Manage, Monitor and Evaluate

The CPP Project will be managed by USAID/Jordan's Office of Population and Family Health. The PFH Office is headed by a well-trained HPN Officer experienced in health, population and family planning project management. His professional staff consists of two Jordanian physicians, one with a NGO background and the other with a strong background in public sector health management. They are responsible for the management of the MBS and FHS Projects. Recruitment for a third position to be filled by a Jordanian public health professional to manage the CPP Project is currently underway.

As family planning and population programs are relatively new areas of focus in Jordan, there are few people in country with the experience in family planning program management, operations research or data collection and analyses, which is essential for the successful planning and implementation of the CPP Project. Therefore, it is highly recommended that the Mission secure the services of a Population Fellow through the University of Michigan to assist USAID, MOH and the other implementing agencies in these activities and to train the FSN staff to assume responsibilities for these functions. Funds have been budgeted under the Project to cover the international travel and local costs of a Population Fellow for up to two years. Salary and other U.S. costs are normally covered by the agreement between R&D Office of Population and the University of Michigan.

6. IMPLEMENTATION PLAN

The CPP Project is composed of many interdependent inputs that require careful coordination during implementation in order to have the fullest possible impact. This section outlines the ways that such coordination can occur and also proposes mechanisms through which the CPP, FHS, and MBS Projects can be effectively linked so as to create synergism of efforts. It then describes the implementation and procurement plans.

The different foci of the MBS, FHS, and CPP Projects clearly indicate USAID/Jordan's conceptualization of a national level population and family health services development strategy for Jordan. The Project paper recommends that this *de facto* strategy be solidified in a formal manner, similar to that undertaken in many of AID/Washington's "priority" countries. The result would be a systematic approach to the coordination of the implementation of all projects. The effort would involve the following:

- 1) Creation of a single document that clearly and succinctly indicates the role of each project in achieving USAID/Jordan's goal of slowed population growth and improved family health.
- 2) Quarterly meetings of a Working Group on USAID health projects.
- 3) Consolidation of Yearly Workplans.

The coordination between the FHS and CPP Projects could be further enhanced if their Resident Advisors share office space.

6.1 Project Implementation Schedule

Implementation of the Project will be coordinated and managed under one major direct USAID Contract. Therefore, USAID/Jordan will issue a request for proposals after the Project receives approval. Interested implementing agencies will submit proposals which will be evaluated on a competitive basis. The Prime Contractor will be involved in all phases of the implementation and will therefore be expected to have the following minimal capacities:

- Extensive experience in the delivery of hospital-based postpartum and postnatal services, including family planning.
- Vast experience in training health professionals in counseling about and provision of contraception and other maternal and child health services;
- Strong institutional capacity to rapidly procure sundry items, including consultancy services, medical, training, and office equipment.
- Expertise in the development of IEC materials and campaigns;
- Expertise in the development and use of referral systems;
- Expertise in programmatic research and evaluation;
- Solid field presence in the region, especially previous experience in planning and implementing contraceptive service delivery programs, preferably in Jordan.

Table 10 provides a summary of the main CPP Project activities by component indicating the approximate timing of implementation for each activity.

After the Contract is awarded to a Prime Contractor, the Contractor will recruit and place a Senior Resident Advisor for the CPP Project in Jordan. The RA will be responsible for setting up the project office and hiring the Jordanian staff members within the first six months in-country. Concurrently, the MOH will appoint a Project Director in the Directorate of Maternal and Child Health. Each of the other 4 service channels will also appoint a CPP Director.

Under the service delivery component, procurement of commodities, contraceptives and equipment will begin early in Year One. Protocol development, focus group interviews with women and planning for the consensus conference will begin in the 3rd quarter of the first project year, shortly after the arrival of the RA in-country. The focus groups will take place late in the 3rd quarter and the consensus conference early in the 4th quarter. Standardization and approval of the protocols will continue into the 1st quarter of the second year. The computerized information system for the CPP Centers will be developed during the second half of Year One. Also during the last half of Year One, facilities upgrading will begin in Phase I sites. These sites will be open and fully operational after the upgrading is completed and the staff have been fully trained. Phase II hospitals will begin upgrading during the first half and Phase III during the last half of Year Two. Programmatic research activities will be initiated following the opening of the CPP Centers in Year Two.

The training consultant team will be brought on board to begin developing the training curriculum towards the end of the fourth quarter of Year One after the focus groups and consensus conference are completed to maximize use of the collected information. The training of trainers will begin after the curriculum is finalized, late in the last quarter of Year One. The training of trainers courses will continue into the second year. After the trainers have completed their training, they will begin the in-country training at the 5 training sites. Out-of-country training will begin during the first quarter of the second year and should be completed by the end of Year Two.

The development of the health education curriculum and supervisory system will begin in the second quarter of Year One and will continue until the second quarter of Year Two. Printed materials also will begin development in the second quarter of Year One and will continue until the end of Year Four. Mass media messages for TV and radio and print ads will begin development during Year Two and will continue into Year Four. Videos will be developed during Years Three through Five. The identification and training of NGOs and the training of the MOH health educators will begin in the second quarter of Year One and will continue through Year Three.

TABLE 10.
Summary Implementation Plan

Activities	Year 1				Year 2				Year 3				Year 4				Year 5			
PROJECT MANAGEMENT																				
Naming of MOH Project Director (PD) and RMS, JUH and Islamic CPP Directors	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Arrival of senior Resident Advisor (RA); ongoing presence until end of project		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
RA sets up project office and hires Jordanian support staff		X	X																	
SERVICE DELIVERY COMPONENT																				
Procurement of commodities and equipment	X	X	X	X	X	X														
Development of protocols for antenatal, delivery and postpartum care: focus groups and consensus conference		X	X	X	X															
Development of computerized information system			X	X																
Facilities upgrading and CPP Center operation - Phase I			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Facilities upgrading and CPP Center operation - Phase II					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Facilities upgrading and CPP Center operation - Phase III							X	X	X	X	X	X	X	X	X	X	X	X	X	X
Programmatic research studies					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

68

Activities	Year 1				Year 2				Year 3				Year 4				Year 5			
TRAINING COMPONENT																				
Training curriculum development			X																	
Training of trainers				X	X	X														
In-country CPP training					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Out-of-country training		X	X	X	X	X	X													
IEC COMPONENT																				
Health education curriculum and supervisory system development		X	X	X	X	X														
Identification and training of NGOs for outreach		X	X	X	X	X	X	X	X	X	X	X								
Develop printed materials		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X				
Develop videos									X	X	X	X	X	X	X	X	X	X	X	X
Develop and air radio, TV spots and print ads					X	X	X	X	X	X	X	X	X	X						
EVALUATION/AUDIT																				
External midterm and final evaluations												X							X	
Audits				X				X				X				X				X

The midterm evaluation is planned for the fourth quarter of Year Three with the final evaluation taking place during the third quarter of the last year. Audits will be conducted during the last quarter of each of the five project years.

See Implementation Action Plan in Annex II.B. for an detailed illustrative outline of the timing and phasing of the implementation/activities of the CPP Project. Table 11 lists the total number of person months needed to effectively implement the Project.

TABLE 11.
Technical Assistance Summary (Person Months)

TECHNICAL ASSISTANCE PERSON MONTHS (PM)						
Component/ Position	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Long-Term - Expatriate	30.00	30.00	12.00	12.00	0.00	84.00
Short-Term - Expatriate	8.00	7.25	7.50	6.50	6.00	35.25
Long-Term Professional Jordanian	43.00	49.00	40.50	36.50	36.00	205.00
Long-Term Other Jordanian	30.00	42.00	42.00	42.00	42.00	198.00
TOTAL	111.00	128.25	102.00	97.00	84.00	522.25

6.2 Procurement Plan

USAID will procure the contraceptive commodities and vehicles for the project. USAID also will recruit and hire a Jordanian to join the PFH staff to manage the CPP project and will secure the services of a Population Fellow for two years through an add-on to the University of Michigan Cooperative Agreement. All other goods and services will be procured by the Prime Contractor. The bulk of the goods and services will be procured in the USA; others will be procured locally. See procurement plan in Annex II.C. for a complete list of individual goods and services including a breakdown by source/origin. Selected services may be procured by the Prime Contractor through subcontracts with other AID/Washington Cooperating Agencies (CAs) with the specializations required for the Project. If funding is available, possible subcontracts would be to a CA that qualifies under the Gray Amendment and provides training to women as managers of family planning programs and/or with a CA that specializes in the Lactational Amenorrhea Method (LAM).

Procurement of goods and services for all USAID-funded activities will conform to AID regulations for full and open competition, and Gray Amendment requirements for contracts exceeding \$500,000.

7. COST ESTIMATE AND FINANCIAL PLAN

7.1. Cost Estimate

Total costs of the CPP Project are expected to be \$11,000,000 US Dollars contributed by USAID, and \$5,458,000 contributed by the GOJ (MOH, RMS, University of Jordan) and participating NGOs. Virtually all local contribution will be in-kind contribution, such as salaries and benefits of existing personnel (estimated person months multiplied by salaries and benefits), building space, equipment and other existing facilities. A detailed breakdown of USAID and local contributions by Project inputs follows:

TABLE 12.
CPP Project Summary Budget - Donor Contributions

Project Input	A.I.D.	GOJ	TOTAL
Service Delivery	4,175,448	3,270,000	7,445,448
Equipment	2,847,239	0	2,847,239
Training	1,091,558	738,000	1,829,558
IEC	1,010,915	736,000	1,746,915
Evaluation	200,000	44,000	244,000
Audit	250,000	0	250,000
Project Management	874,840	670,000	1,544,840
Contingency	550,000	0	550,000
Grand Total	11,000,000	5,458,000	16,458,000

7.1.1 USAID Contribution

Overall A.I.D. costs of the CPP Project are expected to be \$11,000,000 for the five year period. This total A.I.D. contribution for the Project will call for an annual investment of approximately \$4,000,000 in FY1994, \$3,000,000 in FY1995, \$2,000,000 in FY1996 and \$1,000,000 in each FY1997 and FY1998 from DA\POP funds. Actual obligations and disbursements may vary from year to year, as well as from the levels shown in the financial projections presented herein. In general, fund releases will be governed by the provisions of the Project Agreement and subject to funding authorization. For breakdowns on expenditures by local and foreign exchange, see Table 26 Annex III.B.

The following assumptions govern the Project budget as presented herein.

- The CPP Project Agreement will obligate funds from USAID/Jordan's bilateral assistance program for Jordan for the majority of in-country costs for the public and non-government sectors.
- The Project Agreement will support out-of-country costs related to procurement of commodities and equipment, short, medium and long-term technical assistance, transportation, Project support staff and in-country costs related to the provision of technical assistance, e.g. office rental, locally-procured supplies and equipment, local staff and consultants, and transport. See attached chart for specific responsibilities.
- No AID/Washington contributions are anticipated.

7.1.2 Host Country Contribution

MOH's financing of in-country costs will include:

- salaries for hospital staff assigned to the CPP Center, hospital-based trainers, Project manager and IEC component manager;
- equipment and vehicle maintenance, operating costs for vehicles, transportation;
- MOH Project staff office space, equipment and supplies.

7.1.3 Other Contributions

The Royal Medical Service, University Hospital, Islamic Hospital and the Soldier's Welfare Society will provide in-country costs including salaries for hospital staff assigned to the CPP Center, hospital-based trainers, and a Project Director. They will also provide space and limited assistance with facilities upgrading.

7.2 Financial Plan

See Table 25 in Annex III.B. for summary information on the financing of the CPP Project activities. All figures given are composites including the estimated cost of the equipment, salaries, or activities plus 35 percent (estimated maximum Contractor fee) as appropriate, 25 percent shipping on all US-purchased equipment and supplies and 5 percent inflation rate per year on all expenditures from Year 2 to Year 5. The following Table shows methods of financing for each budget line item.

TABLE 13.
Methods of Implementation and Financing (\$000)

Method of Implementation	Method of Financing	Approximate Amount
Service Delivery	U.S. Contractor - Direct Pay USAID - PIO/T	4,200
Equipment/Commodities	USAID - PIO/C	2,800
Training	U.S. Contractor - Direct Pay	1,100
IEC	U.S. Contractor - Direct Pay	1,000
Evaluation	U.S. Contractor - Direct Pay	200
Audit	U.S. Contractor or Other - Direct Pay	250
Project Management	U.S. Contractor - Direct Pay	900
Contingency	U.S. Contractor - Direct Pay	550
Total Project		11,000

Table 14 provides a breakdown of the Project costs. Fifty-five percent of the Project costs are for technical assistance, 12 percent for equipment and supplies, 8 percent for facilities upgrading, 7 percent for training, 5 percent for commodities and 13 percent for other expenses.

8. MONITORING AND EVALUATION

This Project paper envisions that monitoring and evaluation will have two fundamental functions: 1) to assess the Prime Contractor's compliance with its contractual obligations and fulfillment of deliverables; and 2) to *continually* evaluate the Project's progress towards purpose and goal level achievements. Through rapid feedback studies, the simple and effective use of an information system linked to the MCH health record, and regular reporting to USAID/Jordan, the monitoring and evaluation plan sets out a preliminary framework for the full realization of those functions.

8.1 Users of Information Generated by the Monitoring and Evaluation Plan

The major users of the information generated by this plan will be the managers and health professionals at the CPP Centers, the MOH MCH Directorate, and the Prime Contractor; various managerial divisions within the MOH and RMS, and; USAID/Jordan and other international donors. These groups will assist long-term and short-term advisors and consultants to develop a comprehensive monitoring and evaluation plan for the Project during the first year of its implementation.

TABLE 14.
CPP Project Summary Cost Estimate and Financing Plan (US\$)

Project Input	Technical Assistance	Training	Commodities	Equipment & Supplies	Facilities	Other	TOTAL
Service Delivery	3,344,390	0	591,020	744,682	288,931	37,671 ⁶	5,006,694
Training	543,770	815,781	0	237,545	0	0	1,597,096
IEC	2,080,725	0	0	65,812	0	0	2,146,537
Evaluation	61,947	0	0	0	0	512,886 ⁷	574,833
Audit	0	0	0	0	0	250,000	250,000
Project Management	0	0	0	276,082	553,360	45,398 ⁸	874,840
Contingency	0	0	0	0	0	550,000	550,000
Grand Total	6,030,832	815,781	591,020	1,324,121	842,291	1,395,955	11,000,000
Percent of Total	55%	7%	5%	12%	8%	13%	100%

⁶ Includes vehicle maintenance and insurance.

⁷ includes evaluation, ministudies and external evaluations.

⁸ includes transportation and in-country travel costs.

8.1.1 Institutional Locus

The monitoring and evaluation plan intends to draw from the large pool of researchers in Jordan, thus many of the activities discussed below will be subcontracted by the Prime Contractor to Jordanian organizations, such as the Jordanian University of Science and Technology (JUST) and the JUH. Long-term technical assistance will be provided by the Senior Resident Advisor in the first four years of the Project, and by the Senior Jordanian Advisor in the last two years. Long-term technical assistance will also be provided by the data specialist. An estimated two person months in short-term technical assistance from expatriate evaluation experts is foreseen, although it is also expected that the programmatic research consultant will be able to provide technical assistance during her/his TDYs to Jordan.

8.2 Project Purpose, Indicators and Methodologies

USAID/Jordan's Strategic Objective Number 3 is to reduce fertility, which is to be achieved through an increased use of effective contraceptive methods. This in turn is to be accomplished through three sub-programmatic outcomes, two of which are particularly relevant to this Project: 1) improved knowledge of effective contraceptive methods, and 2) increased availability of higher quality family planning services.

8.2.1 Project Purpose

The Project's purpose is in keeping with the above programmatic objective and subprogrammatic outcomes:

To increase the number of women initiating and sustaining the use of effective contraceptive methods during and after the postpartum period.

- Purpose-level question: To what extent have the CPP Centers resulted in increasing contraceptive access for postpartum women?

8.2.2 End of Project Indicators

- Increase in the percentage of women returning for postpartum care from six percent to sixty percent at CPP Project sites;
- Increase the rate of modern contraceptive acceptance, including the Lactational Amenorrhea Method (LAM), among postpartum women participating in the CPP Project to 50 percent.
- Increase the level of contraceptive prevalence from 26.9 percent to 33.9 percent among currently married women.

8.2.3 Data Collection Methodology

Data on the indicators will be collected two ways. First, a simple baseline will be undertaken in the first year of the Project to assess the current percent of women returning to outpatient clinics at CPP hospitals for postpartum care. Second, the evaluation plan takes advantage of the service delivery information system to gather data on women returning for postpartum care and on those accepting contraception. In the first year of the Project, the Prime Contractor will arrange for short-term consultants (Jordanian and expatriate) to develop the information system which will gather data on the above indicators. By tracking the percent of women returning for care and the percent of women accepting a method, it will be feasible to assess the ongoing progress of the Project.

8.3 Project Outputs

Three categories of outputs lead to the achievement of these objectives, namely service delivery, training, and IEC.

- **Output-level questions:** To what degree has the availability of family planning improved as a result of the CPP Project? Has the establishment of 12 CPP Centers led to increased access to family planning services for Jordanian women? To what degree has the MCH health record resulted in improved referral? Has this had any impact on increasing the number of women returning for postpartum care? Will women return for their own health needs if they receive quality services? Did IEC activities result in husbands' increased acceptance of family planning?
- **Indicators:** Opening of at least 12 CPP Centers in hospitals throughout Jordan, the training of more than 1100 medical professionals trained in family planning services and counseling, improved knowledge, attitudes, and practices of medical professionals about quality and the client-perspective, at least 6 programmatic research studies, widespread dissemination and utilization of research results, etc. (See Logframe).
- **Data Collection Methodology:** A variety of methods will be used to collect data on these indicators. Examples are monthly information systems reports, observations of CPP Centers and provider-client interaction, yearly observations by the MOH's Directorate of Quality Assurance, receipt of final reports of research projects, and ministudies, such as focus groups to assess client satisfaction.

8.3.1 Special Studies

The following are examples of studies that would provide useful data on which to assess this project.

- **KAP Study of Providers:** A large part of the training component will emphasize changing physician attitudes towards clients. A baseline KAP study could be done right

before providers enter their training, and then once again in the fourth or fifth year of the Project.

- **Intercept Study:** The Project places a great deal of importance on IEC. An intercept study would ask women when they first arrive to the Center about where they had heard about the CPP services. This type of study could be done in the third year so as to evaluate the effectiveness of different IEC interventions. The MOH's regional health educators could serve as interviewers, thereby decreasing the cost of activity.
- **Follow-up of CPP clientele:** Because women are referred back to the primary health care system after the second or third visit to CPP Centers, it will be difficult to determine the degree to which women continue to use contraception. A study could use the data from the information system to interview women in their homes to find out their contraceptive use status. Because of the complicated design of such a study, one month of short-term expatriate consultancy has been planned to provide technical assistance to the subcontracting agency.

8.4 Other Monitoring Activities

8.4.1 Progress Reports

The Prime Contractor will submit semi-annual progress reports to USAID/Jordan with the purpose of informing AID about general project development in the previous six months. The report should discuss any problems with project implementation and efforts made to rectify them. It should also include a compilation of information system reports from all of the CPP Centers. After the arrival of the senior resident advisor to Amman, s/he will discuss with the AID Project Monitor when to submit the first report.

8.4.2 Workplan

As was suggested in the Implementation Plan, this Project paper strongly suggests that the Contractors for MBS and FHS Projects form a Working Group to reinforce each other's role in making family planning more accessible in Jordan. USAID/PFH staff will ensure that such a Working Group is formed early on during project implementation and that the workplans are discussed and reviewed by the Working Group before they are submitted to USAID to ensure proper coordination of activities and to avoid duplication of efforts.

8.4.3 Yearly Management Reviews

It is recommended that the AID Project Manager conduct management reviews to assess the direction and administration of the Project and suggest mechanisms for resolving problems. In order to avoid overburdening the Mission, it is advised that the reviews only occur at the end of the first, second and fourth years of Project implementation. The external evaluations scheduled for the third and fifth years could address management

issues; management reviews in those years would be repetitive and produce little marginal benefit.

8.5 External Evaluations

A midterm and final external evaluations are planned, the midterm occurring at end of the third year and the final occurring towards the end of the fifth year. The purpose of the midterm will be to assess the Project's progress, specifically looking at mechanisms for improving the Project in the remaining two years. The team will also be asked to determine whether a follow-on Project would be desirable and/or feasible. Information system reports will be available to the team, thereby supplying them with data on acceptance rates among women who return to the Centers. The final evaluation would assess the impact of the Project on improving access to and information about family planning to Jordanian women and men. It is anticipated that the evaluation firm will be a Gray Amendment entity.

8.6 Budget

Approximately \$574,832 has been allotted to monitoring and evaluation activities. This figure includes \$61,947 for expatriate short-term technical assistance, \$281,085 for special studies and \$231,801 for the midterm and final external evaluations. An additional \$250,000 has been allocated for auditing procedures over the 5 years of the Project

9. SUMMARIES OF PROJECT ANALYSES

9.1 Technical Analysis

The Jordanian medical system can be characterized as generally technologically advanced with many well-trained and experienced physicians in both the public and private sectors. Jordanians of all socio-economic categories place a high value on health care for the maintenance of good health for all family members; the majority also value active use of western medical facilities. While preventative care is still in its infancy in Jordan, curative care, especially at tertiary facilities is of high quality. Jordanians actively seek the highest quality services within their means, often bypassing primary health care centers to go directly to tertiary health facilities where the bulk of specialists are located.

The level of technical expertise among Jordanian specialists in the public and private sectors is generally high. Many specialists have received their training abroad in the U.S. or U.K. and are Board eligible. The ratio of physicians to nurses and midwives in Jordan is skewed; nurses, especially, are in short supply but experienced specialists are not, especially in the larger urban areas. Hospital Ob/Gyn and Pediatric Departments tend to be adequately staffed with many well-trained MDs. Thus, in Jordan, specialists can play a much greater role in the provision of postpartum services than would be possible in other countries, thus minimizing the range of training necessary to expand services to include family planning and improve quality of care. The specialists at the sites selected to participate in the Project are

improve quality of care. The specialists at the sites selected to participate in the Project are solidly behind the CPP concept and are eager to initiate the expanded postpartum services. Family planning services are the general exception to the high level of technical expertise found among Jordanian physicians. The CPP project will expand and improve their skills. The general shortage of nurses in Jordan is not unique to the CPP project and is not expected to hinder the implementation of the Project at the 12 selected sites. As a result of the expanded nurse training programs currently underway, it is anticipated that the nursing situation will improve by the end of the Project.

Hospitals in Jordan are well-equipped, although space issues are a major concern for some facilities. Costs to upgrade physical facilities and provide the necessary range of equipment to offer quality and comprehensive postpartum services will be minimal. Quality of care is generally high at hospitals already, as evident in the fact that 80 percent of women choose to deliver in hospitals.

In a small country, such as Jordan, the MOH plays an important role in the provision of health services. Basing the CPP project in the MCH Directorate will further improve the MOH capacity to provide family planning and MCH services effectively and efficiently by expanding the technical and supervisory capacity. Computerization is necessary to systematize and improve information flow and link up the various levels within the health care system.

In sum, no technical issues are anticipated to constrain the implementation of the Project. In fact, the high quality of Jordanian specialists and their interest in the CPP approach is conducive to widespread success of the Project.

9.2 Financial Analysis

The introduction of postpartum contraception in Jordan's hospitals is expected to be a highly cost-effective approach for a number of reasons. First, postpartum contraception targets women of proven fertility who, without contraception, are likely to become pregnant soon again. Second, over 80 percent of deliveries occur in hospitals. Providing hospital-based pre-discharge and postpartum family planning services has the potential to reach large numbers of women through relatively few points of service. Providing services at the relatively small number of hospitals required to reach the majority of postpartum women avoids the expense of integrating family planning into a large number of small health centers around the country.

Studies in other countries providing postpartum family planning have found the provision of family planning during the postpartum period is cost-effective. The marginal cost of providing an effective family planning method (especially sterilization or the IUD) while the woman is being seen for delivery or other health services makes it more cost-effective than interval provision of family planning. At present, approximately 18 percent of family planning services are already provided at hospitals financed by the GOJ. Therefore, of the

possible alternatives for achieving Project objectives, the hospital-based approach was chosen, among other reasons, on the basis of being the most cost-effective approach in Jordan, to the extent this could be determined.

Over the five year life of the CPP Project, approximately \$11 million will be disbursed by USAID/Jordan. Approximately \$591,020 will be contributed directly in the form of contraceptive commodities and \$63,000 in Project vehicles. Activities, technical assistance and equipment will be funded through a Prime Contractor, which will in turn subcontract for selected activities. All GOJ contributions will be in-kind, consisting of salaries, physical space in hospitals and maintenance and replacement of equipment for the CPP Project. No cash or monetary contributions will be required by GOJ. All in-kind contributions will be monitored by PFH and implementing contractor staff. Overall, 55 percent of Project funds will be used for technical assistance, 12 percent for equipment and supplies, 8 percent for facilities upgrading and 7 percent for training and 5 percent for commodities. (See Table 14.)

The initial cost of upgrading and expanding family planning services at the hospital level via Comprehensive Postpartum Centers will be largely subsidized by the Project. However, after this initial investment, the recurrent costs of the Project will be limited to staffing costs, equipment maintenance and replacement, contraceptive commodities, office and other supplies. The MOH, RMS and other sites selected to participate in the Project have already proven their commitment to sustainability as they are providing the bulk of the recurrent costs already under the Project.

9.3 Economic Analysis

Numerous economic benefits are associated with averting unwanted births and with postponing mis-timed births. These benefits accrue both at the national and at the family level. At the national level, benefits are associated primarily with reduced public sector outlays for social infrastructure development, notably housing, education and health, and with reduced unemployment. At the family level, these benefits include reduced expenditures on schooling, health and consumables, and improved household income and living standards.

Over the five year life span of the CPP project, it is estimated that a total of 40,200 births would be averted, and, that by the end of the project, approximately 18,800 births would be averted annually. These figures represent a 15 per cent reduction in annual births as compared with 1991, and a decline in the total fertility rate from 5.6 to 4.9 children per woman during the same period.

Savings in public sector expenditures resulting from these reduced births and fertility are regarded as substantial in Jordan because of the high premium attached to, and the prevailing high costs of, education and health care in the country. Preliminary estimates by the National Population Commission show that, if the above objectives are achieved, annual

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savings of approximately \$12 million in government outlays for schools and \$9 million in outlays for health care could ensue. The savings due to a birth averted is estimated at \$26,500. Using this estimate, the internal rate of return (IRR), which is the discount rate that equates the present value of expected costs with the present value of expected savings and which provides a single measure of return on investment, is estimated to be at least 20 per cent. Thus, the benefit-to-cost ratio for birth spacing in Jordan and for this project is highly favorable.

9.4 Social Soundness and Gender Analysis

For a variety of sociocultural and economic factors, large families and short birth intervals have been the norm in Jordan. Currently, the total fertility rate is 5.6 but levels of fertility used to be even higher, as seen from the large proportion of women age 45 - 49 (39 percent) who in 1990 had 10 or more children. These days, the majority of Jordanian women (52 percent) consider the ideal family size to be at least four children.

High risk fertility behavior is common: eight out of 10 married women are at risk of conceiving a child at increased risk of dying. In the case of two thirds of the women this is because they have already had three or more births, while one third are over age 34. The single most detrimental risk factor is a short birth interval--less than two years--and in Jordan more than half of all births occur less than two years apart.

The Project can be expected to have an important and beneficial impact on problems such as these.

As the CPP Project is primarily a service delivery activity, mothers and infants who use the new comprehensive postpartum services will benefit directly from the Project. However, the husbands and families of these women will also benefit. Men will benefit because of their increased awareness and knowledge about safe motherhood and the impact of child spacing on maternal and child health. Many others will also benefit indirectly, primarily as a result of the Project's IEC activities that will ensure national media coverage for topics related to safe motherhood and birth spacing and wide dissemination of educational materials.

In general, the beneficiaries targeted by the Project include the 350,000 married women of reproductive age and the 125,000 children under one year of age in Jordan. The targeted beneficiaries of IEC activities are the 806,000 women and 856,000 men aged 15 - 49. It is not foreseen that any group will be adversely affected by the Project.

Project beneficiaries will reap dramatic benefits from the CPP Project. Not only will family planning services be offered in a meaningful and convenient context for women, but quality of care will be improved and the range of contraceptive choice will be expanded. The anticipated shift in the knowledge, attitudes and practices of service providers toward a more client-focused approach should allow women and their families access to the information

and services they need in an atmosphere more conducive to behavior change. The emphasis on provision of services by women physicians, whenever possible, will also benefit many women attending the Centers as they will be more comfortable discussing family planning and reproductive health concerns woman to woman.

Jordanian society is strongly patriarchal, with male children being a source of prestige. Women have clearly inferior social status, even in the home where the husband rules and his mother has a powerful influence over her daughter-in-law. This is reflected in a legal system steeped in religious law and social traditions which affect every aspect of women's lives. A woman's upbringing, her legal status and capacity to act as an individual are restricted by civil and personal status law and women are largely unaware of their legal rights.

Women's status also influences their health-seeking behavior. They often place their personal needs after those of their children and husband and, particularly where "shameful" services, such as reproductive health care are concerned, they will often fail to seek medical advice. Indeed, a new mother may be given little freedom to decide when to seek medical care for her infant or what to feed the infant.

The CPP Project will seek to be sensitive to the needs of women in a host of ways. From the very beginning of the Project, the input of women will be sought into what they want from the CPP Centers: the kinds of services and providers, hours, furnishings, etc. There will be special efforts to bring female providers into the Centers to avoid the embarrassment of a male provider examining a woman--a situation that leads to many foregone pelvic examinations--and will feel more comfortable discussing family planning and reproductive health concerns.

The Project design team sought to glean some information about women's perspectives by consulting female physicians and nurses and conducting a series of interviews with women to begin to determine their needs.

The Project can and should measure women's participation in the Project at several levels, from the number of women in managerial positions to the number of women coming for postpartum services and the sensitivity of providers to women.

9.5 Administrative Analysis

During the course of the Project, USAID/Jordan will be collaborating with several public and private Jordanian institutions. The organizational structure and functional capability of these institutions are therefore relevant to the success of the Project.

The World Bank is working with the MOH to help reorganize its management to "enable the MOH to become an effective policy-making, management and planning agency, and to devolve day-to-day operation of MOH services to the regional level." Thus far, the

34
reorganization has led to the creation of three Regional Health Authorities, each under the responsibility of a Regional Assistant Secretary General. The reorganization has also led to the establishment of the Maternal-Child Health Directorate, a move that has been praised by donors and Jordanians alike, particularly given the growing need for a preventive focus in the MOH's service delivery.

The mandate of the MCH Directorate is to strategically plan all of the MOH's MCH activities, not just those located at the level of MCH or PHC centers. This is a fundamental change from before, in which care given at hospitals, including antenatal, delivery and postpartum care, was under the mandate of a different unit. The new organization will improve continuity of care for mothers and babies alike, as well as facilitate the administration of the CPP Project within the MOH. However, because it is a new directorate in a system under transition, it needs strengthening. Thus, this Project paper calls for the presence of a senior resident advisor who will assist the Directorate to implement CPP activities more effectively. It is also hoped that the presence of the resident advisor will strengthen the directorate by facilitating the institutionalization of sound management and decision-making skills.

The MOH Health Education Department will be responsible for the large and complex IEC component of this Project. This talented 20-person department has conducted a number of health communications programs in recent years but a review of their work demonstrates that, while it is technically competent, its effectiveness could be dramatically enhanced by strengthening its strategic planning capability, its ability to develop materials and media that can influence people's behavior and overall program management. Outside donors who have worked with the department believe that full-time expert assistance over a period of a few years could build this department into a highly skilled and well-managed operation that could craft effective health communications campaigns. Accordingly, the Project plans to place a senior IEC advisor in Jordan to work with the department for three years.

The Royal Medical Services (RMS) is administratively more sound than the MOH, principally because of its strong emphasis on the military chain of command. Thus, having the support of the system's chief Ob-Gyn and pediatrician is vitally important to successful implementation. The Project design team has enjoyed the full support of these personnel who have all but guaranteed an effective implementation and administration of the Project in the AID-supported CPP Centers.

Like RMS, Jordan University Hospital is less complex than the MOH. Basically, it is a nearly autonomous organization with no subordinate hospitals to administer. It has a cadre of health professionals with postgraduate training in various arenas, including management. The Project team anticipates few problems in the administration of the CPP Center there.

The NGO sector is a major provider of family planning services in Jordan. Key among the NGOs is the Jordan Association for Family Planning and Protection (JAFPP). JAFPP is the local affiliate of IPPF/London and is currently receiving technical and financial

assistance from USAID (FHS Project) to expand the number of JAFPP clinics in the country and to improve the quality of existing clinic services. Some of the new clinics will be established at the premises of other NGOs, such as the Queen Alia Fund and the General Union for Voluntary Services (GUVS), who are already engaged in providing health care services in a number of locations throughout the country. JAFFP will attempt to integrate birth spacing and family planning services into the ongoing health care services provided by these NGOs. In addition, these NGOs will benefit from the IEC materials produced under the CPP Project.

Two major NGOs will receive direct technical and financial assistance under the CPP Project. These are the Islamic Hospital and the Soldiers Family Welfare Society.

The Islamic Hospital is a major hospital, governed and partially funded by a private non-profit, voluntary foundation in Amman. However, it coordinates closely with the MOH and JUH in training residents. It has demonstrated sound administrative practices and managerial practices in a variety of ways, one of which is how to market services to its clients in very similar ways to those envisaged under the CPP Project. The hospital is also highly regarded in the scientific and Islamic communities.

The Soldiers Family Welfare Society is a NGO established by retired military personnel to serve both retired military families and the civilian population in Zarqa. The Society's focus is on women. It runs a well-managed clinic, several income-generating projects and a training center for women, a nursery and a day care facility for children under five. The Society is managed by a competent and outstanding board of volunteers, consisting primarily of women. Its clinic is well-known and is highly-regarded by the local population and the regional health officials in Zarqa.

The CPP Project will be sited in USAID' Office of Population and Family Health (PFH). This Office is headed by a well-trained, U.S.-Direct Hire HPN Officer, with substantial international experience in integrated health and family planning programs design and management. He is assisted by two qualified Jordanian physicians but who lack family planning program management experience. As population and family planning programs are new areas of focus in Jordan, and as qualified candidates with previous population/family planning experience are not readily available, the placement of a U.S. Population Fellow in the PFH Office is highly recommended. Besides training the FSN staff, the Population Fellow will be responsible for data gathering and analysis, including the development of a planned Household Survey System by the GOJ Department of Statistics (funded separately).

9.6 Environmental Determination/Categorical Exclusion

A categorical exclusion has been granted and is included as Annex I.D.

U.S. Agency for International Development

Comprehensive Post Partum (CPP) Project

Project Paper

Annexes

Amman, Jordan

22

TABLE OF CONTENTS

Page

Project Data Sheet		
Project Authorization		i
Table of Contents		iii
List of Tables and Figures		iv
List of Acronyms		v
Executive Summary		vi
1. Project Background		1
1.1 Demographic Trends in Jordan		1
1.2 Government of Jordan Policy on Population and Birth Spacing		1
1.3 USAID Strategic Objective		2
2. Perceived Problem and Project Rationale		3
2.1 Perceived Problem		3
2.2 Project Rationale		4
2.2.1 A.I.D. Population Assistance		6
2.2.2 Other Donor Assistance		7
3. Project Goal, Purpose, Achievements and Impact		9
3.1 Goal and Purpose		9
3.2 Achievements		9
3.3 Impact		10
4. CPP Project Description		10
4.1 Project Overview		11
4.2 Service Delivery Component		13
4.2.1 CPP Service Delivery System		13
4.2.2 Facilities Upgrade		14
4.2.3 CPP Center Staffing		16
4.2.4 Programmatic Research		17
4.2.5 Service Delivery Component Management		17
4.2.6 Service Delivery Budget		18
4.3 Training		19
4.3.1 In-country Training		19
4.3.2 Out-of-country Training		22

52

4.3.3	Training Component Management	22
4.3.4	Training Budget	23
4.4	Information, Education and Communications Component	23
4.4.1	Health Education	24
4.4.2	Mass Media	25
4.4.3	Outreach	25
4.4.4	IEC Component Management	26
4.4.5	IEC Budget	26
5.	Management Plan	26
5.1	Prime Contractor	27
5.2	Ministry of Health	28
5.2.1	MCH Directorate	28
5.2.2	Health Education Department	29
5.3	Royal Medical Service	30
5.4	Jordan University Hospital	30
5.5	Islamic Hospital	30
5.6	USAID's Capacity to Manage, Monitor and Evaluate	31
6.	Implementation Plan	31
6.1	Project Implementation Schedule	32
6.2	Procurement Plan	36
7.	Cost Estimate and Financial Plan	37
7.1	Cost Estimate	37
7.1.1	USAID Contribution	37
7.1.2	Host Country Contribution	38
7.1.3	Other Contributions	38
7.2	Financial Plan	38
8.	Monitoring and Evaluation Plan	39
9.	Summaries of Project Analyses	44
9.1	Technical Analysis Summary	44
9.2	Financial Analysis Summary	45
9.3	Economic Analysis Summary	46
9.4	Social Soundness and Gender Analysis Summary	47

37

9.5	Administrative Analysis Summary	48
9.6	Environmental Determination	50

Annex I Legal Exhibits

- A. Request for Assistance
- B. Delegation of Authority for PID and PP
- C. Statutory Checklist
- D. Environmental Determination
- E. Conditions Precedent and Covenants
- F. RMS Rationale

Annex II Technical Exhibits

- A. Logical Framework Matrix
- B. Implementation Action Plan
- C. Service Delivery Component
- D. Training Component
- E. IEC Component
- F. Mini-Survey Report
- G. Impact Calculations
- H. PID Issues

Annex III Project Analyses

- A. Technical Analysis
- B. Financial Analysis
- C. Economic Analysis
- D. Social Soundness and Gender Analysis
- E. Administrative Analysis

54

List of Tables

<u>Table</u>	<u>Description</u>	<u>Page</u>
Table 1.	CPP Project Summary Budget	
Table 2.	CPP Project Sites by start-up Phase	16
Table 3.	Summary Service Delivery Budget	19
Table 4.	CPP Project Training Plan	20
Table 5.	Training for Hospital Staff: Estimated Number of Courses	21
Table 6.	Training for Hospital Staff by Professional Level and Service Channel	21
Table 7.	Training for Hospital Staff by Professional Level and Project Year	21
Table 8.	Summary Training Budget	23
Table 9.	Summary IEC Budget	27
Table 10.	Summary Implementation Plan	33
Table 11.	Technical Assistance Summary	36
Table 12.	CPP Project Summary Budget - Donor Contributions	37
Table 13.	Methods of Implementation and Financing for CPP Project	39
Table 14.	CPP Project Summary Cost Estimate and Financial Plan (\$US)	40
Table 15.	Implementation Plan - General Management	Annex II.B.
Table 16.	Service Delivery Component	Annex II.B.
Table 17.	Information System	Annex II.B.
Table 18.	Programmatic Research	Annex II.B.
Table 19.	Training Component	Annex II.B.
Table 20.	IEC Component	Annex II.B.
Table 20.B.	Technical Assistance Person Months	Annex II.B.
Table 21.	Implementation Plan - Monitoring and Evaluation	Annex II.B.
Table 22.	Projected Number of Beneficiaries of CPP Project	Annex II.G.
Table 23.	Projected Number of Immediate Postpartum Family Planning Acceptors	Annex II.G.
Table 24.	Projected Number of Women Returning to CPP Centers	Annex II.G.
Table 25.	Projected Number of Women Accepting Family Planning at CPP Centers	Annex II.G.
Table 26.	CPP Project Expenditures by Fiscal Year (\$US)	Annex II.G.
Table 27.	CPP Project Summary Budget - GOJ Estimated Contributions	Annex III.B.
Table 28.	CPP Project Summary Cost Estimate - Local and Foreign Exchange Costs	Annex III.B.
Table 29.	Procurement Plan	

List of Figures

<u>Figure</u>	<u>Description</u>	
Figure 1.	Diagram of Jordanian Maternal and Child Health Service System	12
Figure 2.	Map of Jordan and CPP Sites	15A
Figure 3.	Ministry of Health Organizational Chart	Annex III.E.

||
55

THE HASHEMITE KINGDOM OF JORDAN
MINISTRY OF PLANNING
AMMAN



المملكة الأردنية الهاشمية
وزارة التخطيط
عمان

Ref. No. 5/4/1/5181
Date 12/12/1993

الرقم
التاريخ
الموافق



Mr. William I. Oliver
Director
USAID/J
Amman.

Dear Mr. Oliver,

Subject: Comprehensive Post Partum Project.

Reference is made to my letter No. 5/4/1/1110 dated March 30, 1993 concerning my request to allocate US \$ 120,000 from ISFS joint program to finance the design and development of a post partum project to be financed from USAID technical assistance extended to Jordan.

Kindly be informed that the project paper for the comprehensive post partum project is being now evaluated by the Ministry of Health, and it will be submitted to you on due time. However, in the mean time you are kindly requested to allocate in principle the amount of US \$ (11) million from USAID technical assistance to Jordan to finance the implementation of this project.

Sincerely yours

Dr. Ziad Fariz
Minister of Planning

cc. Minister of Health

لضيفة، لسياسة
د. زياد فارس
5/4/1/5181

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(See p 2, D.)

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TAGS:

SUBJECT: JORDAN ABS REVIEW - NEW PROJECT DESCRIPTIONS

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1. A REVIEW MEETING WAS HELD ON JULY 1 TO DISCUSS THE FOUR NEW PROJECT DESCRIPTIONS (NPD) SUBMITTED BY USAID AS PART OF ITS ABS SUBMISSION. ON A GENERAL NOTE, BUREAU REQUESTS THAT ALL PIDS INDICATE CLEARLY HOW THE PROPOSED PROJECT WILL SUPPORT MISSION STRATEGY. THE NE BUREAU'S OTHER COMMENTS ARE PROVIDED BELOW:

A. PROJECT 278-0289 - JORDAN TRADE AND INVESTMENT SUPPORT

1. IT WAS NOTED THAT THIS PROJECT WOULD SUPPORT QUOTE TWO PROGRAM OUTCOMES UNQUOTE (EXPORT PROMOTION AND PRIVATE INVESTMENT IN THE EXPORT SECTOR), BUT IT WOULD NOT PROVIDE ASSISTANCE TO THE GOJ IN IMPLEMENTING THE TARGET REFORMS OF THE TRADE AND INVESTMENT POLICY REFORM PROGRAM. IT WOULD APPEAR THAT SUCH TECHNICAL ASSISTANCE WOULD BE ESSENTIAL TO, FOR EXAMPLE, ASSIST GOJ IN WRITING NEW LAWS AND REGULATIONS, AND IN HELPING THEM IN IMPLEMENTING THESE REFORMS. THE MISSION MIGHT WANT TO CONSIDER ADDING A TECHNICAL ASSISTANCE COMPONENT

TO THE PAAD FOR THE TRADE AND INVESTMENT POLICY REFORM PROGRAM FOR THIS PURPOSE.

2. SINCE THIS PROPOSED PROJECT IS LINKED TO THE T AND I POLICY REFORM PROGRAM FOR WHICH AID/W'S DELEGATION OF APPROVAL AUTHORITY HAS BEEN WITHHELD PENDING CERTAIN ACTIONS BY THE MISSION AS DETAILED IN OUR RECENT CABLE ON THE PAIP REVIEW, WE CANNOT AGREE TO DELEGATE AUTHORITY TO THE MISSION TO APPROVE THE PID FOR THIS ANCILLARY PROJECT.

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PROJECT 278-0290 - PVC D-FINANCING

1. IT IS NOT CLEAR HOW THIS PROJECT WOULD LINK TO THE STRATEGY. ALSO, WHAT IS THE PROBLEM THE PROJECT WOULD ADDRESS? THE NFD IS NOT CLEAR IN THIS REGARD.

2. THE PROJECT MAY BENEFIT FROM MORE FOCUS. AS CURRENTLY VISUALIZED, IT WOULD STRENGTHEN PVOS AND NGOS WORKING IN SECTORS SUCH AS WATER, POPULATION, FOREIGN EXCHANGE EARNINGS, GOVERNANCE, DEMOCRACY, THE ENVIRONMENT AND WOMEN IN DEVELOPMENT. THIS IS A VERY BROAD SPECTRUM.

3. CONCERN WAS EXPRESSED REGARDING THE LABOR INTENSIVE NATURE OF THIS PROPOSED PROJECT, I.E. DEALING WITH A MYRIAD OF PVOS AND NGOS IN A WIDE RANGE OF SECTORS. IT WAS SUGGESTED THAT SOME THOUGHT BE GIVEN TO USING AN UMBRELLA PVO TO MANAGE THE ACTIVITIES.

4. IT WAS ALSO SUGGESTED THAT THE FUNDING LEVEL SEEMS HIGH GIVEN THE LIMITED PVO SECTOR IN JORDAN.

5. BUREAU RETAINS PID APPROVAL AUTHORITY GIVEN THE ISSUES SET FORTH ABOVE.

PROJECT 278- 0291 - JORDAN ENVIRONMENT AND TOURISM (JET)

1. THE PID SHOULD STRENGTHEN THE ENVIRONMENTAL ASPECTS OF THE PROJECT (THIS WILL BE PARTICULARLY SIGNIFICANT IN GAINING ILL CONCURRENCE). THE PID SHOULD ALSO HIGHLIGHT INTERNATIONAL EFFORTS TO SAVE THE ARCHEOLOGICAL AND HISTORICAL SITES FREQUENTED BY TOURISTS (E.G. THE ITALIAN, GERMAN, OTHER DONOR EFFORTS TO PROJECT PETRA). THE PROJECT WOULD BENEFIT FROM AN OVERALL PLANNING ELEMENT SO THAT WE

ARE NOT REACTING TO AD HOC NEEDS. WE PLAN TO PROVIDE ADDITIONAL COMMENTS SHORTLY BY SEPTEMBER WHICH WILL FOCUS ON THE BUSINESS OPPORTUNITIES WE SEE AS BEING CENTRAL TO A MORE EFFECTIVE APPROACH TO TOURISM. THE BUREAU COULD PROVIDE SOME DESIGN ASSISTANCE IF MISSION SO DESIRES.

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2. WE DECLINE TO GRANT PID APPROVAL AUTHORITY TO THE MISSION. WE BELIEVE THERE ARE SOME POLICY CHANGES REQUIRED BY THE GOV TO MAKE THIS PROJECT MORE EFFECTIVE AND WE ASSUME PID WILL IDENTIFY THE POLICY REFORMS NEEDED.

PROJECT 278-0293 - POST PARTUM FAMILY PLANNING

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158

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1. AID/W HEREBY DELEGATES AUTHORITY TO THE MISSION TO APPROVE THE PID FOR THIS PROJECT. HOWEVER, THE PID SHOULD PLACE THIS PROJECT IN THE CONTEXT OF THE AS SECTION 02 OF 02 STATE 353671

12356: H/A

SUBJECT: JORDAN ABS REVIEW - NEW PROJECT DESCRIPTIONS

OVERALL AID FAMILY PLANNING EFFORT IN JORDAN. THIS WOULD BE THE THIRD AID FAMILY PLANNING EFFORT IN JORDAN. HOW INTEGRATED ARE OUR EFFORTS IN THIS SECTOR? ARE WE EFFECTIVELY UTILIZING OUR RESOURCES? KANTER

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59

-9-

5C(2) - ASSISTANCE CHECKLIST

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

Yes. Attached.

A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS

1. Host Country Development Efforts (FAA Sec. 601(a)): Information and conclusions on whether assistance 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.

Assistance will improve services of private sector doctors, clinics and hospitals, thereby seeking to achieve (b). As for (e) the project will improve the technical efficiency of the health/population sector. Assistance, while not directed at (a), (c), (d) & (f) will not have an inhibiting effect on same.

2. U.S. Private Trade and Investment (FAA Sec. 601(b)): Information and conclusions on how assistance 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).

The project will encourage US private trade abroad and encourage private US participation in the foreign assistance program by increasing the use of contraceptives, many of which are manufactured in the US.

3. Congressional Notification

a. General requirement (FY 1994 Appropriations Act Sec. 515; FAA Sec. 634A): If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the Appropriations Act notification requirement has been waived because of substantial risk to human health or welfare)?

Yes (State 133534)
CN expired on 18 May 1994.

b. Special notification requirement (FY 1994 Appropriations Act Sec. 520): Are all activities proposed for obligation subject to prior congressional notification?

Yes

c. Notice of account transfer (FY 1994 Appropriations Act Sec. 509): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

N/A

c. Cash transfers and nonproject sector assistance (FY 1994 Appropriations Act Sec. 537(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted?

N/A

4. Engineering and Financial Plans (FAA Sec. 611(a)): Prior to an obligation in excess of \$500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

Appropriate financial and other plans have been prepared for this assistance. The project's financial plan provides a reasonably firm

61

estimate of the
cost.

5. **Legislative Action** (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

N/A

6. **Water Resources** (FAA Sec. 611(b)): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)

N/A

7. **Cash Transfer/Nonproject Sector Assistance Requirements** (FY 1994 Appropriations Act Sec. 537). If assistance is in the form of a cash transfer or nonproject sector assistance:

N/A

a. **Separate account:** Are all such cash payments to be maintained by the country in a separate account and not commingled with any other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)?

b. **Local currencies:** If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c)

162

established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

8. **Capital Assistance** (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?

N/A

9. **Multiple Country Objectives** (FAA Sec. 601(a)): Information and conclusions on whether projects 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.

See item A.1.

10. **U.S. Private Trade** (FAA Sec. 601(b)): Information and conclusions 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).

See item A.2.

11. **Local Currencies**

a. **Recipient Contributions** (FAA Secs. 612(b), 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 in lieu of dollars.

Host country contributions are included in the financial plan.

b. **U.S.-Owned Currency** (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No

12. **Trade Restrictions**

a. **Surplus Commodities** (FY 1994 Appropriations Act Sec. 513(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

N/A

b. **Textiles (Lautenberg Amendment)** (FY 1994 Appropriations Act Sec. 513(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture

No

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43

for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

13. **Tropical Forests** (FY 1991 Appropriations Act Sec. 533(c)(3) (as referenced in section 532(d) of the FY 1993 Appropriations Act): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?

No

14. **PVO Assistance**

a. **Auditing and registration** (FY 1994 Appropriations Act Sec. 568): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

N/A

b. **Funding sources** (FY 1994 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

N/A

15. **Project Agreement Documentation** (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this

The signing date has not yet been set. Upon signature the documentation will be forwarded to Washington and State L/T and USAID/LEG will be advised as appropriate.

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65

provision).

16. **Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy):
Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

Yes

17. **Abortions** (FAA Sec. 104(f); FY 1994 Appropriations Act, Title II, under heading "Population, DA," and Sec. 518):

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

No

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?

No

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?

No

66

44
d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? (As a legal matter, DA only.) Yes

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? (As a legal matter, DA only.) No

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? No

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization? No

18. Cooperatives (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life? No

19. U.S.-Owned Foreign Currencies

a. Use of currencies (FAA Secs. 612(b), 636(h); FY 1994 Appropriations Act Secs. 503, 505): Are steps being taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services. There is no US owned local currency.

b. Release of currencies (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No

67

20. Procurement

a. **Small business** (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? Full & open competition will permit all US businesses to participate equitably.

b. **U.S. procurement** (FAA Sec. 604(a)): Will all procurement be from the U.S., the recipient country, or developing countries except as otherwise determined in accordance with the criteria of this section? Yes

c. **Marine insurance** (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? N/A

d. **Non-U.S. agricultural procurement** (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) N/A

e. **Construction or engineering services** (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.) No

f. **Cargo preference shipping** (FAA Sec. 603): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act No

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68

of 1936, as amended, that at least 50 percent 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 such vessels are available at fair and reasonable rates?

g. Technical assistance

(FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

Yes

N/A

h. U.S. air carriers

(International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

Yes

i. Consulting services

(FY 1994 Appropriations Act Sec. 567): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?

Yes

j. Metric conversion

(Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in

Yes

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69

metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

k. Competitive Selection

Procedures (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes

1. Chemical Weapons (FY 1994 Appropriations Act Sec. 569): Will the assistance be used to finance the procurement of chemicals that may be used for chemical weapons production? No

21. Construction

a. Capital project (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used? Not a capital project (some minor renovation - equivalent of \$288,931 - is planned)

b. Construction contract (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? Yes

c. Large projects, Congressional approval (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 (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress? N/A

70

22. **U.S. Audit Rights** (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? N/A

23. **Communist Assistance** (FAA Sec. 620(h)). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes

24. **Narcotics**

a. **Cash reimbursements** (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? N/A

b. **Assistance to narcotics traffickers** (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance? Yes

25. **Expropriation and Land Reform** (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? Yes

26. **Police and Prisons** (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes

27. **CIA Activities (FAA Sec. 662):** Will assistance preclude use of financing for CIA activities? **Yes**

28. **Motor Vehicles (FAA Sec. 636(i)):** Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? **Yes**

29. **Export of Nuclear Resources (FY 1994 Appropriations Act Sec. 506):** Will assistance preclude use of financing to finance--except for purposes of nuclear safety--the export of nuclear equipment, fuel, or technology? **Yes**

30. **Publicity or Propaganda (FY 1994 Appropriations Act Sec. 557):** Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? **No**

31. **Marine Insurance (FY 1994 Appropriations Act Sec. 531):** Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate? **Yes**

32. **Exchange for Prohibited Act (FY 1994 Appropriations Act Sec. 533):** Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law? **No**

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33. **Commitment of Funds (FAA Sec. 635(h)):** Does a contract or agreement entail a commitment for the expenditure of funds during a period in excess of 5 years from the date of the contract or agreement?

No

34. **Impact on U.S. Jobs (FY 1994 Appropriations Act, Sec. 547):**

a. Will any financial incentive be provided to a business located in the U.S. for the purpose of inducing that business to relocate outside the U.S. in a manner that would likely reduce the number of U.S. employees of that business?

No

b. Will assistance be provided for the purpose of establishing or developing an export processing zone or designated area in which the country's tax, tariff, labor, environment, and safety laws do not apply? If so, has the President determined and certified that such assistance is not likely to cause a loss of jobs within the U.S.?

No

c. Will assistance be provided for a project or activity that contributes to the violation of internationally recognized workers rights, as defined in section 502(a)(4) of the Trade Act of 1974, of workers in the recipient country, or will assistance be for the informal sector, micro or small-scale enterprise, or smallholder agriculture?

No. In this regard the FY 93 Embassy Amman Human Rights Report for Jordan has been reviewed. Project Agreement will incorporate standard provisions barring use of USAID funds for any activity contributing to violation of any such restriction.

B. **CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY**

1. **Agricultural Exports (Bumpers Amendment) (FY 1994 Appropriations Act Sec. 513(b), as interpreted by conference report for original enactment):** If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety

N/A

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improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?

2. **Tied Aid Credits** (FY 1994 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?

N/A

3. **Appropriate Technology** (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

N/A

4. **Indigenous Needs and Resources** (FAA Sec. 281(b)): Describe extent to which the activity 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.

By reducing UNWANTED fertility the project directly responds to the needs & desires of the people. Most work is executed thru local people with training offered to these people.

5. **Economic Development** (FAA Sec. 101(a)): 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?

By reducing high population growth the Project reduces demand on scarce resources enhancing sustained economic growth.

174

26

6. **Special Development Emphases** (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

- (a) The clinics supported by the Project represent most regions of the country and serve all women /children at little cost.
- (b) N/A
- (c) N/A
- (d) By reducing pregnancies women will be more available to participate in the economy.
- (e) N/A

7. **Recipient Country Contribution** (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

Yes

8. **Benefit to Poor Majority** (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

Yes

9. **Contract Awards** (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes

10. **Disadvantaged Enterprises** (FY 1994 Appropriations Act Sec. 558): What portion of the funds will be available

Approximately 5% is specifically identified for Gray

11 25

only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

Amendment firms (external evaluations). Additionally, any contract entered into under this project exceeding \$500,000 shall contain a provision requiring that no less than 10% of the dollar value of the contract be subcontracted to Gray Amendment entities.

11. **Biological Diversity** (FAA Sec. 119(g): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

No

12. **Tropical Forests** (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act):

N/A (A categorical exclusion from formal environmental review for this Project has been granted and approved on October 27, 1993.)

a. **A.I.D. Regulation 16:** Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

b. **Conservation:** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives

|| 76

to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c. **Forest degradation:** Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment

indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

d. Sustainable forestry: If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

e. Environmental impact statements: Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

13. **Energy** (FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act): If assistance relates to energy, will such assistance focus on: (a) end-use energy

N/A

78

efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

14. **Debt-for-Nature Exchange (FAA Sec. 463):** If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

N/A

15. **Deobligation/Reobligation (FY 1994 Appropriations Act Sec. 510):** If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified?

N/A

16. **Loans**

N/A

a. **Repayment capacity (FAA Sec. 122(b)):** Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

b. **Long-range plans (FAA Sec. 122(b)):** Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

c. **Interest rate (FAA Sec. 122(b)):** If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at

11
19

least 3 percent per annum thereafter?

d. Exports to United States

(FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

See item B.6.

17. Development Objectives (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) 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; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

18. Agriculture, Rural Development and Nutrition, and Agricultural Research (FAA Secs. 103 and 103A):

N/A

a. Rural poor and small farmers: If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research,

1180

has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

b. **Nutrition:** Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

c. **Food security:** Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

19. **Population and Health (FAA Secs. 104(b) and (c)):** If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

As a comprehensive postpartum program the project is dedicated to providing low-cost, integrated mother-baby prenatal, natal, and post-natal care and family planning services at selected hospitals and clinics which deliver the vast majority of new borns.

81

20. **Education and Human Resources Development** (FAA Sec. 105): If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

N/A

21. **Energy, Private Voluntary Organizations, and Selected Development Activities** (FAA Sec. 106): If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

N/A

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

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

d. reconstruction after natural or manmade disaster and programs of

disaster preparedness;

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

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

22. **Capital Projects (Jobs Through Export Act of 1992, Secs. 303 and 306(d)):** If assistance is being provided for a capital project, is the project developmentally sound and will the project measurably alleviate the worst manifestations of poverty or directly promote environmental safety and sustainability at the community level?

N/A

C. **CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY**

1. **Economic and Political Stability (FAA Sec. 531(a)):** Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?

N/A

N/A

2. **Military Purposes (FAA Sec. 531(e)):** Will this assistance be used for military or paramilitary purposes?

N/A

3. **Commodity Grants/Separate Accounts (FAA Sec. 609):** If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? (For FY 1994, this provision is superseded by the separate account requirements of FY 1994 Appropriations Act. Sec. 537(a), see Sec. 537(a)(5).)

N/A

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|| 83

4. **Generation and Use of Local Currencies** (FAA Sec. 531(d)): Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106? (For FY 1994, this provision is superseded by the separate account requirements of FY 1994 Appropriations Act Sec. 537(a), see Sec. 537(a)(5).)

N/A

5. **Capital Projects** (Jobs Through Exports Act of 1992, Sec. 306, FY 1993 Appropriations Act, Sec. 595): If assistance is being provided for a capital project, will the project be developmentally-sound and sustainable, i.e., one that is (a) environmentally sustainable, (b) within the financial capacity of the government or recipient to maintain from its own resources, and (c) responsive to a significant development priority initiated by the country to which assistance is being provided. (Please note the definition of "capital project" contained in section 595 of the FY 1993 Appropriations Act. Note, as well, that although a comparable provision does not appear in the FY 94 Appropriations Act, the FY 93 provision applies to, among other things, 2-year ESF funds which could be obligated in FY 94.)

N/A

84

53

Environmental Consideration/Categorical Exclusion

Project Location: Jordan

Project Title/ID: Comprehensive Post Partum (CPP) Project (278-0293)

LOF: US \$11 million

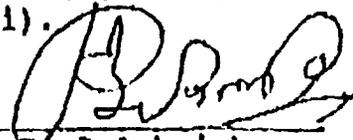
Funding (Fiscal Year and amount): FY 93 US \$3 million.

Environmental Consideration prepared by: Abdullah Ahmad

The CPP Project includes a wide range of technical assistance activities to: train physician-nurse teams in comprehensive post partum family planning counselling and service delivery techniques; establish comprehensive post partum service centers in selected public and private sector hospitals; improve ante and postnatal care; improve the availability of effective contraceptive methods; train family planning counselors; improve breastfeeding practices; and develop informational and educational messages emphasizing maternal health and child spacing. The project will conduct programmatic and clinical research to improve the quality of ante and post partum services delivery. Finally, the project will support minor interior renovation of clinic facilities (e.g. placing partition walls, air conditioners, repainting, etc.)

These activities will not have direct effect on the natural or physical environment and qualify for categorical exclusion from formal environmental review and therefore, no further environmental impact assessment is required. This exclusion is qualified under the provisions of Regulation 16, Section 216.2(o)(2)(viii).

Mission Decision:

Approved: 
P. E. Balakrishnan
Director, Office of
Population and
Family Health

Date: 10/27/93

85

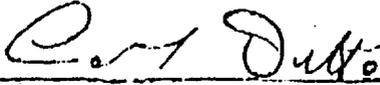
Clearances:



Abdullah Ahmad
Mission Environmental Officer

10/27/93

Date



Carl A. Dutto
Director, Office of Water,
Environment and Agribusiness

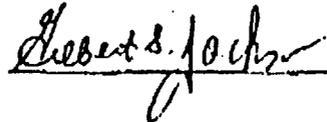
10/27/93

Date

Concurrence:

Bureau Environmental Officer:

Approved:



Disapproved:

Date:

10/27/93

54

ANNEX I.E

CONDITIONS AND COVENANTS

A. Conditions Precedent to Disbursement

1. **First Disbursement:** Prior to the first disbursement under the Grant, or to the issuance by AID of documentation pursuant to which disbursement will be made the Grantee will, except as the Parties may otherwise agree in writing, furnish to AID in form and substance satisfactory to AID:
 - (a) An opinion of counsel acceptable to AID that this Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Grantee, and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all of its terms; and
 - (b) A statement of the name of the person holding or acting in the office of the Grantee specified in Section 8.2, and of any additional representatives, together with a specimen signature of each person specified in such statement.
 - (c) The name of the full time Project Director, who will serve as counterpart to the Project Contractor staff. The Grantee agrees to designate this person as an additional representative as provided for in Section 8.2.

B. Covenants

1. **Project staffing:** The Grantee covenants to provide or seek to have provided (for the NGOs) all core staff essential for the CPP centers and for the implementation of this Project, on a timely basis, and to release candidates selected for training promptly upon notification of training courses and dates.
 2. **Training:** The Grantee covenants to ensure, that, upon completion of training, all staff will be retained in positions for which they were trained during
 3. **Project Evaluation:** The parties agree to establish an Evaluation Program as a part of this Project. Except as the Parties may otherwise agree in writing, the program will include, during the implementation of the Project:
 - (a) Evaluation of progress toward attainment of the objectives of the Project;
 - (b) Identification and evaluation of problem areas or constraints which may inhibit such attainment;
- 87

(c) Assessment of how such information may be used to help overcome such problems; and

(d) Evaluation, to the degree feasible, of the overall development impact of the Project.



U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

ANNEX I.F.

ROYAL MEDICAL SERVICE RATIONALE

To: Project Paper for Comprehensive Postpartum Project

From: John R. Power, ^{RP} USAID/Jordan RLA

Re: Royal Medical Service Rationale - Primary Purpose is Economic Assistance

Date: October 28, 1993

FACTS

According to the Project Paper, the Comprehensive Postpartum Project will include assistance to three military hospitals. Those hospitals are the King Hussein Medical Center in Amman, the Military Hospital in Irbid, and the Princess Hayya Hospital in Aqaba. These hospitals are all part of the Royal Medical Service (RMS), which runs the military hospitals in Jordan.

The project will provide assistance to establish comprehensive pregnancy counseling, ante and post natal care, and family planning information and services in a comprehensive and integrated manner. More particularly, the assistance will consist of three components: i) a service delivery component, ii) a training component, and iii) an (IEC) information, education and communications component.

Under the service delivery component, facilities will be upgraded at twelve selected sites (eleven hospitals and one clinic), including the above-named three military hospitals, to provide the appropriate space and equipment for comprehensive postpartum services and to make the project centers attractive to users. To varying degrees, USAID will provide petitions, paint, plaster, clinical and other equipment for counseling and providing services at the twelve sites. The cost of renovation at King Hussein Medical Center is anticipated to be \$37,000, and on average \$12,000 at the other sites. Standardized clinical and educational equipment and furniture will be provided at the sites, the amount of which is to be based on the number of examining rooms at each center and the number of deliveries at the site.

The training component will not only train the obstetric and pediatric staffs of the twelve project hospitals in family planning but will reach beyond them in an effort to ensure that the project concept is thoroughly integrated into the Jordanian medical system. The project's training sites will be located in the country's major teaching hospitals. Up to 2 physician/nurse teams will receive

training in the U.S. or a third country. No salaries or other personnel support will be provided.

The IEC component will seek to inform the general public of the benefits of the new comprehensive postpartum approach and encourage effective contraceptive use. It will use the mass media and interpersonal communications through community-based NGO's and other systems and develop innovative materials.

The reason for including the military medical facilities in the project is that they provide substantial medical services to the civilian population, in addition to the uniformed men and their families. Regarding the Princess Hayya Hospital in Aqaba, it is worth noting that there is no civilian hospital in Aqaba. Consequently, all medical services to the civilian population in Aqaba covered by the government health scheme are provided by this military hospital. In addition, between 40 and 60 per cent of the clients at the military hospitals in Amman and Irbid are civilians covered by the government health scheme. Also public institutions, such as the Royal Jordanian, Civil Aviation Authority and Telecommunications Authority, have all agreements with the RMS provide health care services to the employees and their families.

The military hospitals currently do not have comprehensive postpartum programs and do not budget for these items. Thus, no subsidy to the military budget is involved. The beneficiaries of the project will be mostly mothers and children from the civilian population but will also include some uniformed women and their children. Note that only less than 10 per cent of the uniformed personnel are women in Jordan.

QUESTION

Is the involvement of three military hospitals in the project legally permissible?

CONCLUSION

Yes. As the primary purpose of the assistance to be provided by this project is economic, the involvement of three military hospitals in the project is legally permissible.

DISCUSSION

(1) Legal Standards

Section 531(e) of the Foreign Assistance Act provides that ESF funds "shall be available only for economic programs and may not be used for military or paramilitary purposes. A.I.D. Handbook 1B, 4d states that "[e]conomic assistance funds may not be used to finance any goods and services when the primary purpose of such assistance is to meet military requirements of the cooperating country. There

is no exception to this policy."

As stated in General Counsel (GC) opinions, the basic test is the primary purpose of the assistance. In practice this is essentially a two stage test. The primary purpose of the project itself must be consistent with the purposes of Part I of the FAA. Then, with respect to the procurement of goods and services, as stated in HB 1B: "given the objective facts surrounding a transaction," the crucial factor in determining eligibility for A.I.D. financing is whether "the purpose of the funding at the time of the transaction is to provide economic or military assistance."

If the purpose of a project is consistent with Part I, the military may be used to implement the project if that is the most practical method or if the use of the military is desirable in furthering economic assistance purposes as set forth in Part I.

Assuming military participation in implementation, goods or services must not be essentially military in nature or specifically designed for military use and the military must not be the primary beneficiary of the project or of specific goods or training provided.

General Counsel opinions have concluded that family planning activities which provide benefits to military personnel and their dependents may be financed from the economic assistance accounts when the primary purpose of the project is to address a country's family planning needs and benefits where provided to military personnel as part of a broader nationwide program available to the general population of the country. A recent 1988 General Counsel's opinion concluded that providing condoms to the Tanzanian People's Defense Force as part of the Tanzanian National AIDs Control Program is economic assistance.

(2) Application

The primary purpose of this project - to increase the number of women initiating and sustaining use of effective contraceptive methods during the postpartum period - is clearly within the purposes of Part I of the FAA and Section 104 in particular. With respect to the procurement of goods and services, the purpose of A.I.D. funding is just as clearly to provide economic assistance as the project is directed at postpartum family planning.

The goods and services to be procured with project funding - the services, training and information, education and communications - are not essentially military in nature or specifically designed for military use. The hospital renovation planned, it is worth stating here, is limited to providing the appropriate space and equipment for comprehensive postpartum services and to make the project centers attractive to users.

Note here that a centrally funded Cooperating Agency, the Association for Voluntary Surgical Contraception, has had a long standing relationship and agreement with the Royal Medical Service to provide surgical contraception services through the King Hussein Medical Center and its affiliated clinics in Amman under their Cooperative Agreement with AID/Washington.

The military, given that the three military hospitals at issue provide substantial medical services to the civil population and that less than 10% of the uniformed personnel are women, will not be the primary beneficiary of the project or of the specific goods and services to be provided.

In summary the primary purpose of the assistance to be provided by this project is economic, and the involvement of five military hospitals in the project is legally permissible.

92

29

ANNEX IIA.
LOGICAL FRAMEWORK - COMPREHENSIVE POSTPARTUM PROJECT

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Sector Goal: To reduce fertility.	Decrease in total fertility rate.	MOH annual statistics, Census data Demographic and Health surveys Sample Surveys	Political stability and continued support for birth spacing.
Project Purpose: To increase the number of women initiating the use of effective contraceptive methods during and after the postpartum period.	End of Project Status: Increase the number of women returning for postpartum care from 6% to 60% at CPP Project sites. Increase in the rate of modern contraceptive acceptance among postpartum women participating in the CPP project to 50%. Increase in contraceptive prevalence rate from 26.9% to 33.9% among currently married women.	MOH annual statistics Evaluations Research and survey results	
Outputs: A. Service Delivery 1. Expansion of Contraceptive Mix 2. Family Planning Counseling and Service Delivery Availability 3. Comprehensive Postpartum Service Protocol 4. Referral/Follow-up System 5. Family Planning Knowledge, Attitudes and Practices	Magnitude of Outputs: 1. Two additional contraceptives methods offered to postpartum women. 2a 12 comprehensive postpartum sites established. 2b Increase in the rate of modern contraceptive acceptance among women participating in the CPP project to 50%. 3. Standardized guidelines and checklist of services/counseling developed for: -prenatal visits -delivery/pradischarge care -postpartum visits 4. Referral/Follow-up System developed and put into operation. 5. Improved knowledge, attitudes and practices of health providers at CPP sites.	1. Approval received from MOH. 2. MOH annual statistics, project progress reports, baseline surveys, site visits. 3. Receipt of guidelines and checklists. 4. Completed forms, MIS reports. 5. KAP baseline and follow-up surveys.	Registration of Norplant and Depo-Provera completed expeditiously. Cooperation between primary, secondary, tertiary levels of service providers.

57

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Outputs: (cont)</p> <p>5. Continuity of Care</p> <p>6. Medical Records and Management Information Systems Support</p> <p>7. Programmatic Research</p> <p>8. Monitoring System</p> <p>B. Training</p> <p>1. Comprehensive Postpartum Services Curriculum</p> <p>2. Training of Trainers</p> <p>3. Training Sites</p> <p>4. Staff Development (clinical, counseling, management) -OB/GYNs -Pediatricians -Nurses (all levels) -Midwives -Health Educators -Managers</p> <p>5. Medical, Nursing and Midwifery Student Orientation</p> <p>6. Observation of Postpartum Projects Abroad</p> <p>7. Training in New Contraceptive Techniques (IPPI and Norplant)</p> <p>8. Health Education Training</p>	<p>Magnitude of Outputs: (cont)</p> <p>5. Maternal and Child Health Booklet developed and put into operation.</p> <p>6. Computerized appointment and records management system installed in all CPP centers.</p> <p>7a At least 6 programmatic research projects conducted. 7b Widespread dissemination and utilization of findings.</p> <p>8. Ongoing performance of CPP centers monitored.</p> <p>1. Curriculum designed.</p> <p>2. 24 MDs certified as CPP TOTs. 18 nurses/midwives certified as CPP TOTs. 8 health educators certified as CPP TOTs</p> <p>3. 5 Training sites established.</p> <p>4. CPP training received by: -at least 300 OB/GYNs -at least 240 pediatricians -at least 320 nurses -at least 280 midwives -at least 20 health educators -at least 1 managers/center</p> <p>5. All students in participating hospitals oriented in comprehensive postpartum approach to maternal and child health care.</p> <p>6. At least 8 people observe postpartum sites.</p> <p>7. At least 15 Ob/Gyns and Midwives trained in IPPI; 1 Ob/Gyn and 1 midwife in Norplant insertion and removal.</p> <p>8. 3 MOH central health education staff trained.</p>	<p>5. Receipt of Passport, MIS reports.</p> <p>6. Site visits, project progress reports.</p> <p>7. Research reports, observation, interviews with health professionals.</p> <p>8. Monitoring/Follow-up assessments and reports.</p> <p>1. Receipt of curriculum.</p> <p>2. TOT training records, project progress reports.</p> <p>3. Training records, project progress reports.</p> <p>4. Training records, project progress reports.</p> <p>5. Training reports, project progress reports.</p> <p>6. Trip reports.</p> <p>7. Trip reports, initiation of IPPI services at all training sites, initiation of Norplant at JUH.</p> <p>8. Report on IEC program management training, report on materials development training.</p>	

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>C. Information and Education</p> <p>1. Two-part Educational Booklet</p> <p>2. Educational and Promotional Material</p> <p>3. Mass Media Promotion</p> <p>4. Outreach</p> <p>5. Health Education</p>	<p>1. Booklets produced.</p> <p>2a Materials on birth spacing and contraceptive methods in use at CPP sites.</p> <p>2b At least 2 promotional materials produced.</p> <p>2c 3 videos produced.</p> <p>3. At least 5 TV spots and 5 radio spots developed and aired; at least 4 advertisements in newspapers and magazines.</p> <p>4. At least 5000 people reached through outreach in catchment area of each CPP Center.</p> <p>5. One health educator at each CPP Center.</p>	<p>1. Booklets available at CPP sites. Site visits.</p> <p>2. Copies of materials visible at CPP sites, observation of patient education sessions, distribution plan for materials dissemination.</p> <p>3. Video and audio cassettes of spots; broadcast reports; copies of newspaper and magazine ads.</p> <p>4. Reports of outreach activities.</p> <p>5. Observation at CPP sites, job descriptions, supervisory check-list.</p>	<p>No religious or political opposition to use of mass media (TV and radio) for birth spacing messages.</p> <p>Continued existence of MOH regional health education staff.</p>
<p>Inputs:</p> <p>Service Delivery</p> <p>Training</p> <p>IEC</p> <p>Evaluation</p> <p>Audit</p> <p>Project Management</p> <p>Contingency</p>	<p><u>Magnitude (\$000s)</u></p> <p>5,006</p> <p>1,598</p> <p>2,146</p> <p>575</p> <p>250</p> <p>875</p> <p>550</p> <p>-----</p> <p>11,000</p>	<p>Technical assistance reports.</p> <p>Invoices.</p> <p>Field observations.</p> <p>Evaluation reports.</p> <p>AID audits.</p> <p>Quarterly reports from grantees and cooperating agencies.</p>	<p>Inputs available on a timely basis.</p>

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19

TABLE 16.
IMPLEMENTATION PLAN - SERVICE DELIVERY COMPONENT

Activities	Schedule																Responsibility							
	Year 1				Year 2				Year 3				Year 4				Year 5				MOH (PD)	OTHER (RAS, JHM, etc.)	CA/EA	USAID
SERVICE DELIVERY COMPONENT																								
1. Naming and presence of MD in MOH Directorate in charge of protocol development	X	X	X	X																				
2. Short-term TA from research consultant on design and analysis of focus groups for protocol development, planning for consensus meeting, etc. (2 PA total)	X		X	X																				
3. Development of protocols for standardization of antenatal, delivery and postpartum care; focus groups and consensus conference	X	X	X	X																	R	P	R	P
4. Upgrading of facilities at sites of Phase I hospitals: Al-Bashir King Hussein JUH Islamic			X	X																	R	R	R	I
5. Upgrading of facilities at sites of Phase II hospitals: Princess Basma RAS-Irbid MOH-Karak Princess Hayya					X	X															R	R	R	I
6. Upgrading of facilities at sites of Phase III hospitals: MOH-Zarga (at Soldier's Welfare Society until 1995) RAS-Zarga MOH-Matruh MOH-Madaba						X	X														R	R	R	I
7. Phase I facilities open; ongoing running of centers					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	R	R	R	A
8. Phase II facilities open; ongoing running of centers						X	X		X	X	X	X	X	X	X	X	X	X	X	X	R	R	R	A
9. Phase III facilities open; ongoing running of centers									X	X	X	X	X	X	X	X	X	X	X	X	R	R	R	A
10. Semi-annual supervisory visits of RA to all CPP centers; MOH PD and RAS project directors will attend visits to centers in their system; where possible visits will be done in collaboration with the MOH Directorate of Quality Assurance					X		X		X		X		X		X		X		X		R	R	R	P

59

TABLE 18.
IMPLEMENTATION PLAN - PROGRAMMATIC RESEARCH SUBCOMPONENT

Activities	Schedule																				Responsibility								
	Year 1					Year 2					Year 3					Year 4					Year 5					MOM (PD)	OTHER (BAS, JLN, etc.)	CA/RA	USAID
PROGRAMMATIC RESEARCH																													
1. Hiring of short-term expatriate consultant; will perform 2 week TDYS four times a year (in first year, consultant supply TA with baseline ministudy on postpartum women and with design of focus groups for protocol development)	X					X	X	X	X		X	X	X	X		X	X	X	X		X	X	X	X		I	I	R	A
2. Identification of potential local research organizations	X																											R	I
3. Identification of research topics, i.e. service-delivery problems, management problems, demonstrations						X	X	X	X		X	X	X	X		X										P	P	R	A
4. Two to three larger research projects							X	X	X		X	X	X	X		X	X	X	X		X	X				P	P	R	A
5. Five to six smaller rapid studies or activities						X	X	X	X		X	X	X	X		X	X	X	X		X	X	X	X		P	P	R	A
6. Three seminars for health professionals on research-related topics (i.e. cost-effectiveness, data for decision-making)								X					X					X								P	P	R	P

TABLE 20.
IMPLEMENTATION PLAN - IEC COMPONENT

Activities	Schedule																				Responsibility			
	Year 1				Year 2				Year 3				Year 4				Year 5				MCH (PD)	MCHS	CA/ IEC RA	USAID
1. Naming ongoing presence of MCH Health Education Personnel assigned to CPP project: Chief - 40% 2 professionals - 100% 1 secretary - 100%	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	R	I	I	I
2. Placement of IEC advisor		X	X	X	X	X	X	X	X	X	X	X	X								A	I	R	A
3. Development of program image		X																			R	P	R	I
4. Establish IEC Working Group		X																			R	P	R	I
5. Constituency development			X	X	X	X	X	X	X	X	X	X	X	X	X	X					R	R	R	P
6. Participate in health education curriculum development with training consultant		X	X																		P	I	P	I
7. Participate in development of health education supervisory system					X	X	X	X													P	I	P	I
8. Identification and training of MCHS for outreach		X	X	X	X	X	X	X	X	X	X	X									R	P	R	I
9. Develop MCH Passport with input from information systems experts and FHS resident advisor			X	X	X	X	X	X													P		R	I
10. Develop Appointment Card				X	X																R	P	R	I
11. Develop Booklet, Volumes I and II		X	X	X	X	X															R	P	R	I
12. Develop other materials		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	R	P	R	I
13. Develop videos									X	X	X	X	X	X	X	X	X	X	X	X	R	I	R	I
14. Develop and air radio, TV spots and print ads					X	X	X	X	X	X	X	X	X	X							R	P	R	I
15. Seminars for journalists					X								X								R	P	R	P
16. Other mass media activities		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	R	P	R	I

61

**Annex II.B.
TABLE 20B.**

Technical Assistance Person Months

TECHNICAL ASSISTANCE PERSON MONTHS (PM)						
Component/ Position	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Long-Term Expatriate						
General Management/ Senior Resident Advisor	12	12	12	12	0	48
Population Fellow	12	12	0	0	0	24
Training/Consultant	6	6	0	0	0	12
TOTAL	30.00	30.00	12.00	12.00	0.00	84.00
Short-Term Expatriate						
Service Delivery/Consultant for Protocol standardization	1.25	.75				2
Service Delivery/ Information system expert	1	.5	.5			2.0
Training/Refresher Training	1		2		2	5
IEC/Assistance with start-up and development of videos	4	4	3	3	1	15
Research/Assistance with design and implementation of subprojects; seminars	.25	2	2	2	2	8.25
Evaluation/Assistance with postpartum baseline and continuation rate study	.5			.5	1	2.0
TOTAL	8.00	7.25	7.50	5.50	6.00	34.25

20

TECHNICAL ASSISTANCE PERSON MONTHS (PM)						
Component/ Position	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Jordanian						
General Management/ Senior in-country advisor	12	12	12	12	12	60
USAID Project Manager	12	12	12	12	12	60
Service Delivery/ Information System Consultant	4	1	5	5		6
Service Delivery/Data Specialist	3	12	12	12	12	51
Training/Consultant	12	12	4		4	32
IEC Research Evaluation	Not included; these services will be procured through subcontracts with local advertising agencies and research and/or health organizations; they are already included in the price of the activity (see budget)					
TOTAL	43.00	48.00	40.50	36.50	36.00	205.00
Other						
General Management/ U.S.- based project backstop	12	6	6	6	6	36
General Management/ accountant	6	12	12	12	12	54
General Management/ Secretary	6	12	12	12	12	54
General Management/ messenger	6	12	12	12	12	54
TOTAL	30.00	42.00	42.00	42.00	42.00	198.00

103

101

TABLE 21.
IMPLEMENTATION PLAN - MONITORING AND EVALUATION

Activities	Schedule																Responsibility A = approve I = information P = participate R = responsible											
	Year 1				Year 2				Year 3				Year 4				Year 5				MOH (PD)	OTHER (RAS, JLM, etc.)	CA/ RA	USAID				
MONITORING AND EVALUATION																												
1. Quarterly submission of information system reports by data specialist to RA, PDS, and Working Group members					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	P	P	R	I				
2. Prime Cooperating Agency submits semi-annual progress reports, including information systems reports, to USAID. In last semester CA submits final report			X			X		X		X		X		X		X		X		X			R	A				
3. Submission of combined workplan by Working Group		X			X				X				X				X				P	P	R	A				
4. Yearly management reviews by USAID project manager			X					X								X							P	R				
5. Baselines, mini surveys and studies	X		X		X	X	X			X	X		X	X	X	X	X	X	X	X	P	P	R	I				
6. Yearly reviews of CPP centers by MOH's of Quality Assurance						X				X				X				X			R	P	P	I				
7. External midterm and final evaluations												X								X			P	R				
8. Audits			X					X				X				X							P	R				

ANNEX II.C.

TECHNICAL EXHIBITS

Service Delivery Component

A. Facilities Upgrading

Each of the five health channels (MOH, RMS, JUH, Islamic Hospital and the Soldier's Welfare Society) has agreed to provide dedicated space comprehensive postpartum services can be provided for mothers and infants. The CPP Project will provide partitions, paint, plaster, clinical and other equipment necessary to upgrade the space and to improve the quality of services.

CPP Training Centers:

Residents of pediatrics and Ob/Gyn as well as students or nursing midwifery and medicine will be trained as they rotate through one of five CPP training sites. Current Ob/Gyn and pediatric specialists also will receive training at one of the five training sites. Some of the dedicated space at these training sites will require significant special petitioning. For example, the King Hussein Hospital in Amman will serve as the central training point for almost all RMS doctors, residents, nurses and midwives as well as for students of medicine, nursing and midwifery. In order to accommodate this number of trainees plus the large number of postpartum returnees expected at King Hussein Hospital, the cost of renovation is anticipated at \$ 37,000. Within the MOH system, Al- Bashir Hospital will serve as the main training center for the same kind of type of resident, student and staff. The cost of renovating the space is estimated at \$ 40,000 of which the MOH will contribute 50 per cent.

JUH agreed to pay all the costs of renovating its CPP space if USAID provided a much needed neonatal monitor for teaching purposes. The cost of upgrading the space at the other two CPP training sites is estimated at \$ 15,000 each.

CPP Service Centers:

In addition to the five training centers, postpartum information and services will be provided at an additional four MOH and two RMS hospitals, as well as plus one NGO Clinic (Soldiers Welfare Society in Zarqa). The cost of renovating the MOH and RMS Hospitals to establish CPP centers is estimated to cost on average \$12,000. The cost at the Soldiers Welfare Center for establishing a CPP center is \$45,000 since it will be necessary to extend an existing room.

It should be remembered that the Soldier's Welfare Society facility will be offering postpartum care for more than 10,000 mothers being delivered at the overcrowded MOH and RMS hospitals in Zarqa. The Society has assured the design team that the RMS will provide the staff required to operate the Center.

Equipment:

Standardized clinical and educational equipment and furniture will be provided at the CPP training and service centers. The amount of these resources will be determined by the number of examining rooms at each center which in turn is a factor of the number of deliveries at the hospital. The equipment requirements were developed in discussions with officials of the five cooperating health channels to be involved in the Project.

Implementation Responsibility:

Except where otherwise noted in this section, all procurement of equipment and arrangements for renovation will be the responsibility of the Prime Contractor. Type, time and costs of equipment and site renovation at 12 CPP centers are listed in following Procurement Plan.

B. Programmatic Research

The Project will support approximately seven programmatic research or research-related subprojects to assist the various CPP public and private organizations implement their activities. In the form of studies and technical assistance, the programmatic research component will strive to increase access to and improve the quality of information and services delivered through the Project. Studies that also assist in the evaluation of the overall Project may also be undertaken.

The Prime Contractor will be responsible for implementing the programmatic research component. Because the research component must be flexible to aptly meet the CPP's service delivery, training and IEC needs, the following enumeration of activities is only illustrative:

- Approximately two to three larger, more expensive studies could begin in the second or third years. These would be studies that needed longer, more controlled interventions or environments in order to more precisely measure results.
- Approximately five to six smaller studies would be undertaken throughout the Project's life. These would place emphasis on topics that are studied quickly, thereby increasing utility of results to service providers and program managers.
- Approximately three small seminars (\$10,000 each) could occur in the second, third and fourth years. These would have the objective of enhancing the non-medical skills of Jordanian health professionals. Example topics are cost-effectiveness or the use of data in management decision-making.

Annex II.C.
Service Delivery Exhibit

The programmatic research component intends to draw from the large pool of researchers in Jordan; thus, the vast majority of activities can be subcontracted by the Prime Contractor to Jordanian organizations, such as the Jordanian University of Science and Technology (JUST) and the JUH, or local NGOs.

Short-term technical assistance will be required from an international expert in programmatic research. Such a person will assist local organizations in the identification of research opportunities and will then aid in the design, implementation, and analysis of results of the subproject. S/he may also be asked to assist the senior resident advisor in the design and implementation of more complicated evaluation activities. An example would be the provision of TA in the design of focus groups planned to precede the consensus conference on protocols. It is estimated that such short-term technical assistance by an expatriate would total to 8.25 person months.

When the short-term consultant is not in Jordan, the senior resident advisor will be primarily responsible for providing technical assistance to the subcontracting researchers. S/he will be assisted by the data specialist, who is envisioned as gaining a solid understanding of programmatic research from such experience.

Research topics will be chosen based on their relevance and potential impact on the CPP's access, quality, and cost-effectiveness. The quarterly meetings of the Working Group will provide an excellent opportunity for the identification of programmatically relevant issues. The topics described herein should only be considered illustrative:

- **Referral MCH Health Booklet:** The health booklet will play a crucial role in providing women continuity of care in a segmented health care system. Yet, experience with the current referral sheet suggests that its successful utilization by both clients and providers will be challenging. The Programmatic Research Component can provide a continual assessment of the utilization of the booklet and suggest and/or test mechanisms for improvement. (NOTE: Because the FHS Project will be working with the MOH's health centers, it is strongly recommended that this research activity be undertaken in close coordination with FHS implementing agencies.)
- **IEC:** IEC constitutes a large endeavor within this Project, and as such should also be a priority for the research component. It should be creative in looking for new ways to communicate messages to hard-to-reach audiences, such as men, or women in the hospital before discharge. An example might be placing televisions and VCRs in every recuperation room on a maternity ward. These would be used to provide recently-delivered mothers with educational messages for herself and her newborn. Such IEC might be expensive but perhaps cost-effective given the lack of health education staff on maternity wards. Research could be done to look at the

intervention's cost-effectiveness as well as women's perspectives about its appropriateness at such a stressful time.

- **Capacity of Non-Physician Professionals in the Provision of Family Planning:** Ministry of Health norms currently permit only physicians to provide all forms of modern contraceptives, while nurses and midwives are allowed to distribute only oral contraceptives and condoms. By not permitting non-physician professionals to provide certain methods, specifically IUDs and tubal ligations, clients often are unable to receive their method of choice. This problem will be further exacerbated when postplacental insertion of IUDs is incorporated into the national family planning program, as nurses and midwives are more likely to be attending normal deliveries. Because this issue is politically sensitive, it may be necessary to do a demonstration project in which the capacity of nurses and midwives to provide clinical methods is proven.
- **Gender:** Interviews with various health professionals indicated that gender is an important consideration for family planning programs in Jordan. An example is that many women resist pelvic examination by male physicians. The result has been two-fold: 1) many women simply do not get the method they want, particularly the IUD; and 2) women who do choose IUDs are given ultrasounds as a part of routine care (to ensure that the IUD is in place) at considerable expense to both the client and the health care system. Furthermore, ultrasounds are not able to determine the presence of Pelvic Inflammatory Disease (PID), leaving many women at risk of a dangerous medical condition. However, many male physicians and policymakers are hesitant to believe that women feel this way, or that it affects their acceptance of family planning. A study could examine the difference in family planning acceptance among clients of male and female providers and be used to demonstrate the importance of gender within the Jordanian MCH program.
- **Introduction of other progestin-only methods into postpartum family planning programs:** The "minipill" is currently the only hormonal method available to lactating women. Norplant and Depo-Provera could considerably increase the range of methods available to these women, but the MOH has not yet approved either methods for use in Jordan. If necessary, a programmatic research project could document the demand for and safety of both methods and thereby facilitate their approval by the MOH. Such a study would also assess the acceptability of the methods in the Jordanian context.

Both quantitative and qualitative research methodologies will be used in carrying out research activities, including diagnostic studies; baseline studies; knowledge, attitude and practice studies; and service facility surveys; focus groups, in-depth interviews, and observational studies; time-series analyses; and quasi-experiments.

102

25

Annex II.C.
Service Delivery Exhibit

The dissemination and utilization of research results will be emphasized throughout the entire CPP Project. Each subproject will end with a final conference in which results are clearly and concisely presented to program managers, service providers, policy-makers, and AID/Amman personnel. Reader-friendly final reports will be prepared as well, and attempts will be made for them to be published in Arabic and English language professional journals. A monthly bulletin aimed at supplying health providers with continuing education on family planning and maternal and child health, will also focus editions on research results. Furthermore, efforts will be made to upscale program improvements to all CPP sites, and where relevant, to other levels of the health care system.

ANNEX II.D.

TECHNICAL EXHIBITS

Training Component

The activities of this Project are to establish a continuum of care for women during pregnancy, delivery and into the postpartum period. The emphasis will be not only on medical care but on education. The educational content will be directed towards maternal nutrition and full breastfeeding for early growth of the infant, and will emphasize the utilization of effective contraception and helping the infant reach the classic milestones of development along with full immunization. The adoption and continued use of contraception is crucial for the infant's health and ultimately provides a means of self determination of the mother's fertility.

Current Jordanian institutional service structure generally fragments the provision of antenatal care, delivery service and postpartum care. Although 80 percent of Jordanian deliveries occur in hospitals, only a small proportion of women receive their antenatal care in the same hospital and even fewer return for postpartum care. Except for a brief attempt to spot congenital abnormalities, there is no routine monitoring of the growth and development of the child until immunizations begin in the third month. Postpartum care is so successfully separated from the infant care and immunizations as to be almost totally ignored except for those mothers at high risk or with serious complications. Physicians and nurses providing these services in the public sector find themselves focused on, and responsible for, an isolated segment of this cycle and expect someone else to pick up the next step in the cycle of care. The thrill and relief of the successful delivery result in total attention to the infant at the expense of maternal care, education and provision of a prompt and effective contraceptive method.

This project aims to reorient institutional patient flow patterns, renew medical and nursing skills to establish an active patient education program, and a comprehensive postpartum center (CPP) to provide health services for both mother and infant at the same time and place. The educational aspect will begin during the antenatal clinic visits, be reinforced at hospital delivery time, and vigorously pursued at the CPP center, where the mother can be provided with an effective birth spacing method and the growth and development of the child will be monitored.

This project will concentrate first on the mother to educate her during each antenatal, delivery and postpartum contact on the importance of using an effective contraceptive method to improve the health of her baby and herself. Second, the project will concentrate on training all doctors and nurses in contact with pregnant women to educate them on the important health benefits of birth spacing. And thirdly the project will assist in establishing

CPP centers to bring about increased acceptance of family planning in the postpartum period by Jordanian women who deliver in hospitals.

As already noted, the project will be established in four parallel channels of health services: the Ministry of Health hospitals, the Royal Medical Services hospitals, the Jordan University Medical Center, and the Islamic Hospital. The latter provides almost a third of deliveries done in the private sector and thus represents private hospitals. A special clinic and training site will be established in the chief hospital in each of the channels in Amman as well as in Irbid in the north.

In-Country Training

Training is to be provided for obstetrical and pediatric staff and their residents as well as for the nursing and midwifery staff who support the antenatal, delivery, postpartum and newborn services of selected hospitals of each of the four channels. It is expected that each hospital will select at least one staff member to be a full time health educator to be trained for the project.

Training Sites

The selection of central Jordan for the first training and service sites is a reflection of its population density, the location of large numbers of deliveries and established training institutions.

The principal training center for the Ministry of Health will be at the Al Bashir hospital in a building already selected by its director for a CPP center. Both postpartum and infant care services will be provided here there will be training facilities for obstetricians, pediatricians, residents, nurses and midwives. It will also serve as a base for the training consultants and be the principal training center for the project. North Jordan will have a CPP center and training site when the MOH hospital at Irbid is completed in November 1993. From these sites the staffs of regional MOH hospitals will be trained.

The King Hussein Medical Center will be the training site for the medical, midwifery and nursing staff involved in antenatal, delivery, postpartum and pediatric care in all of the RMS hospitals. Space has been allocated for the special CPP center where training will be carried out for the whole RMS system. As all obstetric and pediatric staff and their residents rotate through the King Hussein Medical Center, a special training schedule will be arranged.

The Islamic Hospital will be the training site for private sector doctors and nurses. Given that 50 percent of women delivered at Islamic receive their antenatal, postpartum and pediatric care from the hospital's outpatient clinics, and that the remaining women receive care from private obstetricians, Islamic Hospital is ideal as a training site for the private sector. Special space will be assigned for the CPP unit as soon as the location of the obstetric clinic is moved to be adjacent to the pediatric clinic area.

Jordan University has been selected as the principal academic training unit. Space for the special CPP center will be designated. It is anticipated that the training to be provided to the senior medical and nursing staff will be reflected in the curricula of the undergraduate medical and nursing students as well as that of the residents.

Management Training for Directors of the Training Units

A carefully orchestrated project introduction and management training program will be given for the MOH Project Director and staff together with the medical and nursing directors from each CPP training site. This will be held for one week at the Jordan University of Science and Technology Conference Center. The CPP service plan, curriculum and training methodology will be reviewed and finalized. This will then become the basis for the management training for the project as a whole and for each center. The management content will stress supportive supervision throughout the service centers, without which the services will soon disintegrate.

Training Site Activities

Format

The principal activity of the training sites will be to provide comprehensive postpartum services to demonstrate the effectiveness of the concurrent care of mother and child, emphasizing the provision of family planning services for the mother and growth monitoring for the infant. This demonstration will periodically be used as a training base for the obstetric, pediatric, nursing and midwifery staff who provide antenatal, delivery, postpartum and pediatric care in the hospital.

Training Courses

In order to prepare senior hospital staff to be trainers for the project, a special group of training consultants will provide a four-day training of trainers (TOT) for these seniors. Thereafter, the training site will be used periodically to provide courses of three weeks duration to small classes of no more than 16 participants. The participants will be all hospital staff who provide services to pregnant women, women in labor and their newborn

infants. When appropriate, staff may be included from nearby comprehensive health centers (CHC) which refer many patients to the hospital.

The courses will provide an update on current contraceptive technology with an emphasis on contraceptive counseling and the education of mothers about the health benefits of birth spacing. New approaches to the quality of care in this national project will be presented. A second segment of the course will provide a choice in competency based clinical training, and a special segment for managers.

Training of Trainers: Location and Sequence

Training of trainers (TOT) will have to be provided to a carefully selected training staff (including an obstetrician, a pediatrician, a nurse and a health educator) from the initial four hospital training sites in Amman. In the second phase of training, the TOT will be arranged for the training staff of the MOH hospital at Irbid. The third phase program will be designed for the MOH hospitals at Madaba and at Mafraq and for the RMS Hospital at Zarka. The special situation of the Soldiers Welfare Clinic at Zarka, which is given medical staff from RMS and has a small but significant nursing support from the MOH, will allow its inclusion into the program by phase three. (See the section on Facilities Upgrading in the Project Description. The phasing of each of these TOT programs hinges on the available space for the CPP center and the availability of the training consultants. It is anticipated that the trainers of the FHS programs and the MOH health education training coordinator will be included in one of the early TOT programs. Any available additional slots should be offered to the members of the MOH Health Education Department.

The TOT course must include a serious review of curriculum content to set the learning and behavioral objectives as appropriate for the specific institutional staff to be trained and for the overall project aims. The TOT course at each site will be followed by a three week hospital staff training (see below), with full participation, as participants, of those who have just been trained as trainers. Following the trainers' participation as trainees in the hospital staff training, each site will be prepared to organize its own training program for its own staff using the tested curriculum and being monitored by the consultant. It is anticipated that the Islamic Hospital will provide this training to its house staff plus the obstetricians and pediatricians who have staff privileges and admit numbers of patients to the hospital. Staff from other private hospitals such as Al Amal may be accepted at the Islamic or at the Jordan University Hospital training programs as desired.

The training consultants will monitor the first two training programs of each Center.

Hospital Staff Training: Core Curriculum

The standard training for hospital staff will include a core curriculum of two weeks followed by a week of competency-based clinical training. For those who are to manage the CPP centers, a brief management course may be substituted for the clinical week. The core curriculum will include units which provide updates on current contraceptive methods, counseling based on the Bruce elements of quality of care, adult and group education methods, minimal standards for medical and nursing protocols, including those for growth monitoring and for contraceptive methods, and use of the MCH passport and the referral system.

Hospital Staff Training: Competency-Based Clinical Training

Competency-based clinical training will focus on counseling techniques, using the "gather" method, and on training in IUD insertion for appropriate staff members. For pediatricians clinical training will focus on the growth and development of the infant to follow weight gain, head circumference, and the milestones of early motor development. Counseling of parents on these as well as congenital abnormalities will be practiced, using the MCH passport's page for the infant as a guideline.

Project Manager Training

The project manager's course in this third week will pay special attention to the staffing patterns, training requirements, patient flow, team building, the MIS, supplies of contraceptives and patient education activities. Support for the stream of education through the antenatal, delivery, postpartum and neonatal steps will need to include supportive supervisory skills for the achievement of well-informed mothers who will make full use of the services provided. Completion of the passport data, making appointments and other aspects of follow-up are crucial to the quality and effectiveness of the program. Monthly reports and orders will need to be reviewed recommendations from center managers will be welcomed.

Hours of Training Hospital Staff

It is anticipated that the hospital staff training will be given daily for the three weeks. The core curriculum will last two weeks and be followed by the week of clinical training in the provision of contraception for the obstetricians, growth and development milestones for the pediatrician, or management training for managers. Because of heavy clinical responsibilities of the staff, the actual time required for the course will have to be determined by the training consultants after a review of the curriculum and the center

functions with the director of each training site to assure that the aims of training and of the overall project will be met.

Training Methods

Although many of the persons selected to be trained as trainers have excellent teaching experience and, indeed, many are currently teaching, the importance of a unified focus with equally strong training skills at each site cannot be over-emphasized. The program involves new approaches to patient education with an emphasis on the quality of care as measured by the information given to patients, patients' choice, professional competence, warm interpersonal relations, the constellation of available services and an effective acceptable follow-up methodology. There is a clear need to utilize modern teaching methods to set goals and measurable learning and behavioral objectives, to use group activities and even role playing. For many, these will be new methods and will need to be understood to be used successfully. Doctors learn surgery by doing surgery and experiential learning will be needed for this vigorous project proposal. The TOT will last four days and be carried out by the training consultants.

Overview of Hospital Staff Course: Core Curriculum

The hospital staff training core curriculum will be introduced with a review of Jordanian fertility statistics and their relationship to international data on fertility and health. It will update the technical knowledge on specific contraceptive methods: breastfeeding, oral contraceptives, injectable hormones, Norplant, IUDs, the immediate post-placental insertion of IUDs, and female sterilization with minilaps or laparoscope. Traditional medical criteria and procedures which unnecessarily or inadvertently limit the use of modern contraceptives will be critically assessed with a view to their removal. Of equal importance will be to upgrade counseling skills in order to meet the information needs of women who are increasingly aware of family planning and who may have briefly experimented with a method but who have not had the advantage of a frank discussion of contraception or an opportunity to make a choice or learn about the important health benefits for her child and for herself when pregnancies are spaced more than two years apart. Counseling techniques, using the "gather" method and the six Bruce elements which make up the quality of care are to be thoroughly explored as related to current services and proposed modifications.

The format of the CPP project will be presented, emphasizing its client orientation to family planning methods. A protocol for antenatal and postpartum care of the mother-child unit will be reviewed for its application to each hospital system in relation to its quality of care standards. This protocol will have been developed based on special focus group studies of women's needs and expectations followed by deliberations by a consensus conference of leading obstetric and nursing experts. A scientific procedure for following the growth and

development of newborns and infants will be presented by pediatricians for the protocol (in contrast to the more usual custom of leaving such observations to the extended family of aunts and grandmothers).

The MIS will draw on data from the MCH passport for data on each newborn and its individual growth and development chart through the period of immunizations. A special growth and development page of the passport will be developed by the Chief of Pediatrics at Al Bashir Hospital. The immunization record could be a perforated leaf in the passport that can be torn out when the child enters school. In tandem with the passport will be a special appointment card for the postpartum period, given to the mother at the time of hospital discharge after delivery. The appointment card for the initial immunization in the third month could be included and provide for adjustment according to the follow-up needed for the specific contraceptive method begun.

Educational materials are to be introduced and reviewed and their use discussed. The responsibility of each staff member for patient education is stressed to clarify the role of the health educator as coordinator.

Health Education Training Needs

For the MOH Health Education Department, which will manage the national IEC program, the staff involved will receive training appropriate to their job responsibilities for the project. For the Chief of Health Education, a program in IEC program management is needed. Two other staff members should receive training in advanced materials development--training that could well be provided by a local advertising agency. And the department's health education training coordinator for the project could participate in one of the project's TOTs to gain training skills.

The MOH's 40 member regional health education staff who are responsible for community education, will have an important role to play under the project in community outreach. They will need training in innovative outreach techniques, such as story-telling and improvised drama, as well as in family planning and the concept of the CPP program. There will be at least three regional training sessions for these staff conducted by a short term consultant along with a Jordanian counterpart such as an educator from Rada Barnan. The curriculum will be developed by the consultant trainer in consultation with the Health Education Department. The same curriculum can also serve as a model for the NGO training envisioned in the project's IEC component.

Out-of-Country Training

The training needs of this project include a limited amount of out-of-country training. The first is to strengthen the management of the MOH Department of Health Education. The second is to enable the introduction of three new contraceptive techniques. And the third is for a limited study tour to Sfax University in Tunisia where a successful comprehensive postpartum project is well-established..

IEC Management Training

The Chief of the Health Education Department will be responsible for the implementation of the ambitious IEC component of the project and could benefit from management training. Training of this type is available once a year in a special one month program at the University of California, Santa Cruz, in the Center for International Health Programs. This training should be provided as soon as possible.

Training in New Clinical Contraception

Three new contraceptive methods have been requested by the MOH as an addition to the current family planning program. They are (1) immediate post-placental insertion of IUDs (IPPI), whereby the IUD is inserted immediately after the expulsion of the placenta; (2) Norplant, that is the use of subdermal implants of silastic capsules containing progestin that are effective for five years. (Norplant has been requested for training purposes and to investigate its acceptance and continuity of use in Jordanian women.) (3) Depo Provera, an injectable form of progestin that prevents conception for three months. This method, too, is requested to explore its acceptability for Jordanian women.

The MOH has requested that the immediate post-placental insertion of IUDs (IPPI) be introduced at each of the CPP project's training sites. There are essentially three requisite conditions for this: an obstetrician or midwife experienced in the use of IUDs, a large number of deliveries in the proposed hospital, and sufficient opportunity for antenatal education of the pregnant woman to assure informed consent for this procedure. All four of the first training sites in this project meet these requirements. Therefore the Ministry has requested that two persons from each site receive this training as soon as possible. It will be particularly important for these eight persons to be sent for this training as quickly to permit the initiation of that phase of the program before formal training of the hospital staffs begins. The University has requested that one midwife be included in this training and the MOH has given its consent. It is expected that these four sites will keep careful track of the characteristics of the women included, the predelivery counseling provided to them, the continuation/expulsion rates, and causes for removal. In Phase II, two additional physicians will be trained in IPPI for the MOH and RMS hospitals in Irbid.

The requisite short term training for IPPI is available in Turkey, a neighboring Islamic country with a national postpartum program.

Jordan University has requested training for one obstetrician and one midwife in the placement and removal of Norplant capsules and a supply of 400 sets of Norplant for this investigation in the University Medical Center. The Ministry of Health has given approval for this investigation. It should be promptly arranged by the principal contractor.

Use of Training Consultants

Almost all the training required for this project is in-country training. This national hospital based comprehensive postpartum program will require the training of hundreds of doctors, nurses and health educators in four separate health systems: the Ministry of Health, the Royal Medical Services, Jordan University and the Islamic Hospital. The attached tables indicate the initial numbers of staff to be trained. Because of high turnover--the extent of which cannot be defined--the probable need for another round of TOT for the training sites is planned for the third and fifth years of the project. The implementing agency will engage a training consultative group to further assess needs, plan the curricula, train the trainers, and to assist and monitor the subsequent training of doctors, nurses and health educators. The consultants will be provided working space at the training site at Al Bashir. Modern training methodologies which set specific learning and behavioral objectives will be used.

It is expected that the training consultative group will advise on the development of the CPP training units, will direct the development of appropriate and effective training programs, will train the trainers and will monitor the subsequent training activities as indicated in the sections above. They will recommend the timely use and content of refresher courses for the established training centers of the MOH, the RMS, the Universities and the Islamic Hospital, as well as a supervisory mechanisms to assess the effectiveness of services provided by persons trained and practicing out in the field.

Training units, each of which will specify learning and behavioral objectives, will be developed by the training consultants to be used in a variety of training courses. These will include:

1. Training of trainers
2. The national design of the Project
3. Adult education methods; setting learning objectives
4. Values clarification exercises
5. Hormones in reproductive physiology
6. Current contraceptive methodologies
- at medical and nursing levels

- 02
- at health educator level
 - 7. Medical barriers to contraception and their removal
 - 8. Unified protocols for clinical and educational services
 - 9. Counseling skills (the "gather" method)
 - 10. Quality of care in family planning: Bruce's six elements
 - 11. Milestones and measurement of growth and development
 - 12. The use of educational materials for pregnant women, new mothers and fathers
 - 13. Outreach techniques
 - 14. The MCH passport as medical record, referral instrument and priority:
 - appointments and follow up
 - 15. Management and supervision

With the development of these educational units by the training consultants in collaboration with the directors of the four primary training sites, full curricula can be assembled for the new and ongoing training programs identified as essential for this project.

Training Consultant Group Qualifications

The training consultant group should include a senior obstetrician skilled in the use of current contraceptives, in counseling, in quality of care standards, and in training methodologies. There should also be two others, preferably nurses skilled in counseling and health education, who are active experts in modern educational techniques for groups, for individuals, and for facilitating consensus on difficult problems. It is very important that at least one, and preferably both of these, speak Arabic. It will be most effective if these two are Jordanians.

Duration of Training Consultancy

It is anticipated that the principal work of the training consultants will be accomplished in the first year of the project. However it is imperative that the consultants be available for an evaluation of the training in the third year and probably for a refresher TOT program to overcome the potential problem of staff turnover at the training sites. The third and fifth years' activities are expected to be for two months.

It is crucial that the obstetrician be highly qualified and skilled in the techniques identified if the needed behavioral changes are to be achieved in the medical trainees. His experience will be valuable in organizing the clinical flow. To acquire such a highly qualified and skilled obstetrician it may be necessary to modify his involvement to the period of curriculum development and for TOT activities only. This will be possible if the selection of the Jordanian nurses as trainers is stringent.

HOSPITAL STAFF TRAINING: ANTICIPATED TRAINING COURSES

Channel	Year 2	Year 3	Year 4	Year 5	TOTAL
MOH	10	13	4	4	31
RMS	10	6	3	3	22
University	5	3	3	2	13
Islamic	5	1	1	1	8
Totals	30	23	11	11	74

The bulk of the staff training will be accomplished at the University and Islamic Hospital in the second year and for the MOH and RMS in year three. The training in years four and five will be largely for residents and students who, if successfully trained, will assure the future of the comprehensive postpartum concept.

TRAINING FOR HOSPITAL STAFF BY PROFESSIONAL LEVEL AND HEALTH CHANNEL

Service Channel	Ob/Gyn	Pedia-trician	Nurse	Midwife	Health Educator	Total
RMS	85	58	102	99	8	352
MOH	144	104	125	115	12	502
Univ	52	56	58	40	2	208
Islam	31	28	35	32	2	128
Totals	312	246	320	286	24	1188

TRAINING FOR HOSPITAL STAFF
BY PROFESSIONAL LEVEL AND PROJECT YEAR

YEAR	Ob/Gyn	Pedia- trician	Nurse	Midwife	Health Educator	Total
2	124	111	123	102	24	484
3	102	63	98	105		360
4	43	36	52	45		176
5	43	36	47	34		160
Totals	312	246	320	286	24	1188

ANNEX II.E.

TECHNICAL EXHIBITS

Information, Education and Communications Component

The IEC component is the CPP project's primary means of achieving the Mission's goal of reducing fertility by improving knowledge of effective contraception (Country Program Statement, Sub-Program Outcome 3.1.1). It is also an essential element of successful postpartum projects elsewhere in the world. Experience in Lebanon, Peru and Mexico, for example, has shown that contraceptive acceptance increases dramatically when strong IEC programs are implemented, particularly programs with a solid interpersonal communications component.

As noted elsewhere in this paper, the GOJ position on family planning is to support "birth spacing" with a view to promoting maternal and child health. Thus, the IEC program is framed in terms of promoting maternal and infant health care, including family planning, so that its scope and public image will be somewhat broader than the Mission's fertility objective. Nevertheless, at the heart of the program will be three primary objectives:

- o To educate pregnant women and new mothers about the benefits of birth spacing and the safety and efficacy of contraception;
- o To encourage pregnant women and new mothers to adopt an effective contraceptive method at the time of delivery or postpartum; and
- o To promote effective contraceptive use by couples who adopt a method.

A variety of strategies will be used to achieve these objectives.

To achieve the first objective relating to improving the knowledge and attitudes of all Jordanians, the mass media will be the main channel of communication. This will be backed up by interpersonal communication through outreach activities and the widespread availability of educational materials.

To achieve the second objective of encouraging the adoption of effective contraception, the primary vehicle will be education and counseling provided to pregnant women and those who deliver in the hospital. This will be supported by materials that encourage women, in subtle ways, to seek care throughout pregnancy and the postpartum period; by a "client-friendly" atmosphere in the CPP centers; and by mass media promotion. For those women who receive care through maternal and child health centers or private providers, the project's materials will help encourage them to seek continuity of care, including family

planning. And education and counseling for women at the health center level will be assured through the FHS project's training activities.

The third objective of promoting effective contraceptive use will be achieved through education and counseling for acceptors, backed up by materials to be taken home.

The IEC program will be designed to build on the experience of past health education and marketing programs in Jordan which have shown mass media and printed materials to be highly effective and relatively inexpensive communications media for reaching a wide public. It will also seek to use interpersonal communications channels that are not yet widely used in Jordan but which show promise in a culture where information from family, neighbors and friends is highly prized and--on medical matters--where the advice of the medical and health profession is valued. Thus, there will also be a major push to educate health professionals about the importance of birth spacing and the safety of contraceptive methods, along with efforts to reach Jordanians in their home communities through outreach workers with close links to the community.

Many IEC programs are content simply to raise public awareness of family planning and its availability. This program will be characterized by its use of motivational messages designed to maximize the chances of influencing behavior and not merely improving knowledge. The messages will be conveyed through a mix of media that are known to be effective. And generally accepted communications techniques will be used to ensure the effectiveness and cost-effectiveness of material and media produced through the project. These techniques include messages targeted to specific audiences based on the findings of research; pretesting; and frequent monitoring and evaluation of program impact so as to be able to fine-tune the program whenever necessary.

The program will face a major challenge in reaching men who play a major role in decisions about childbearing and family planning. Numerous experts were unable to identify means of reaching this population other than television and religious gatherings. The desires of mothers-in-law for many grandchildren--or male grandchildren--are also crucial to childbearing and family planning decisions. Yet this group, too, is not easy to reach. All elements of the IEC program will be targeted to these groups to the extent possible, using appropriate messages and media, in light of the best information available about how to reach them.

Project IEC activities will be designed to complement and build on the activities of current and planned programs, such as AID/Jordan's Marketing of Birth Spacing and Family Health Services Project and UNICEF's breastfeeding campaign. The MBS project plans to undertake a variety of IEC activities to increase and improve contraceptive practice. The CPP project will take a more indirect approach--especially in its mass media activities--by

addressing family planning in the context of care related to pregnancy and improved child health. It will also plan to use the materials, such as leaflets and flip charts on contraceptive methods, being produced under the MBS project. Coordination between the two projects will be crucial to the success of both and there will be regular meetings to ensure that activities are complementary. Plans will also be coordinated with other donors, such as UNICEF which is about to launch a major breastfeeding campaign. UNICEF has agreed to share its materials with the project and its work will help promote good breastfeeding practices, including those that protect women against pregnancy. The vehicle for this coordination will be the quarterly meetings described in the Implementation Plan.

Since knowledge of contraception is already close to universal in Jordan, the effectiveness of IEC activities will be measured more by utilization of family planning and postpartum services than by the traditional KAP survey. However, the IEC component of the project will make extensive use of ongoing monitoring and evaluation to measure its success and guide the evolution of the program.

4.2.2 IEC Program Management

The Health Education Department in the Ministry of Health will be responsible for the overall strategy and execution of the IEC program, with the advice of an experienced expatriate technical consultant.

The MOH will make available, at a minimum, the following staff for the duration of the project; 40 percent of the time of the Chief of Health Education Department; two full-time (or equivalent) professional staff with background in materials development and health education or training; and a full-time secretary. The department will receive equipment needed for the execution of the project, such as a computer with graphic capability and some additional video equipment to permit the production of simple videos in-house.

The prime contractor will secure the services of a senior technical consultant in Jordan for four months/year during the first two years of the project.* Such technical consultancy was requested by the Chief of Health Education, the Secretary General and other senior staff at the MOH in order to upgrade the skills of the Health Education Department (HED). The HED has conducted a number of health communications programs in recent years but a review of their work demonstrates that, while it is technically competent, its effectiveness could be dramatically enhanced by strengthening its strategic planning capability, its ability to develop materials and media that can influence people's behavior and overall program management. Other donors who have worked with the department concur that expert

* 3 months/year during years 3 and 4 and 1 month during years.

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**Annex II.E.
IEC Exhibit**

technical assistance over a period of years could build this department into a highly skilled and well-managed operation that could craft effective health communications campaigns. (The job description for the advisor is attached to Appendix II.E.)

The HED and the IEC technical consultant will establish a working group including representatives from NGOs, such as the Jordan Association of Family Planning and Protection, an advertising agency and other interested parties to carry out the IEC program. They will also seek the guidance of the MOH Maternal and Child Health Department, major CPP centers and others who may be considered appropriate in the development of the overall strategy and specific activities. As already noted, all plans will be closely coordinated with representatives from the MBS and FHS projects through the participation of the Chief of Health Education and the IEC advisor in the quarterly meetings between the three AID-funded projects.

The implementing agency will enter into an agreement with a local advertising agency to develop an "identity" ("corporate image") for the CPP Project, to advise on strategies to encourage women to seek regular care throughout pregnancy and the postpartum period, to work with the MOH on the development of materials and messages, to develop promotional and public education campaigns for the mass media and to perform other functions considered appropriate by the MOH and the IEC advisor. The services of such an agency are essential to the development of a high quality IEC campaign and to enable the Jordanian staff and the IEC advisor to carry out the ambitious program set out below.

While the main thrust of the Health Education Department's program will be national, it will also need to be responsive to the needs of the individual CPP centers as they develop their own educational and promotional activities.

Another important element will be the management of the MOH's network of 40 health educators around the country who will have a major role in the project's outreach activities. The Health Education Department will be involved in the development of the training program for this cadre of people along with a monitoring and supervisory system to evaluate their performance and assess their needs for follow-up training on a continuing basis. A similar supervisory system will be established for the health educators in the CPP centers. The project will also provide needed audio visual equipment for the health educators in the three governates that are not yet equipped.

The major program elements to be included in the project's IEC component are described below.

125

4.2.3 Identity for the CPP Project

One of the first tasks for the project's IEC component will be to develop an "identity" for the CPP project and its centers. A successful "identity" can be expected to raise the visibility and the attractiveness of the CPP project and its centers to the public. Since the practice of postpartum care is the exception rather than the rule in Jordan, it will be important to make the centers' services as attractive as possible. Informal interviews and focus groups organized by the design team with women in Jordan indicated that quality of care, including not only good medical attention but also a patient-focus, was of paramount importance to them. One way of demonstrating a patient focus is by creating an attractive, friendly environment that makes the patient feel a part of a successful enterprise. A carefully developed project "identity" can go a long way toward achieving that.

There will be several components to this identity. The CPP Project and its centers should have a short, catchy name in Arabic such as the Healthy Start or Baby-Mother Program. The name will be consistent with the overall promotional theme that will be used to encourage women to attend the centers. There will also be visual themes that run throughout the project. For example, all the CPP centers will have a unified decor and all printed materials will have a coherent appearance. The project could also explore an audio theme that would appear in all radio and TV spots and audio productions.

This project's identity will be defined after two preliminary activities are undertaken. First--if possible prior to project start-up-- a series of focus groups will be conducted with men and women around the country to determine Jordanian's perceived needs for maternal and infant health care in the postpartum period, barriers to seeking such care and the elements that make up a quality service in the public mind. The information gleaned in these focus groups will be presented to a consensus conference of leaders in the maternal and infant health community who, in turn, will be asked to define the proposed medical services and schedule of visits for the CPP Centers. Based on these two activities, the "marketing" theme for the project will be developed by the advertising agency.

The consensus conference can also serve as a vehicle to introduce the project concept to the medical and health community and could afford an excellent opportunity to officially "launch" the CPP project in the public eye, through media coverage.

4.2.4 Constituency Development/Professional Education

To ensure the success of the CPP project in the conservative environment of Jordan, it will be important to have the support of key groups in Jordanian society such as the medical profession, women, community, religious and political leaders. A number of activities could be envisioned under this rubric.

74

The building of support among religious leaders is a sensitive and complicated task. Yet it is of crucial importance to the success and sustainability of the CPP project and has implications for broadening support among men for the services provided under the project. Prior to opening any of the CPP clinics, a strategy for ensuring the support of religious leaders will be developed and put into effect.

Contact will be made early on with women's groups to make them aware of the project and to solicit their participation in reaching women with messages about birth spacing and the availability of the CPP centers. Seminars will be held around the country for women's groups, especially in communities close to the CPP centers.

A major emphasis will be on reaching the medical profession (especially Ob-Gyns, pediatricians and general practitioners) and the leadership of the hospital community with information about the project's services and its client-oriented approach to services. Representatives from the relevant professional societies and hospital associations should be contacted soon after project start-up to invite their participation in the consensus conference and to discuss the dissemination of materials produced by the project to their members. The objective of such discussions will be to disseminate the educational materials developed through the project to a large number of private providers of maternal and infant care in order that they will make them available to their patients. The project will need to develop a cost-recovery policy for distribution of expensive items, such as videos and/or bulk orders of printed materials, to private providers who are not participating in the CPP project.

The project will also seek to include at least one presentation at each of the relevant professional societies' general meetings and conferences as well as to promote its materials at major medical fairs and other occasions. This will be backed up with articles and advertisements in professional journals. An early opportunity is presented by the September 1994 national conference of the Jordanian Association of Obstetricians and Gynecologists.

4.2.5 Health Education at the CPP Sites

A core element of the project's IEC component will be to strengthen and upgrade the health education provided in hospitals, at least in the CPP centers and in- and out-patient obstetric and pediatric services. The purpose of this education is to encourage women to seek regular health care throughout pregnancy and the postpartum period and to help them adopt behaviors that will improve their own and their infant's health, most particularly family planning. There is little such education in the current Jordanian health system but a growing number of providers recognize its importance and cost-effectiveness.

Hospitals participating in the project will provide a full-time health educator to educate and counsel women when they come for postpartum services. A number of topics will be covered but there will be special emphasis on the importance of birth spacing, the different contraceptive methods available and correct breast-feeding practices to protect against pregnancy. The health educator will also conduct group education sessions, will follow up on drop-outs and will make every effort to reach out to husbands and include them in counseling and group education sessions. In addition, he/she will be responsible for ensuring that education on family planning topics is conducted in the delivery ward and in outpatient obstetrical and pediatric services and he/she will manage the hospital's supply of educational materials and audio-visual equipment provided under the project. Individuals selected for these positions may come from a variety of backgrounds but should be chosen primarily based on their ability to communicate effectively with the public and hospital staff.

Each center will work closely with the MOH's regional health education staff and with at least one NGO in the community to develop and implement an effective outreach program. These outreach activities will make couples in the community aware of the benefits and availability of family planning and maternal and infant health care services. Each center will have a well-publicized official opening to make key persons and the public aware of its services.

The health educator will ensure that all patients who come to the hospital for outpatient prenatal care are educated about the importance of regular health care during pregnancy and postpartum and the availability and benefits of the contraceptive methods available at the time of delivery or postpartum. This education will be undertaken by outpatient clinic staff and should not only be provided once, but will be reinforced at each visit. Women will also be given an MCH passport and a copy of a special educational booklet when they come for prenatal care (both these items are discussed in the section on materials development below). While this project will not be working directly at the health center level, its work will be closely coordinated with the FHS project to ensure that women attending MCH clinics in the CPP centers' catchment areas receive the same information, materials and referrals as those in the hospital outpatient clinic.

Health education will be particularly crucial during the few hours the patient is in the hospital for the delivery. When she recovers from childbirth, delivery ward staff will seek to talk with her about proper breast-feeding practices and the importance of birth spacing. Prior to discharge, when she is usually fetched by her husband or other family members, hospital staff will take the opportunity to reinforce key messages with family members. When the parents are given the birth certificate and a prescription prior to discharge, they will also receive a copy of a short educational booklet and an attractive appointment card for the postpartum visit. Family members will be encouraged to read the booklet, discuss its contents, and be sure that the woman and her baby return for postpartum care.

52

Centers will be provided with a TV, VCR and slide projector as well as with educational materials, videos and slide shows. It is planned that extensive use will be made of videos to attract, educate and entertain patients and their families while they are waiting at the CPP center or elsewhere in the hospital.

The hospital's health education activities should be evaluated through periodic supervisory visits as well as through occasional operations research studies involving exit interviews with women leaving the CPP center. Statistics on utilization of the clinic and return rates will also provide a valuable assessment.

4.2.6 Materials Production

Literacy is relatively high in Jordan--at least among younger, urban groups--and printed and audio-visual materials are generally considered by Jordanian communications professionals to be effective media to reach large segments of the population. The project plans to make extensive use of such materials to further its three overriding IEC program objectives.

One of the key tools of the project will be an MCH health booklet. The booklet is expected to improve continuity of care from the health center services to the hospital, then to the CPP clinic and back to the health center. It will be attractive, durable and will fit in with the CPP project's visual identity. From the provider's perspective, it will provide key information about the medical services and health education a woman has received prior to coming to the hospital for delivery and in the course of delivery and postpartum care. It will also cover the infant's care, including perhaps tear-out vaccination cards for two or three children. From the patient's perspective, it will serve as a convenient reminder of the services she and her baby need--and have received--during pregnancy and afterwards. It is hoped that this will encourage her to adhere to the recommended schedule of visits, including the postpartum visit. This booklet would be given to women receiving antenatal care in participating hospitals and in health centers, as well as to women delivering in one of the hospitals.

A second key tool will be an attractive, easy-to-read, clearly illustrated booklet in two parts--along the lines of a very brief "Dr. Spock." The first part would be given to women during antenatal care and would address the need for regular health care during pregnancy, delivery and the postpartum period. It would address topics known to be of concern to women during pregnancy and would discuss birth spacing and contraceptive methods, particularly those available at the time of delivery. At the end, it would lead the reader to seek out the second volume which would be available in hospital maternity wards and CPP centers. The second part would focus on women's health concerns after delivery and would discuss the need for birth spacing and the contraceptive methods available postpartum. These booklets would be available not only in participating hospitals but other public and

129

private hospitals in maternal and child health centers, doctors' offices, pharmacies, NGOs and elsewhere.

As further incentive to women to stay in the CPP program, the project could contemplate small inexpensive gifts, such as a "blue eye" pin that could be given to mothers to protect their newborn against the "evil eye" that many Jordanians believe could harm, and even kill, their newborn.

The development of leaflets on methods of contraception is not envisioned, since it is assumed that these will be produced under the MBS project. Similarly, it is assumed that a flip-chart for patient counseling will be developed under that project and that the UNICEF flyer on breast-feeding will be used. Funds have been allotted, however, to pay for the printing of additional copies of these items for the CPP project.

Other printed materials for the public, for health professionals and for opinion leaders should also be developed or procured. These could include a brochure on the project; wall posters on the methods of contraception to serve as a reminder for medical staff; a short reference book to assist in prescribing the different methods of contraception; posters oriented toward the public; a wall calendar, etc.

With the low availability of staff for health education in most hospitals, the project design team found a great demand for videos to educate patients. Accordingly, it is proposed that videos (or slide shows) be produced or procured on topics such as: the benefits of birth spacing, methods of contraception, care for the woman during pregnancy and postpartum, and breastfeeding. The project will produce at least three videos. These videos can not only be used in the hospitals participating in this project but should be made available to other hospitals, health centers, health care providers, NGOs and others, in accordance with the cost recovery policy established by the project.

It would be important for staff in the CPP centers, as well as other interested parties to receive periodic information about pertinent new medical developments, successful activities of other centers, etc. The project should explore the feasibility of building on the MBS newsletter to met this need for the CPP project.

All materials will be developed using processes to ensure their effectiveness. At a minimum, each item will be pre-tested before being finalized and the major items, such as the MCH passport and the two-part booklet, will only be prepared after focus groups have been conducted to identify key content areas and to test ideas for presentation. It is anticipated that the advertising agency will play an important role in the design and development of materials, although, of course, the MOH and the IEC advisor will be responsible for the technical content as well as the overall products. When initial supplies of printed and

h2

audio-visual materials run out, they will only be reprinted or reproduced if it is clear that there is a demand for them and that they are effective in communicating the desired messages.

4.2.7 Mass media

With virtually every household in Jordan having a television and almost nine out of 10 having a radio, these are powerful tools for any communications campaign and this project proposes to make use of them. Indeed, television and radio will be the major vehicles to reach the broad public with messages about the benefits of birth spacing, the need to seek care during pregnancy and postpartum, and the availability of the CPP centers.

Since the most effective way of communicating through the mass media is by frequent repetition of carefully designed, short messages, the project's primary mass media communications strategy will be 30-60 second spots aired in prime time and repeated frequently. With the Ministry of Health's ability to obtain free air time for health messages, even in prime time, this strategy promises to be highly cost-effective. It is projected that TV spots and the same number of radio spots will be produced during the project's five years.

Since the MBS project plans to address correct use of contraceptive methods in its mass media campaign, this project expects to focus more broadly on educational and motivational spots dealing with care during pregnancy and postpartum, the benefits of birth spacing for maternal and infant health and the services available through the CPP centers.

It is envisioned that there will be several mass media campaigns over a couple of years, using a number of different spots in each campaign. The spots should be aired intensively in the first few weeks of each campaign and then be cut back, with rest periods in between campaigns to avoid audience fatigue. Spots will be targeted not only at women of childbearing age but also at other key target groups such as men, mothers-in-law and physicians. While extensive use will be made of prime time broadcasting slots, the media placement plan will take into account the media habits of specific target audiences, for example women who often listen to the radio at home in the mornings.

Spots will be developed based on audience research and will be thoroughly pre-tested prior to broadcast. In addition, research will be undertaken after the initial weeks of each campaign to assess public awareness of the spots, understanding of the messages and reaction to them. This rapid feed-back will be useful in refining mass media and overall IEC strategy as well as evaluating the impact of each campaign.

131

Newspaper and magazine advertising will also be used to promote the CPP centers and educational messages on maternal and infant health. Advertisements will be produced and placed in major newspapers and magazines.

A very important adjunct to the mass media activities outlined above will be the coverage of birth spacing topics, including family planning, in the regular programming of radio and television and articles in the press. There is the potential, for example for a soap opera series to be produced around the project's topics--a series watched by about three quarters of adult Jordanians each evening. There is also willingness on the part of the creator of Jordan's popular "street theater", who also works with television, to cooperate with the project on the development of a humorous program with educational messages. On a more modest scale, there are regular health programs, a doctor who responds to questions from the public, programs dealing with family concerns and, of course, news programs, features and articles.

The project could also explore the use other mass communications channels, such as billboards, street banners and other media. Inserts into packages of products used by pregnant women and new mothers, such as sanitary napkins and diapers, could be investigated and, in some communities, there is the potential for house-to-house visits and leafleting in the areas feeding the hospital.

While the MOH Health Education Department and the IEC consultant will be responsible for the mass media activities, it is anticipated that the bulk of the work will be carried out by the advertising agency.

4.2.8 Outreach

While the mass media can be extremely effective in raising awareness, in order to have an impact on behavior, they need to be reinforced through other channels of communication that are more personal and more conducive to discussion. In Jordan, where family and friends are of paramount importance, interpersonal communication should be a persuasive method of communicating more directly and in-depth on family planning topics.

One important channel for interpersonal communication will be through NGOs that already have strong roots in communities in many areas of the country. The project will enter into agreements with selected NGOs, such as the Queen Alia Social Welfare Fund, the Queen Noor Foundation and/or Save the Children, to use their staff and volunteers to reach members of the communities they serve, especially those in which there are CPP centers. The project will provide training on family planning topics and innovative outreach techniques, along with needed materials, for the selected NGOs to conduct their outreach.

27

The second channel will be the network of 40 MOH health educators around the country. This group will be trained and will work closely with the central Health Education Department and their local CPP center to reach out to local community groups with messages on family planning topics. To the extent possible, the health educators, like the NGOs, will be trained in modern interpersonal communications strategies, such as story-telling and improvised drama, to attract and retain the public's attention. In order to ensure that the messages conveyed during these outreach activities are consistent with national communications, a series of brief outlines for educational sessions will be developed and tested during the health educators' training so that they can take them back to their own communities and use them.

The second vehicle for community outreach will be NGOs. The project will enter into agreements with selected NGOs, such as the Queen Alia and Queen Noor Foundations and Save the Children, which have strong relationships with families and community groups in many areas of the country. These organizations will use their staff and volunteers to reach members of the communities they serve, especially those in which there are CPP centers, with information about maternal and infant health and family planning and the availability of the CPP centers. The project will provide training and funding for the selected NGOs to conduct this outreach.

Since the project will be working with RMS hospitals in several areas of the country, men in the military could be an easy-to-reach target population. As the project works with the RMS in developing the CPP centers, it should explore mechanisms to reach this group with information about birth spacing and contraception.

It is notoriously difficult to assess the impact of outreach activities. The project proposes that this be done through end-of-session audience feed-back techniques to verify that key messages have gotten across, accompanied by brief reports from the educator on the size and type of audience reached and the topic of the session. The MOH health educators' activities can be more effectively monitored through supervisory activities.

ANNEX II.F.

REPORT ON MINI-SURVEY CONDUCTED FOR COMPREHENSIVE POSTPARTUM PROJECT PAPER

Introduction

In order to gain the perspective of women in the development of the Comprehensive Postpartum Project, the design team decided to conduct a small-scale survey of women. Save the Children kindly offered the services of three community health workers to carry out the survey. They interviewed 42 women in their homes, using an Arabic translation of a simple questionnaire developed by the design team. 32 of the women lived in Amman and are considered urban for the purposes of this analysis, while 10 lived in Bani Hamida and are considered rural.

The survey was conducted informally and the results should not be considered representative of the population as a whole. Many of the questions invited multiple responses and there were a number of non-responses. In general, proportions--rather than numbers or percentages--are used in the analysis below to reflect the informal nature of the survey.

It should also be kept in mind that the community health workers who conducted the surveys have worked intensively in the communities where the interviews were conducted, so that families are likely to be better informed on health matters than elsewhere.

Important Events after Birth

The women were asked what they considered to be the most important social events in the first six weeks after a baby is born. The urban women were evenly divided between two groups. One group considered the increase in the number of visitors the most important event, while the other group said that there was nothing special in terms of social events. The rural women, too, considered the visits to be very important, but two thirds also attached great value to the gifts received and a third cited the money they received.

None of the urban women said that they celebrated the 40th day. Among the rural women, by contrast, half celebrated and half did not. As far as the baby was concerned the celebrations almost always entailed bathing; for the mother they also entailed a bath and, in most cases, the re-start of prayer.

ANNEX II.F.
Mini Survey Results

Unitary Services for Mother and Baby at the Hospital

The women were asked if they would be willing to return to the same hospital where they delivered if special services were available for mother and baby to have health check-ups together. Among the urban women, 23 said they would be willing to return to the hospital, while nine said no. Among those who said no, however, most had not delivered their baby in a hospital. The women reported that it took them between 10 minutes and two hours to go to the hospital, with the average time being just over 3/4 hour. They said that the trip cost them between 300 fils and 2JD, the average being 777 fils.

Eight out of 10 of the rural women said they would be willing to return to the hospital. Their travel time ranged from two hours to a day, the average being 3 3/4 hours; and the cost ranged from 500 fils to 1 1/2JD, averaging 675 fils.

Care Desired for the Baby and the Mother

Virtually all the urban women said they wanted to be sure their baby receives a general examination in the first couple of months of life, and half cited growth monitoring and a BCG vaccination. About 20 percent wanted blood tests and a few mentioned immunizations and hip dislocation.

All the rural women cited immunizations and eight out of 10 cited growth monitoring and a general examination.

In terms of the health care a woman should receive in the first couple of months, virtually all the urban women thought a general and/or gynecological examination was needed and about half thought the woman should have a blood test. Roughly a quarter thought her weight should be checked.

Eight out of 10 of the rural women thought there should be a general and/or gynecological examination and seven out of 10 thought a woman should receive information about family planning.

Source of Medical Care for the Baby

In the urban areas, two thirds of the women went either to UNRWA or to private doctors for medical care for their baby, with only one third going to an MOH center. Of those who went to MOH centers, almost all were satisfied with the information and services they got there. When asked about the kinds of information they wished to receive, most wanted advice, lectures or videos on how to care for a child, while a few cited other topics. They

**ANNEX II.F.
Mini Survey Results**

preferred to receive information from a doctor or a health worker and there was a strong preference for women as providers of information.

Three quarters of the women did not take their children to the health center and, of those who did, none found that this presented any particular problem. The mothers tended to think that 10 o'clock was the most convenient hour, but a few favored 9 a.m. Most women felt that no changes were needed at the health center.

The few women who were not satisfied with the MOH noted a variety of complaints: no medicines, incomplete health care, postponement of appointments, lack of respect for patients and unsatisfactory information. They wanted a better-organized service, shorter waits and supplies of medicines.

Among the rural women, nine out of ten went to an MOH center. These women were satisfied with the quality of care at the center and said that they received satisfactory answers to their questions. Nevertheless, they wanted information on a variety of topics: generally on breast-feeding and women's health during pregnancy, but sometimes on family planning and child health care. They wanted to get information on their own and the baby's health from a doctor, but were not concerned whether the doctor was male or female.

Most of the rural women did not bring their other children when they took the baby for a check-up and the preferred time was the morning. Six out of 10 thought that changes should be made at the health center, but had no suggestions as to what kinds of changes.

Source of Medical Care for the Mother

Almost two thirds of the urban women went to a private doctor for their own medical care, but in this situation the baby would not normally be checked at the same time as the woman. One third of the urban women went to UNRWA and only two women went to MOH centers. At these two types of facilities, the baby would normally be checked at the same time as the mother.

Nine out of 10 of the rural women went to a private doctor for their own care and half of these reported that the baby is checked at the same time. One woman went to an MOH facility but her baby was not checked there.

Information about Breast-Feeding at Time of Delivery

Virtually none of the urban women received any information about breast-feeding at the time of their last delivery. Seven out of 10 of the rural women, by contrast, had received such information, which generally stressed the importance of starting to breast-feed

136

ANEX II.F.
Mini Survey Results

immediately. Two thirds of the time, it was a nurse or a midwife who provided the information to the rural women and one third of the time a doctor.

Postpartum Check-Ups

Two thirds of the urban women did not go for a medical check-up after their last birth--usually because everything was going OK so that it didn't seem to be necessary. Of the one third who went for a check-up, almost half went to a private physician and the others went to a hospital or UNRWA and in all cases the baby was checked at the same time as the mother. The postpartum visit occurred any time from a week after delivery to six weeks afterwards, with most being one week to one month later.

Six out of 10 of the rural women went for a postpartum check-up and in two thirds of these cases the baby was checked, too. The visits tended to be 1 - 2 weeks after delivery and were usually with a private physician. Those women who did not go thought there was no reason to do so.

Preferred Sources of Information about Birth Spacing

The urban women were evenly divided between those who would prefer to get information about birth spacing from a doctor and those who preferred a health educator. Almost all of the women preferred to get information from a woman.

All of the rural women wanted to receive their information from a doctor but, unlike the urban women, it didn't matter to them whether the doctor was male or female.

Use of a Birth Spacing Method

Nine of the women in urban areas were using a birth spacing method and they said they had started using it between 40 days and one year postpartum. Four of them had not changed their method and did not plan to change, while five either had changed or expected to do so. They all planned to switch to the IUD but for different reasons: because it is safer than natural family planning or the pill; because it is more effective than breastfeeding as a contraceptive; or to avoid headaches. All except one said their husband believed in modern contraception but opinions were divided on which other opinions would be important to them. Two thirds would not necessarily use a method if their mother or mother-in-law suggested it; but two thirds would follow a doctor's recommendation and almost as many would follow a midwife's or nurse's recommendation.

**ANNEX II.F.
Mini Survey Results**

Two thirds of the urban women were not using contraception. The reasons given most frequently for not doing so were that the woman loves to produce children, the husband is opposed, or she is pregnant. A couple of women also noted that they had experienced side effects. Every one of the women not using contraception would do so if her husband suggested she use a method and, while opinions were divided on the influence of other family members and the health profession, the majority would not necessarily adopt a method if they advised it.

Among the rural women, six were using contraception and four were not. Five out of the six users had not changed their method and did not plan to do so. In all cases, the husband was supportive and the users were unanimous in their willingness to accept their husband's or a doctor's recommendation concerning contraception, while rejecting the advice of their mother, mother-in-law, a nurse or a midwife. Of the four non-users, two were breast-feeding. The non-users all reported that their husbands were supportive of contraception and that they would use a method if their husband or a doctor recommended it, while they would not necessarily follow the recommendation of their mother, mother-in-law, a nurse or a midwife.

The Comprehensive Postpartum Clinic Concept

If it were possible to get a method of birth spacing at the same time and in the same place as having the baby's health checked, two thirds of the urban women said they would go and all of the rural women said they would do so.

MINI SURVEY QUESTIONNAIRE FOR WOMEN

Note: This questionnaire is only for young mothers (under 35) and women who are pregnant. If the woman is not already a mother, or pregnant, do not interview her.

1. What do you consider the most important events in the first few weeks after a baby is born?

For the mother?

For the baby?

2. What do you do on the 40th day after the birth of a baby?

**ANNEX II.F.
Mini Survey Results**

For yourself?

For the baby?

3. **Would you be willing to return to the hospital where you delivered your baby on the 40th day to have a check-up for yourself and the baby?**

How long does it take you to go to the hospital?

How much does it cost?

4. **What medical care do you want to be sure your baby receives in the first couple of months of life?**

5. **What medical care do you think a woman should receive in the first couple of months after childbirth?**

6. **Where would you normally go for medical care for your baby?**

[If a clinic or hospital, explain that you are going to ask for their ideas on how the services there can be improved.]

Are you satisfied with the quality of the medical care there?

If not, why not?

Do you receive all the information you need to care for your own health and your baby's health?

**ANNEX II.F.
Mini Survey Results**

If not, what information would you like to receive?

From which staff would you prefer to receive information about health?

Could the setting be improved to make it more appropriate or more welcoming?

If yes, how?

**Do you take your children with you when you go?
If yes, does that present any problems?**

What hours would be most convenient to you?

Are there any other changes you would like to see?

7. Where would you normally go for medical care for yourself?

Do they also check the baby at the same place?

8. At the time of your last delivery, were you given any information about breast-feeding?

If yes, Who gave you that information?

What did they tell you?

For how long did you feed the baby with nothing but breast milk?

ANNEX II.F.
Mini Survey Results

9. Did you go for a medical check-up after your last birth?
If yes, Where did you go?

How many weeks after the delivery did you go?

Did they examine the baby, too?

If no, why not?

10. Have you ever received information about birth spacing?
If yes, From whom?

Are there other people with whom you would like to talk about birth spacing? Who?

If no, With whom would you like to talk about birth spacing?

11. Are you using a birth spacing method?
If yes, For how long have you been using a method?

Have you ever changed methods, or are you thinking about changing?
If yes, why?

What does your husband think of the method?

If no, Why not?

ANNEX II.F.
Mini Survey Results

If your husband suggested you use a birth spacing method, would you do so?

If your mother or mother-in-law suggested you use a method, would you do so?

If your doctor advised it, would you do so?

If a midwife or nurse advised it, would you do so?

- 12. If you were able to get a method of birth spacing at the same time you went to have your baby's health checked, and in the same place, would that be more convenient to you?**

THANK YOU VERY MUCH FOR YOUR HELP!

28

ANNEX I.I.G.

IMPACT CALCULATIONS

The Futures Group International

80 Glastonbury Blvd.

Glastonbury, CT 06033 USA

Tel: (203) 633-3501 Fax: (203) 657-9701

To: Asta Kenney Room 507	From: John Slover
Fax: 011-962-6-670-100	Date: June 25, 1993
Telephone: 011-962-6-660-100	Project Number: 5100.935
Number of pages: 1	

I have adjusted the calculations using the same number of acceptors per year, but distributing them according to the current distribution of acceptors. This works out to be approximately the following: pill = 44%; IUD = 37%; condom = 8%; female sterilization = 5%; VFT = 6%. I realize you specified DMA instead of VFT, but that change will not significantly affect the results reported below. This new acceptor mix reduces the total number of births averted from 63,400 to 55,000. I also adjusted the number of births to equal 120,000 in 1990. This also reduces the number of births averted to a cumulative total of 40,000.

Project Year	Increase in Prevalence	Decrease in TFR	Births Averted	Percent of All Births That Are Averted
0	0	0	0	0
1	0	0	0	0
2	1.0	0.09	2,300	1.6
3	2.7	0.25	6,800	4.5
4	4.8	0.44	12,300	7.9
5	7.0	0.65	18,800	11.6
Total			40,200	3.2

143

Annex II.G.
Table 22

Projected Number of Beneficiaries over the Life of the CPP Project (Based on 1992 Hospital Delivery Figures)

HOSPITAL	Year 1		Year 2		Year 3		Year 4		Year 5		Center Total LOP
	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	
Al Bashir Hospital-Amman	0	0	5261	5261	5261	5261	5261	5261	5261	5261	42084
King Hussein Medical Center-Amman	0	0	2079	2079	2079	2079	2079	2079	2079	2079	16632
Jordan University Hospital-Amman	0	0	1366	1366	1366	1366	1366	1366	1366	1366	10928
Islamic Hospital-Amman	0	0	4800	4800	4800	4800	4800	4800	4800	4800	38400
Princess Basma Hospital-Irbid	0	0	0	4367	4367	4367	4367	4367	4367	4367	30566
Irbid RMS Hospital	0	0	0	3304	3304	3304	3304	3304	3304	3304	23125
Karak MOH Hospital	0	0	0	828	828	828	828	828	828	828	5796
Princess Hayya Hospital-Aqaba	0	0	0	986	986	986	986	986	986	986	6902
Zarqa MOH Hospital	0	0	0	0	3547	3547	3547	3547	3547	3547	21282
Mafraq MOH Hospital	0	0	0	0	1656	1656	1656	1656	1656	1656	9933
Madaba MOH Hospital	0	0	0	0	1168	1168	1168	1168	1168	1168	7005
Soldier's Welfare Society-Zarqa**	0	0	0	0	1969	1969	1969	1969	1969	1969	11811
Project Year Total	0	0	13506	22990	31328	31328	31328	31328	31328	31328	224463

144

Annex II.G.
Table 23

Projected Number of Immediate Postpartum Family Planning Acceptors (Based on 1992 Hospital Delivery Figures)
(All Methods)

HOSPITAL	Year 1		Year 2		Year 3		Year 4		Year 5		Center Total LOP
	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	
Al Bashir Hospital-Ammen	0	0	263	263	526	526	789	789	1052	1052	5261
King Hussein Medical Center-Ammen	0	0	104	104	208	208	312	312	416	416	2079
Jordan University Hospital-Ammen	0	0	68	68	137	137	205	205	273	273	1366
Islamic Hospital-Ammen	0	0	240	240	480	480	720	720	960	960	4800
Princess Basma Hospital-Irbid	0	0	0	218	218	437	437	655	655	873	3493
Irbid RMS Hospital	0	0	0	165	165	330	330	496	496	661	2643
Karak MOH Hospital	0	0	0	41	41	83	83	124	124	166	662
Princess Hayya Hospital-Aqaba	0	0	0	49	49	99	99	148	148	197	789
Zarqa MOH Hospital	0	0	0	0	177	177	355	355	532	532	2128
Mafraq MOH Hospital	0	0	0	0	83	83	166	166	248	248	993
Madaba MOH Hospital	0	0	0	0	58	58	117	117	175	175	701
Soldier's Welfare Society-Zarqa**	0	0	0	0	0	0	0	0	0	0	0
Project Year Total	0	0	675	1149	2143	2617	3611	4085	5079	5553	24915

**Approximation Using RMS Zarqa Delivery Figures

Estimated Rates of Predischarge Acceptance of Family Planning:

- First Year of CPP Center Operation - 5 percent of women delivering in hospital accept
- Second Year of CPP Center Operation - 10 percent of women delivering in hospital accept
- Third Year of CPP Center Operation - 15 percent of women delivering in hospital accept
- Fourth Year of CPP Center Operation - 20 percent of women delivering in hospital accept

Annex II.G.
Table 24

Projected Numbers of Women Returning to CPP Center for Postpartum Care (Based on 1992 Hospital Delivery Figures)

HOSPITAL	Year 1		Year 2		Year 3		Year 4		Year 5		Center Total LOP
	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	
Al Bashir Hospital-Ammen	0	0	1841	1841	2367	2367	2893	2893	3156	3156	20516
King Hussein Medical Center-Ammen	0	0	728	728	936	936	1143	1143	1247	1247	8108
Jordan University Hospital-Ammen	0	0	478	478	615	615	751	751	820	820	5327
Islamic Hospital-Ammen	0	0	1680	1680	2160	2160	2640	2640	3156	3156	19273
Princess Basma Hospital-Irbid	0	0	0	1528	1528	1965	1965	2402	2402	2620	14409
Irbid RMS Hospital	0	0	0	1156	1156	1487	1487	1817	1817	1982	10902
Farak MOH Hospital	0	0	0	290	290	373	373	455	455	497	2732
Princess Hayya Hospital-Aqaba	0	0	0	345	345	444	444	542	542	592	3254
Zarqa MOH Hospital	0	0	0	0	1241	1241	1596	1596	1951	1951	9577
Al-Fraq MOH Hospital	0	0	0	0	579	579	745	745	911	911	7622
Al-Jadaba MOH Hospital	0	0	0	0	409	409	525	525	642	642	8467
Soldier's Welfare Society-Zarqa**	0	0	0	0	689	689	886	886	1083	1083	5315
Project Year Total	0	0	4727	8046	12315	13264	15448	16397	18182	18656	115502

*Approximation Using RMS Zarqa Delivery Figures

Estimated Rates of Return to CPP Center:

- First Year of CPP Center Operation - 35 percent of women delivering in hospital return
- Second Year of CPP Center Operation - 45 percent of women delivering in hospital return
- Third Year of CPP Center Operation - 55 percent of women delivering in hospital return
- Fourth Year of CPP Center Operation - 60 percent of women delivering in hospital return

179

Annex II.G.
Table 25

Projected Numbers of Women Accepting Family Planning at CPP Centers (Based on 1992 Hospital Delivery Figures)
(Condom, Pill, IUD)

HOSPITAL	Year 1		Year 2		Year 3		Year 4		Year 5		Center Total LOP
	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	6 mos	
Al Bashir Hospital-Amman	0	0	552	552	829	829	1244	1244	1578	1578	8406
King Hussein Medical Center-Amman	0	0	218	218	327	327	492	492	624	624	3322
Jordan University Hospital-Amman	0	0	143	143	215	215	323	323	410	410	2183
Islamic Hospital-Amman	0	0	504	504	756	756	1135	1135	1440	1440	7670
Princess Basma Hosiptal-Irbid	0	0	0	458	458	688	688	1033	1033	1310	5668
Irbid RMS Hospital	0	0	0	347	347	520	520	781	781	991	4288
Karak MOH Hospital	0	0	0	87	87	130	130	196	196	248	1075
Princess Hayya Hospital-Aqaba	0	0	0	104	104	155	155	233	233	296	1280
Zarqa MOH Hospital	0	0	0	0	372	372	559	559	839	839	3540
Mafraq MOH Hospital	0	0	0	0	174	174	261	261	392	392	1652
Madaba MOH Hospital	0	0	0	0	123	123	184	184	276	276	1165
Soldier's Welfare Society-Zarqa**	0	0	0	0	207	207	310	310	466	466	1965
Project Year Total	0	0	1418	2414	3998	4496	6001	6750	8267	8869	42214

**Approximation Using RMS Zarqa Delivery Figures

Estimated Rates of Return to CPP Center:

- First Year of CPP Center Operation - 35 percent of women delivering in hospital return
- Second Year of CPP Center Operation - 45 percent of women delivering in hospital return
- Third Year of CPP Center Operation - 55 percent of women delivering in hospital return
- Fourth Year of CPP Center Operation - 60 percent of women delivering in hospital return

Projected Rate of Acceptance of Postpartum Family Planning at CPP Center

- First Year of CPP Center Operation - 30 percent of women accept a modern method
- Second Year of CPP Center Operation - 35 percent of women accept a modern method
- Third Year of CPP Center Operation - 43 percent of women accept a modern method
- Fourth Year of CPP Center Operation - 50 percent of women accept a modern method

Annex II.G.

Table 26

CPP PROJECT EXPENDITURES BY FISCAL YEAR (\$US)
(Including Overhead (35%) and Shipping (25%))

Project Component/Activity	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
1. SERVICE DELIVERY						
A. Technical Assistance						
1. Long Term	375,237	589,995	507,866	559,827	304,757	2,337,682
2. Short Term	77,625	94,795	75,814	63,977	65,637	377,849
B. Contraceptives	109,725	172,817	181,458	127,020	0	591,020
C. Clinical Equipment	397,690	0	0	0	0	397,690
D. Other Equipment						
1. Center	95,719	0	0	0	0	95,719
2. Vehicles	63,000	0	0	0	0	63,000
3. Vehicle maint/insurance	6,818	7,158	7,516	7,892	8,287	37,671
E. Facilities Upgrade	99,939	188,992	0	0	0	288,931
F. Protocol Development	60,750	0	0	0	0	60,750
G. Data Collection						
1. Equipment	74,360	20,475	0	0	0	94,835
2. Computer Forms/Supplies	17,260	18,123	37,634	19,980	443	93,439
H. Programmatic Research						
1. Subproject Activities	0	177,188	186,047	78,140	82,047	523,421
2. Seminars	0	14,175	14,884	15,628	0	44,687
Subtotal	1,378,122	1,283,718	1,011,219	872,464	461,171	5,006,694
2. TRAINING						
A. Technical Assistance						
1. Medium Term	318,938	76,191	0	0	0	395,128
2. Short Term	0	0	70,698	0	77,944	148,642
B. Workshops/Seminars						
1. Per Diem	88,661	210,109	107,163	70,326	73,842	550,101
2. Supplies	20,250	56,700	44,651	22,326	24,614	168,541
C. Overseas Training	129,600	136,080	0	0	0	265,680
D. Equipment	69,004	0	0	0	0	69,004
Sub-Total	626,453	479,080	222,512	92,651	176,400	1,597,096
3. IEC						
A. Technical Assistance						
1. Short Term	108,000	113,400	119,070	125,024	131,275	596,768
B. Equipment and Materials	65,812	0	0	0	0	65,812
C. Seminars, Training, Mtgs	79,412	100,059	96,307	0	0	275,777
D. Materials Development	67,500	398,776	103,967	109,166	114,624	794,033
E. Mass Media	19,853	125,074	131,327	137,894	0	414,147
Sub-Total	340,577	737,308	450,671	372,083	245,899	2,146,538

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4. EVALUATION

1. Technical Assistance	13,500	0	0	15,628	32,819	61,947
1. Ministudies	20,250	21,263	29,768	70,326	139,479	281,085
2. External Evaluation	0	0	110,250	0	121,551	231,801
Sub-Total	33,750	21,263	140,018	85,954	293,848	574,832

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5. AUDIT	50,000	50,000	50,000	50,000	50,000	250,000
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6. PROGRAM MANAGEMENT

1. Supplies	166,109	25,515	26,791	28,130	29,537	276,082
2. Office Costs	101,250	104,895	110,140	115,647	121,429	553,361
3. Transportation	8,100	0	0	0	0	8,100
4. In-country travel	6,750	7,088	7,442	7,814	8,205	37,298
Subtotal	282,209	137,498	144,372	151,591	159,171	874,840

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7. CONTINGENCY (5%)	150,000	150,000	100,000	75,000	75,000	550,000
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GRAND TOTAL	2,861,110	2,858,866	2,118,792	1,699,743	1,461,489	11,000,000
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ANNEX II.H.

P.I.D. ISSUES

The Project Identification Document for the CPP project set out three issues to be addressed by the project design team. What follows is a summary of the team's deliberations and conclusions on these issues.

Issue # 1: Antenatal counseling and services are an essential component of the comprehensive approach taken by the CPP project. The ways in which antenatal care will be incorporated will be determined by the PP team after a thorough assessment of the options.

The team proposes that following antenatal counseling and services be provided under the project:

1. The hospitals that participate in the CPP project already provide antenatal care on site and the staffs of their antenatal clinics will receive a clinical update as well as training in the provision of antenatal counseling and education on family planning and related topics. Educational materials will also be available to pregnant women coming through these clinics so that they can learn about health care practices themselves.
2. The bulk of antenatal care in Jordan is provided by private physicians and MCH clinics. These providers will receive educational materials produced through the project so that their patients may benefit from the information provided to women in the CPP centers.
3. The project proposes to develop national standards and guidelines for antenatal and postnatal care in an effort to standardize and improve the content of prenatal care.

It was decided not to train antenatal care providers at the health center level since such training is already included in AID's FHS project. However, the CPP project plans to collaborate with the FHS project in the development of a referral system between health centers and the hospital to improve continuity of care for patients.

Issue # 2: Because of differences in delivery approaches in the private and public sectors in Jordan, the exact modalities of establishing CPP centers and providing comprehensive postpartum services is a project design issue which will be addressed by the PP team.

Annex II.H.
PID Issues

The project design team has decided to focus the project primarily in public sector hospitals. There are a number of reasons for this: (a) the bulk (69 percent) of deliveries occur in public hospitals; (b) most of the public hospitals have large caseloads, so that resources invested at one site will have a greater impact; (c) there is greater potential for increasing contraceptive prevalence in the public sector because demand for contraception there is not yet high; (c) public hospitals are in greater need of assistance because they have fewer resources and a needier population than those in the private sector.

Private hospitals are less suited to the CPP model than public ones. Their patients are middle and upper class and generally have established ties with private physicians, so that they do not wish to go to a facility where they and/or their infant will be seen by another physician. For these women, a visit to the hospital for a delivery is simply a stopping point along the continuum of care for mother and baby. Moreover, women who seek care in the private sector are already more likely to be using contraception than those in the public sector.

Nevertheless, the project does not plan to ignore the private sector. Private hospitals expressed a strong interest in using educational materials produced by the project and it is planned to make them available not only to private hospitals but also to ob-gyns and pediatricians in private practice. There will also be efforts to reach private providers with information about the CPP project's approach, through articles and advertisements in professional journals, presentations at professional meetings and other means.

There will also be two private sector CPP sites: Islamic Hospital in Amman and Soldiers' Welfare Fund in Zarka. The first was selected because of the large number of deliveries performed there, a caseload that is more middle-class than that of most private hospitals, its strong interest in participating and its important links with the religious community. Soldiers' Welfare Fund was chosen in order to include a non-governmental facility, because of staffing and space constraints at the public hospital in Zarka, because of its strong track-record on family planning and its interest in participating in the project.

Issue # 3: In Jordan, childhood immunization is provided at various service points: CHC and MCH centers, hospitals, private sector clinics, school health teams, national health campaigns and by mobile EPI teams. The PP team should investigate the various models that could be used to incorporate maternal health services with the successful immunization program.

**Annex II.H.
PID Issues**

Unfortunately, maternal health care and medical family planning are more complicated services than immunization, inasmuch as they require an unclothed physical examination and a modicum of sterile equipment. Thus, many of the approaches used in Jordan to take immunization to the people cannot be readily adapted for family planning. Once the task of integrating family planning into the medical system is accomplished and public opinion is more accepting of making contraception readily available, the possibility of building community-based distribution of contraceptives onto the successful vaccination system should be carefully considered.

It is not too early, though, for family planning counseling to be grafted onto the vaccination program. Visits for immunization provide a unique opportunity to raise the issue of contraception. Since these visits occur at two months, three months, four months and nine months, health care providers can discuss contraception with mothers at that time, responding to any problems that users may be experiencing and discussing the option of starting a method with non-users. The possibilities of building such counseling onto the CPP centers' services are limited, however, because vaccination is usually provided at the health center level or in private physicians' offices, rather than in hospitals. Hospitals are understandably reluctant to take on vaccinations, since the current system works well and they could find themselves overwhelmed with the demand for that and other primary care services. The team believes that the FHS project's training for health workers in maternal and child health centers should help vaccinators discuss family planning topics with mothers each time they come for a vaccination.

48

ANNEX III.A.

TECHNICAL ANALYSIS

The Jordanian medical system can be characterized as generally technologically advanced with many well-trained and experienced physicians in both the public and private sectors. Jordanians of all socio-economic categories place a high value on health care for the maintenance of good health for all family members; the majority also value active use of western medical facilities. While preventative care is still in its infancy in Jordan, curative care, especially at tertiary facilities is of high quality. Jordanians actively seek the highest quality services within their means, often bypassing primary health care centers to go directly to tertiary health facilities where the bulk of specialists are located.

The level of technical expertise among Jordanian specialists in the public and private sectors is generally high. Many physicians have received their training abroad in the U.S. or U.K. and are Board eligible. The ratio of physicians to nurses and midwives in Jordan is skewed; nurses, especially, are in short supply but experienced specialists are not, especially in the larger urban areas. Hospital Ob/Gyn and Pediatric Departments tend to be adequately staffed with many well-trained MDs. Thus, in Jordan, specialists can play a much greater role in the provision of postpartum services than would be possible in other countries, thus minimizing the range of training necessary to expand services to include family planning and improve quality of care. The specialists at the sites selected to participate in the Project are solidly behind the CPP concept and are eager to initiate the expanded postpartum services. Family planning services are the general exception to the high level of technical expertise found among Jordanian physicians. The CPP project will expand and improve their skills. The general shortage of nurses in Jordan is not unique to the CPP project and is not expected to hinder the implementation of the Project at the 12 selected sites. As a result of the expanded nurse training programs currently underway, it is anticipated that the nursing situation will improve by the end of the Project.

Hospitals in Jordan are well-equipped, although space issues are a major concern for some facilities. Costs to upgrade physical facilities and provide the necessary range of equipment to offer quality and comprehensive postpartum services will be minimal. Quality of care is generally high at hospitals already, as evident in the fact that 80 percent of women choose to deliver in hospitals.

In a small country, such as Jordan, the MOH plays an important role in the provision of health services. Basing the CPP project in the MCH Directorate will further improve the MOH capacity to provide family planning and MCH services effectively and efficiently by expanding the technical and supervisory capacity. Computerization is necessary to systematize and improve information flow and link up the various levels of the health care system.

**Annex III.A.
Technical Analysis**

In sum, no technical issues are anticipated to constrain the implementation of the Project. In fact, the high quality of Jordanian specialists and their interest in the CPP approach is conducive to widespread success of the Project.

ANNEX III.B.

FINANCIAL ANALYSIS

The purpose of this financial analysis is to assess:

- The overall financial soundness of the project's approach, and the extent to which project resources will be used cost-effectively;
- The flow of project resources including the mechanisms for funds disbursement, cost estimates and USAID and GOJ contributions.
- Long-term prospects for project activities to become institutionally and financially sustainable.

1.0 Overall Cost-Effectiveness of Project Approach

The introduction of postpartum contraception in Jordan's hospitals is expected to be a highly cost-effective approach for a number of reasons. First, postpartum contraception targets women of proven fertility who, without contraception, are likely to become pregnant again soon. Second, over 80 percent of deliveries occur in hospitals. Providing hospital-based predischarge and postpartum family planning services has the potential to reach large numbers of women through relatively few points of service delivery. Providing services at the relatively small number of hospitals required to reach the majority of postpartum women avoids the expense of upgrading, equipping and training staff in a large number of small health centers around the country. Studies in other countries providing postpartum family planning have found that the provision of family planning following delivery or during postpartum follow-up is cost-effective. The marginal cost of providing an effective family planning method (especially sterilization or the IUD) while the woman is being seen for other delivery/health services makes it more cost effective than interval provision of family planning. At present approximately 18 percent of family planning services already are provided at hospitals financed directly by the Government of Jordan. Therefore, of the possible alternatives for achieving project objectives, the hospital-based approach to the provision of postpartum family planning was chosen on the basis of being the most cost-effective approach in Jordan, to the extent that this could be determined.

The CPP project is one of the largest bilateral population efforts ever undertaken by A.I.D. to provide postpartum family planning services. Its intent is to have a major impact on the rate of population growth and the health status of mothers and infants in Jordan. As such, the project needs to take a comprehensive approach over its 5-year life by utilizing all major channels that can be mobilized effectively to achieve project objectives. The project's main components (service delivery, training, IEC) represent only marginal investments to upgrade and expand existing systems and capacities. The majority of project funds will be expended

**Annex III.B.
Financial Analysis**

on activities carried out through infrastructures and organizations already active in these areas.

The public sector is represented by the Ministry of Health and the Royal Medical Services which nationwide operate 19 and 8 hospitals, respectively. Surveys show that these facilities provide opportunities for family planning service delivery that heretofore have been largely untapped. The addition of better staff training, education and counseling, commodities management, improved quality of care, a wider range of contraceptives and strengthened supervision can increase effectiveness of public sector hospital-based family planning at low relative cost. It is anticipated that by the end of the project, the CPP Project approach and activities will be replicated in all MOH and RMS hospitals, with the costs of hospitals not included in the Project being borne by the respective governmental body.

The project's non-governmental activities will take place both with universities and non-profit groups, such as Islamic Hospital, Soldier's Welfare Society and other NGOs. This strategy is cost-effective because, like the public sector, these institutions offer solid opportunities to tap into existing service and distribution networks through investments at the margin. Other private sector physicians and hospitals will receive IEC materials produced by the Project. While the Project will not work directly with the private, for profit sector in establishing CPP Centers, it is anticipated that the approach will be adopted by individual physicians and hospitals.

In countries with low prevalence and a mixed record in the public sector, NGOs have often played a catalytic role in stimulating demand and widening the acceptance of various family planning methods. The more than 600 NGOs, 90 of which current provide health care education and/or services, offer an opportunity to utilize another possibly potent channel for achieving project objectives. Several of the NGOs are organizations which have the capability of promoting and providing family planning services as envisioned by the CPP project.

The research and evaluation activity will least take advantage of existing structures and capacities. The project will assist these local organizations to build up capacity to perform the required research and evaluation activities planned in the scope of work. The outputs of the research activity will have a major influence on improving cost-effectiveness as the results of policy, operation and survey research are fed back into the implementation components.

2.0 Flow of Project Resources

Over the five-year life of the CPP Project, approximately \$11 million will be disbursed by USAID/Amman. The USAID/Amman contribution primarily will come indirectly through cooperating agencies. Approximately 654,020 will be contributed directly in the form of contraceptive commodities and project vehicles.

2.1 Inputs and Budget Estimates

In developing budget estimates, unit costs based on current U.S. and local prices and recent USAID/Amman project experience were used for long- and short-term personnel salaries, travel, contraceptives, training, equipment and other inputs. Budget estimates were calculated for each project component and then compiled. Cost data are desegregated into projected expenditures by each type and source in the attached Tables.

2.2 Mode of Payment

Public and private sector activities, technical assistance and equipment will be funded through a direct AID contract with a Prime Contractor, which will in turn subcontract for some activities. Contraceptive commodities and vehicles will be provided directly by USAID/Amman. (See Table in Cost and Financial Plan Section)

2.3 Host Country Contribution

The Government of Jordan will provide salaries, physical space in hospitals and maintenance and replacement of equipment and repair and maintenance of vehicles for the CPP Project. The GOJ contributions will not have to be accounted for through systematic tracking and recording procedures as the Project will be funded using ESF grant funds.

3.0 Sustainability

The initial cost of upgrading and expanding family planning services at the hospital level via postpartum centers will be largely subsidized by the Project. However, after this initial investment, the recurrent costs of the project will be limited to staffing costs, equipment maintenance and replacement, contraceptive commodities, office and other supplies. The MOH, RMS and other sites selected to participate in the Project have already proven their commitment to sustainability as they are providing the bulk of the recurrent costs already under the Project.

Annex III.B. Financial Analysis

Family planning and MCH services are available free through the MOH system, and for a minimal fee for service at the RMS and most of the other hospitals. Thus, the project design includes efforts to develop family planning services which will ultimately be fully paid for by users and the government. At present the MOH offers family planning and maternal and child health services free of charge. There is no plan at this time to initiate a cost recovery program.

NGOs will be supported and strengthened through the project. While NGOs rarely operate without subsidies, the NGOs receiving grants and technical assistance through the CPP project will be encouraged to diversify their base of financial support by attracting additional contributions from the community and other donors, thus improving their long-term sustainability.

The above assumptions of financial sustainability are dependent on assumptions about rising demand for family planning and the long-term commitment of the Government of Jordan to family planning. The Project contains several activities specifically designed to raise demand for services, along with an IEC component which will raise awareness about the value of project activities among key constituencies and the general public.

The broad scope of training, wide dissemination of IEC materials and constituency development provided by the CPP Project will contribute significantly to the institutionalization of the comprehensive postpartum concept (continuity of pregnancy, delivery and postpartum care and the unitary provision of services for postpartum mothers and their infants) in Jordan. It is anticipated that the CPP concept will be fully integrated into the Jordanian medical system by the end of the Project. It is anticipated that not only will all public sector hospitals adopt the approach, but MCH and CHC centers will also. Private sector hospitals and NGO clinics not involved in the project are also expected to adopt the CPP concept as appropriate to their activities. By having all medical, nursing and midwifery students exposed to the new mode of service delivery through their schooling, internship and residency programs will further promote institutionalization among of the concept and approach throughout the Jordanian health system.

By the end of the project, the mass media component is expected to have raised awareness and demand for postpartum services and thus intensive efforts will no longer be necessary. The IEC materials developed under the Project will continue to be used by the sites participating in the CPP Project, as well as by other public and private sector hospitals and service providers.

Annex III.B.
Table 27

Summary Budget: Government of Jordan Estimated Contributions					
ACTIVITY	PERSONNEL	PERSON MONTHS (per person)	ESTIMATED SALARY & BENEFITS ¹ (JD)	DOLLAR VALUE (X=.68)	TOTAL COST
Service Delivery: minimum center staff is 1 Ob/gyn; 1 Pediatrician; 2 nurses; 1 health educator; 1 clerical person Total GOJ centers - 10	20 doctors	51	1200	1,764.71	1,800,004.20
	20 nurses	51	500	735.29	749,995.80
	10 health educators	51	600	882.35	449,998.50
	10 clericals	51	360	529.41	269,999.10
	SERVICE DELIVERY TOTAL				
Training: sessions scheduled to last .75 PM; USAID is contributing some per diems. CPP center staff NOT included because their salaries are included above.	371 MDs	.75	1200	1,764.71	491,030.56
	441 midwives or nurses	.75	500	735.29	243,197.17
	6 health educators	.75	600	882.35	3,970.58
	TRAINING TOTAL				

**Summary Budget:
Government of Jordan Estimated Contributions**

ACTIVITY	PERSONNEL	PERSON MONTHS (per person)	ESTIMATED SALARY & BENEFITS ¹ (JD)	DOLLAR VALUE (X=.68)	TOTAL COST
Information, Education and Communication: from Department of Health Education: Chief (40%); 2 full-time health professionals; 1 secretary; 40 regional health (20%)	1 Chief	24	1800	2,647.06	63,529.44
	2 profs	60	1000	1,470.59	176,470.80
	40 health educa	9.6	800	1,176.47	451,764.48
	1 secretary	60	500	735.29	44,117.40
	IEC TOTAL				
Central Management: 1 Project Director for MOH and RMS; For MOH only: 1 Training/Quality Assurance MD; 1 MD for protocol development; 1 person responsible for facilities upgrade; 1 secretary; 1 driver	2 MDs	60	1800	2,647.06	317,647.20
	1 MD	60	1200	1,764.71	105,882.60
	1 MD	60	1200	1,764.71	105,882.60
	1 MD (protocols)	12	1200	1,764.71	21,176.52
	1 for upgrade	24	900	1,323.53	31,764.72
	1 secretary	60	500	735.29	44,117.40
	1 driver	60	500	735.29	44,117.40
	MANAGEMENT TOTAL				

Summary Budget: Government of Jordan Estimated Contributions					
ACTIVITY	PERSONNEL	PERSON MONTHS (per person)	ESTIMATED SALARY & BENEFITS ¹ (JD)	DOLLAR VALUE (X=.68)	TOTAL COST
Evaluation: yearly assessment of CPP centers by Department of Quality Assurance: 8 visits in 2nd year; 12 in 3rd, 4th, and 5th years (44 visits total); Estimate that each visit costs \$1000					
			EVALUATION TOTAL		44,000
GRAND TOTAL: SERVICE DELIVERY, TRAINING, IEC, MANAGEMENT, EVALUATION					5,458,666.47

1. Benefits are estimated to be 100 percent of salary; therefore, mid-level doctors cost an estimated 600 JD/month multiplied by two; senior doctors cost an estimated 900 JD/month times two.

Annex III.B.
Table 28

SUMMARY COST ESTIMATE

Project Component/Activity	AID Contribution		TOTAL
	FX	LC	
1. SERVICE DELIVERY			
A. Technical Assistance	1,888,960	826,571	2,715,531
B. Contraceptives	591,020	0	591,020
C. Clinical Equipment	384,904	12,786	397,690
D. Other Equipment			
1. Center	85,389	10,330	95,719
2. Vehicles	63,000	0	63,000
3. Vehicle maint/insurance	0	37,671	37,671
E. Facilities Upgrade	0	288,931	288,931
F. Protocol Development	0	60,750	60,750
G. Data Collection			
1. Equipment	94,835	0	94,835
2. Computer Forms/Supplies	0	93,439	93,439
H. Programmatic Research			
1. Subproject Activities	0	523,421	523,421
2. Seminars	0	44,687	44,687
Subtotal	3,108,108	1,898,586	5,006,694
2. TRAINING			
A. Technical Assistance			
1. Medium Term	334,378	60,750	395,128
2. Short Term	101,702	46,940	148,642
B. Workshops/Seminars			
1. Per Diem	0	550,101	550,101
2. Supplies	0	168,541	168,541
C. Overseas Training	265,680	0	265,680
D. Equipment	64,698	4,306	69,004
Sub-Total	766,458	830,638	1,597,096
3. IEC			
A. Technical Assistance			
1. Short-term	596,768	0	596,768
B. Equipment and Materials	65,812	0	65,812
C. Seminars, Training, Mtgs	0	275,777	275,777
D. Materials Development	0	794,033	794,033
E. Mass Media	0	414,147	414,147
Sub-Total	662,580	1,483,957	2,146,537

162

26

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4. EVALUATION			
1. Technical Assistance	61,947	0	61,947
2. Ministudies	41,513	239,572	281,085
3. External Evaluation	231,801	0	231,801
Sub-Total	335,261	239,572	574,833
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5. AUDIT	250,000	0	250,000
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6. PROJECT MANAGEMENT			
1. Supplies	207,117	68,965	276,082
2. Office Costs	0	553,360	553,360
3. Transportation	0	8,100	8,100
4. In-country Travel	0	37,298	37,298
Subtotal	207,117	667,723	874,840
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7. Contingency (5%)	400,000	150,000	550,000
GRAND TOTAL	5,729,524	5,270,476	11,000,000

Table 29
Annex III.B.

CPP PROJECT - PROCUREMENT PLAN

The procurement is itemized below. Local commodities will be purchased according to local currency regulations contained in Chapter 18 of Handbook 18 or by utilizing any necessary waivers on a case by case basis.

Commodity		Number	Unit	Resp.	Procurement	Method of	Payment	Procurement	
	Unit	of Units	Cost	Cost (\$)	Agency	Source/Origin	Procurement	Procedure	Schedule
1. Technical Resources									
Resident Advisor	Year	2	147,500	295,000	Prime C	USA	Contract	Reimburse	Years 1, 4
	Year	2	130,500	261,000				Reimburse	Year 2, 3
Senior Advisor	Year	4	52,941	211,764	Prime C	Jordan	Contract	Reimburse	Years 2-5
USAID Project Manager	Year	5	28,000	140,000	USAID	Jordan	Contract	Direct	Years 1-5
Michigan Fellow	Year	2	100,000	200,000	USAID	USA	Buy-in	Direct	Years 1, 2
Accountant	Year	4.5	24,375	109,688	Prime C	Jordan	Contract	Reimburse	Years 1-5
Secretary	Year	4.5	11,406	51,328	Prime C	Jordan	Contract	Reimburse	Years 1-5
Driver	Year	4.5	8,750	39,375	Prime C	Jordan	Contract	Reimburse	Years 1-5
Data Specialist	Year	4.25	28,750	122,188	Prime C	Jordan	Contract	Reimburse	Years 1-5
CA Backstop	Year	3	63,000	189,000	Prime C	Jordan	Contract	Reimburse	Years 1-5
Training Consultant	Year	1	168,750	168,750	Prime C	USA	Contract	Reimburse	Year 1
Short Term Consultants	PM	33.25	20,000	665,000	Prime C	USA	Contract	Reimburse	Year 1-5

				2,453,092					
2. Commodities									
A. Contraceptives									
Ovrette	Cycle	100,000	0.25	25,000	USAID	USA	AID/W Buy-in	Direct	Years 1-4
Lo-Feminol	Cycle	175,000	0.25	43,750	USAID	USA	AID/W Buy-in	Direct	Years 1-4
Condoms	Unit	400,000	0.10	40,000	USAID	USA	AID/W Buy-in	Direct	Years 1-4
CuT 380A IUD	Unit	200,000	1.25	250,000	USAID	USA	AID/W Buy-in	Direct	Years 1-4
Norplant	Sets	400	25.00	10,000	USAID	USA	AID/W Buy-in	Direct	Years 1-4
Depo-provera	Units	130,000	1.00	130,000	USAID	USA	AID/W Buy-in	Direct	Years 1-4

				498,750					
B. Clinical Equipment									
IUD Insertion Kit	Each	35	100	3,500	Prime C	USA	Purchase Order	Direct	Year 1
IUD Backup Kit	Each	18	268	4,824	Prime C	USA	Purchase Order	Direct	Year 1
Minilap Kit	Each	45	135	6,075	Prime C	USA	Purchase Order	Direct	Year 1
Instrument Table	Each	35	78	2,734	Prime C	USA	Purchase Order	Direct	Year 1
Goose Neck Lamp	Each	35	234	8,203	Prime C	USA	Purchase Order	Direct	Year 1
Autoclave	Each	12	781	9,375	Prime C	USA	Purchase Order	Direct	Year 1
Gynecological Exam Table	Each	35	500	17,500	Prime C	USA	Purchase Order	Direct	Year 1
Gyn Stools	Each	35	47	1,641	Prime C	USA	Purchase Order	Direct	Year 1
Steel Bowl Set	Each	70	117	8,203	Prime C	USA	Purchase Order	Direct	Year 1
Storage Cupboard	Each	35	234	8,203	Prime C	USA	Purchase Order	Direct	Year 1
Privacy Screen	Each	35	109	3,828	Prime C	Jordan	Purchase Order	Direct	Year 1
Falop Ring	Box of	2	150	300	Prime C	USA	Purchase Order	Direct	Year 1
Laparoscope with Falop					Prime C	USA	Purchase Order	Direct	Year 1
Ring Adapter	Each	12	6,000	72,000	Prime C	USA	Purchase Order	Direct	Year 1
Teaching Attachment	Each	4	5,400	21,600	Prime C	USA	Purchase Order	Direct	Year 1
Baby Examining Table/Sides	Each	35	156	5,469	Prime C	Jordan	Purchase Order	Direct	Year 1
Baby Scale	Each	35	47	1,641	Prime C	Jordan	Purchase Order	Direct	Year 1

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164

CPP PROJECT - PROCUREMENT PLAN

Baby Head Measuring Tape	Each	70	3	219	Prime C	Jordan	Purchase Order	Direct	Year 1
ENT Diagnostic Set	Each	35	78	2,734	Prime C	USA	Purchase Order	Direct	Year 1
Wash Sink	Each	35	47	1,641	Prime C	Jordan	Purchase Order	Direct	Year 1
Vickers Incubators	Each	24	8,000	192,000	Prime C	USA	Purchase Order	Direct	Year 1
Neonatal Monitor	Each	1	23,000	23,000	Prime C	USA	Purchase Order	Direct	Year 1
Small Refrigerators	Each	12	250	3,000	Prime C	USA	Purchase Order	Direct	Year 1

397,690

C. Training Equipment

Dry-erase Board	Each	5	100	500	Prime C	USA	Purchase Order	Direct	Year 1
Overhead Projector	Each	5	600	3,000	Prime C	USA	Purchase Order	Direct	Year 1
Screen	Each	5	250	1,250	Prime C	USA	Purchase Order	Direct	Year 1
Easel/Flipchart	Each	5	100	500	Prime C	USA	Purchase Order	Direct	Year 1
Training Video		5	1,000	5,000	Prime C	USA	Purchase Order	Direct	Year 1
Resource Books		5	1,000	5,000	Prime C	USA	Purchase Order	Direct	Year 1
Storage Cabinet	Each	5	250	1,250	Prime C	Jordan	Purchase Order	Direct	Year 1
Bulletin Board	Each	5	40	200	Prime C	Jordan	Purchase Order	Direct	Year 1
Pelvic Model	Each	20	395	7,900	Prime C	USA	Purchase Order	Direct	Year 1
Norplant Arm Model	Each	8	14	108					
Arm Replacement Skin	Each	100	2	200					
Other Models and Charts		5	1,000	5,000	Prime C	USA	Purchase Order	Direct	Year 1
Copy Machines	Each	5	3,000	15,000	Prime C	USA	Purchase Order	Direct	Year 1
Tables	Each	10	200	2,000	Prime C	Jordan	Purchase Order	Direct	Year 1
Chairs	Each	100	70	7,000	Prime C	USA	Purchase Order	Direct	Year 1

53,908

D. IEC Equipment

Apple Computer & Software	Each	1	16,000	16,000	Prime C	USA	Purchase Order	Direct	Year 1
A/V Mixing Equipment etc.		1	6,000	6,000	Prime C	USA	Purchase Order	Direct	Year 1
Cassette Recorders	Each	10	50	500	Prime C	USA	Purchase Order	Direct	Year 1
VCR & Television	Each	3	1,700	5,100	Prime C	USA	Purchase Order	Direct	Year 1
Easel/Flipchart	Each	3	80	240	Prime C	USA	Purchase Order	Direct	Year 1
Overhead Projector	Each	1	600	600	Prime C	USA	Purchase Order	Direct	Year 1
IEC Videos	Each	70	50	3,500	Prime C	USA	Purchase Order	Direct	Year 1
Slide Shows	Each	70	80	5,600	Prime C	USA	Purchase Order	Direct	Year 1
IUD Demo Model	Each	100	15	1,500	Prime C	USA	Purchase Order	Direct	Year 1
Video Tape	Each	100	10	1,000	Prime C	USA	Purchase Order	Direct	Year 1
Audio Cassette	Each	100	2	200	Prime C	USA	Purchase Order	Direct	Year 1

40,240

E. Information System Equipment

Am 486 Dxx Computer	Each	13	3,500	45,500	Prime C	USA	Purchase Order	Direct	Year 1
Computer Printer	Each	13	400	5,200	Prime C	USA	Purchase Order	Direct	Year 1
Computer Diskette	Box	100	30	3,000	Prime C	USA	Purchase Order	Direct	Year 1
Laptop computer	Each	1	3,500	3,500	Prime C	USA	Purchase Order	Direct	Year 1

57,200

1 US\$ = .68 JD

165

CPP PROJECT - PROCUREMENT PLAN

F. Office and Supplies

Bulletin Board	Each	2	40	80	Prime C	Jordan	Purchase Order	Direct	Year 1
White Board	Each	4	100	400	Prime C	USA	Purchase Order	Direct	Year 1
Filing Cabinet	Each	3	234	702	Prime C	Jordan	Purchase Order	Direct	Year 1
Laptop computer	Each	2	3,500	7,000	Prime C	USA	Purchase Order	Direct	Year 1
Table Top Computer	Each	2	3,500	7,000	Prime C	USA	Purchase Order	Direct	Year 1
Laser Printer	Each	2	1,250	2,500	Prime C	USA	Purchase Order	Direct	Year 1
Software			2,000	2,000	Prime C	Jordan	Purchase Order	Direct	Year 1
Transformers	Each	6	75	450	Prime C	Jordan	Purchase Order	Direct	Year 1
Copy Machine	Each	1	10,000	10,000	Prime C	USA	Purchase Order	Direct	Year 1
Fax Machine	Each	1	500	500	Prime C	USA	Purchase Order	Direct	Year 1
Overhead Projector	Each	1	600	600	Prime C	USA	Purchase Order	Direct	Year 1
Bookcase	Each	3	60	180	Prime C	Jordan	Purchase Order	Direct	Year 1
Cupboards	Each	2	250	500	Prime C	Jordan	Purchase Order	Direct	Year 1
Project Folder				2,344	Prime C	Jordan	Purchase Order	Direct	Year 1
Misc. Office Supplies				8,000	Prime C	Jordan	Purchase Order	Direct	Year 1-5
Subscriptions				10,000	Prime C	USA	Purchase Order	Direct	Year 1-5
Resource Books				1,000	Prime C	USA	Purchase Order	Direct	Year 1
Flipchart Easel	Each	1	80	80	Prime C	USA	Purchase Order	Direct	Year 1
Office Decoration				1,000	Prime C	Jordan	Purchase Order	Direct	Year 1

126,336

G. Other Equipment

Filing Cabinet	Each	12	300	3,600	Prime C	Jordan	Purchase Order	Direct	Year 1
Desks with chair	Each	75	234	17,578	Prime C	USA	Purchase Order	Direct	Year 1
Waiting Room Bench	Each	40	156	6,250	Prime C	USA	Purchase Order	Direct	Year 1
Armless Chair	Each	200	86	17,188	Prime C	Jordan	Purchase Order	Direct	Year 1
TV/VCR Combo	Each	12	1,700	20,400	Prime C	USA	Purchase Order	Direct	Year 1
Slide Projector	Each	12	400	4,800	Prime C	USA	Purchase Order	Direct	Year 1
Screen	Each	12	250	3,000	Prime C	USA	Purchase Order	Direct	Year 1
Easel for flipchart	Each	12	100	1,200	Prime C	USA	Purchase Order	Direct	Year 1
Bulletin Board	Each	12	40	480	Prime C	Jordan	Purchase Order	Direct	Year 1
White Board	Each	12	100	1,200	Prime C	USA	Purchase Order	Direct	Year 1

75,696

3. Facilities Upgrading

Plaster, Paint, Electric and Plumbing Lines, Lumber, Room Dividers, Labor		12	15,166	181,992	Prime C	Jordan	Purchase Order	Direct	Year 1/2
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4. Vehicles

Chevrolet Suburban Vans	Each	3	17,000	51,000	USAID	USA	PIO/C	Direct	Year 1
Gas & Maintenance		1	4,000	4,000	Prime C	Jordan	Purchase Order	Direct	Year 1-5
Insurance	Year	3	350	1,050	Prime C	Jordan	Purchase Order	Direct	Year 1-5
Shipping of Vehicle		3	4000	12,000	USAID		Purchase Order	Direct	Year 1
Rental Vehicle & Driver	Month	2	3000	6,000	Prime C	Jordan	Purchase Order	Direct	Year 1

94,250

1 US\$ = .68 JD

166

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CPP PROJECT - PROCUREMENT PLAN

5. Office Space & Utilities

Furnished Office Space	Year	5	30,000	150,000	Prime C	Jordan	Purchase order	Direct	Years 1-5
Utilities	Year	5	3,000	15,000	Prime C	Jordan	Purchase order	Direct	Years 1-5
Communications	Year	5	40,000	200,000	Prime C	Jordan	Purchase order	Direct	Years 1-5
Telephone & Installation	Year	5	1,000	5,000	Prime C	Jordan	Purchase order	Direct	Years 1-5
Equipment maintenance	Year	5	1,000	5,000	Prime C	Jordan	Purchase order	Direct	Years 1-5

375,000

GRAND TOTAL 4,354,153

1 US\$ = .68 JD

167

ANNEX III.C.

ECONOMIC ANALYSIS

Economic Analysis

Numerous economic benefits are associated with averting unwanted births and with postponing mis-timed births. These benefits accrue both at the national and at the family level. At the national level, benefits are associated primarily with reduced public sector outlays for social infrastructure development, notably housing, education and health, and with reduced unemployment. At the family level, these benefits include reduced expenditures on schooling, health and consumables, and improved household income and living standards.

Over the five year life span of the CPP project, it is estimated that a total of 40,200 births would be averted, and, that by the end of the project, approximately 18,800 births would be averted annually. These figures represent a 15 per cent reduction in annual births as compared with 1991, and a decline in the total fertility rate from 5.6 to 4.9 children per woman during the same period.

Savings in public sector expenditures resulting from these reduced births and fertility are regarded as substantial in Jordan because of the high premium attached to, and the prevailing high costs of, education and health care in the country. Preliminary estimates by the National Population Commission show that, if the above objectives are achieved, annual savings of approximately \$12 million in government outlays for schools and \$9 million in outlays for health care could ensue. The savings due to a birth averted is estimated at \$26,500. Using this estimate, the internal rate of return (IRR), which is the discount rate that equates the present value of expected costs with the present value of expected savings and which provides a single measure of return on investment, is estimated to be at least 20 per cent. Thus, the benefit-to-cost ratio for birth spacing in Jordan and for this project is highly favorable.

A more detailed analysis of the economic benefits of reduced fertility in Jordan follows:

The Economic Impact of Fertility Decline

Fertility has already begun to fall in Jordan and it is reasonable to expect the CPP project to contribute in a significant way to a continuation of that decline. While the effects of a fertility decline on key economic indicators would be hard to quantify--especially over a brief five year period--the kinds of economic benefits that might be expected would be:

- Reduced pressure on the country's finite natural resources--most importantly water--as a result of slower population growth;

56

Annex III.C. Economic Analysis

- Potentially lower unemployment as a smaller population reduces the employment surplus;
- Lower demand for expensive public sector services such as education and health care;
- A slowing of the decline in per capita income that has occurred in recent years as a result of the interaction of increasing population and diminishing economic performance.

Impact of the Project on Fertility

This project is expected to have a significant impact on fertility, as discussed in Annex II of the paper.

Over the life of the project, it is anticipated that 67,100 women will accept a contraceptive method at the project's 12 sites and, by the end of the project, at least 27,800 women per year will be doing so. Applying The Futures Group's Target-Cost Model to these figures, it is estimated that 40,200 births could be averted over the five-year life-span of the project and, by the end of the project, approximately 18,800 births per year may be averted--over 15 percent of the 120,000 reported births in 1991. Contraceptive prevalence (modern methods only) could increase from 26.9 to 33.9 percent among currently married women and the total fertility rate could decline from 5.6 to 4.9 per woman.

The above figures are probably somewhat over-stated inasmuch as they do not take into account that a certain number of acceptors in the project are likely to be women who would have obtained contraception even in the absence of the CPP Project. Conversely, they are conservative inasmuch as they do not take into account the contraceptive effect of breastfeeding, when practiced properly--a method that will be actively promoted at the CPP centers. They also do not take into account the fact that the project should have a spill-over effect beyond its 12 sites because of the training and IEC activities that extend into both the public and private sectors.

Health Sector Expenditures

Since family planning services are known to improve maternal and child health, the project can be expected to have a beneficial impact on the health sector. With health care expenditures in Jordan rising at a disturbing rate--from roughly four percent of GDP in 1980 to over 10 percent in 1991--any strategies to control health costs merit serious attention.

Annex III.C.
Economic Analysis

Worldwide studies clearly show that spacing births two or more years apart and avoiding high risk births significantly reduces the risk of death and illness for women, their infants and even older siblings. This, in turn, lessens the need for expenditures on maternal and child health care. It has been estimated that if all Jordanian births were at least 24 months apart, the infant mortality rate would fall by 40 percent, or 4,000 deaths/year, and maternal mortality would drop by 29 percent. At the same time, morbidity, too, would be reduced.

Studies from other countries have sought to quantify the cost-effectiveness of family planning. For example, the Mexican Social Security Institute found that every peso spent on family planning in urban areas saved eight pesos in maternal and child health care expenditures. Indeed, it was estimated that the family planning program had averted expenditures equal to 8.5 percent of the institute's total health budget. In India, at the Tata Steel Family Welfare Program in Jamshedpur, each rupee invested by Tata Steel in family planning yielded an overall savings of 2.39 rupees. In a Philippine study, it was found that for every dollar expended on family planning services for women who wanted no more children, \$18 per year were saved in Ministry of Education budgets. It should be noted, however, that these savings do not show up immediately, but only over a longer time period.

Impact on Family Economics

The positive impact of family planning services is seen most powerfully not at the macro level but at the level of each family. Improved family health and reduced expenditures for food, housing, health care and education for a smaller family are among the most compelling arguments for the provision of contraceptive services. A study in Thailand found that smaller families are wealthier, spend more on consumer goods and save more than larger families. They also have better-educated children than larger families with similar backgrounds.

Family planning also has the effect of enabling women to participate more actively in the work force, if they choose to do so, thus contributing to the family income as well as the national economy. For those women who work in the home, they have more time to contribute to meeting the needs of each family member, enhancing the health, education and welfare of the family unit and each individual family member.

Cost-Effectiveness of the Postpartum Approach

The introduction of postpartum contraception in Jordan's hospitals is expected to be a highly cost-effective approach for a number of reasons:

- It is an extremely targeted approach inasmuch as virtually all women who are about to have a baby, or have just done so, should be thinking about adopting contraception. Postpartum contraception is aimed at women of proven fertility who, without contraception, are likely to become pregnant soon again. Thus, valuable resources are not wasted on reaching large numbers of women of whom only a few are at risk of unwanted pregnancy.
- The postpartum approach reaches women at a small number of sites--namely the hospital where they deliver--avoiding the expense of setting up (or integrating family planning into) a large number of clinics around the country.
- It is a sustainable approach that uses existing facilities and staff. While start-up costs are expensive--equipping the hospitals, training staff, making the population aware of the new services and integrating services into the current health care system--by the end of the project postpartum family planning should be institutionalized.

There is a body of evidence from other countries about the cost-effectiveness of the postpartum approach. In Honduras, for example, the marginal cost of adding postpartum family planning and breastfeeding promotion to the social security program in the city of San Pedro Sula was only \$772 for every 1 percent change in contraceptive prevalence among women at six months postpartum.

A number of the specific interventions planned for the project have also been shown to be cost-effective.

One of the planned activities is to integrate immediate post-placental IUD insertion into the services offered by hospitals when the woman comes to deliver her baby. This means that an "interval" visit--i.e. a separate clinic visit--for IUD insertion can be avoided. A 1992 study in Kenya showed that the first year marginal costs of interval IUD insertion were 42 percent higher than immediate post-placental insertion, saving scarce hospital resources. Even when IUD insertion is not done within minutes after delivery, but only prior to hospital discharge, costs are lower. In the social security system of Peru, the marginal cost of a postpartum IUD insertion within 24 hours following a birth was found to be small compared with the cost for an interval insertion. It was estimated that substituting half of the interval IUD insertions in Lima with postpartum insertion would reduce the total cost of all family planning consultations by about 10 percent.

Annex III.C.
Economic Analysis

The introduction of two new highly effective long-term contraceptive methods--Depo-Provera and Norplant--can also be expected to have an important impact on program costs. This would be attributable to the widely recognized fact that when a broader range of methods is made available, contraceptive use increases; and also to the fact that some women who have used less effective methods can be expected to switch to these more effective methods. This means that contraceptive use can be expected to increase at the same time as use of the most effective methods would increase.

Among the services to be offered at the time of delivery is voluntary female sterilization. While this is not a widely accepted method of birth control in Jordan at this time, about 47 percent of married women in Jordan say that they do not want any more children (JPFHS) and a certain number can be expected to avail themselves of this service. Sterilization can be costly at the time of the procedure but it provides absolute protection against unwanted pregnancy for years to come, so that it is extraordinarily cost-effective in the long-run.

The project's emphasis on IEC, while costly, is crucial to its success. Contraceptive use in Jordan is unlikely to increase so long as the array of barriers to its use are not combatted and dispelled. Experience in a number of countries reinforces the importance of IEC. A Lebanese hospital study found that 86 percent of postpartum mothers who had received education about family planning chose a method at their nine-week postpartum visit compared with 52 percent of mothers who did not receive that education. And in Lima, Peru, 40 percent of a group of women who received prenatal counseling and were offered postpartum contraception received an IUD by six months postpartum; only 27 percent of a control group who did not receive the counseling had accepted an IUD by six months postpartum. Based upon the 13 percent increased IUD use within the counseled group, the potential annual cost savings were calculated to be \$52,000 and a decision was made to integrate this approach throughout all hospitals in the system.

Rooming-in for mother and baby (i.e. mothers having their newborns with them rather than in separate nurseries) is another cost-effective service that will be promoted through the project. Not only does this contribute to the infant's health and to bonding between the woman and her newborn, but it reduces the demands on nursing staff for infant care and virtually eliminates the need for nursery facilities for low-risk healthy infants. Stimulating successful lactation also greatly reduces the need for costly infant formulas. For example, adding breast-feeding promotion to postpartum services in the social security system of Honduras reduced by over 80 percent expenditures for infant formulas, a savings of approximately \$33,000 per year. This is a significant contribution to the financing of postpartum services.

120

**Annex III.C.
Economic Analysis**

Thus, this project promises to institutionalize a number of cost-effective approaches to the delivery of family planning services and, in the long run, these services can be expected to save the GOJ money in a variety of sectors.

123

ANNEX III.D.

SOCIAL SOUNDNESS/GENDER ANALYSIS

1. SOCIO-CULTURAL CONTEXT OF JORDAN

1.1 General Population

1.1.1 Population Size and Density

In 1979, the total population of Jordan was 2.13 million¹. By 1990, the population had increased to 3.45 million, an average increase of 4.3 percent annually.² At the current rate of growth, the population can be expected to double in just 16 years³. The Kingdom's high natural population growth rate has been exacerbated by three massive population influxes: Palestinian refugees numbering 400,000 and 350,000 following the Arab-Israeli wars of 1948 and 1967, respectively, and some 300,000 returnees from Kuwait and other Gulf States in the wake of the Gulf War.

Population density ranges from 319 per square kilometer in Irbid (North) to only 3 per square kilometer in Ma'an (South). Over 80 percent of the returnees have settled in the Amman-Zarqa metropolitan area, representing a major increase in population density in these areas.

Overall, the Jordanian population is highly urbanized as more than 70 percent of the population live in localities of more than 5,000 inhabitants. In contrast, only 35 percent of the population was urbanized in 1950. Underlying this rural-urban shift has been a change in Jordanian society from a largely rural and agrarian one, enjoying a powerful social support system based on extended families, to a largely urban, wage oriented society, with extended family structures slowly giving way to nuclear families.

In 1990, Amman governorate, the financial and industrial center, included about 25 percent of the total population. Irbid and Zarqa contained about 5 and 10 percent of the total population, respectively.

¹Department of Statistics, 1982.

²National Population Commission, 1991.

³Jordan Population and Family Health Survey (JPFHS), 1990.

8b

Annex III.D.
Social Soundness Analysis

1.1.2 Ethnic and Religious Composition

History shows that the original Jordanians are descended from several hundred tribes who have lived in the area for centuries. A majority migrated from Mesopotamia, others from the Hejaz, Palestine, Egypt and Yemen, or trekked south from Lebanon and Syria. These Arabic-speaking Arabs, are predominantly Sunni Moslems and follow the orthodox branch of Islam.⁴

Ninety-six percent of Jordanians are Moslem⁵. Roughly 4 percent are Christians, including Greek Orthodox, Protestant and Roman Catholic, who trace their origins from early Christian converts in the area, and from the west Bank towns where Christianity was born. Christians are mainly found in Amman, Madaba, Karak and Salt.

The non-Arab Sunni Moslem minority known as the Circassians who settled in Jordan in the late nineteenth century trace their origins to two Indo-European Moslem tribes who migrated south and settled in Wadi Seer and Na'ur. Today, Jordan's Circassian community numbers some 25,000 and consists of several tribes. Two seats in parliament are allotted to Circassians from each community. Circassians occupy many influential posts in the government and the army, although a majority are agricultural workers and urban landlords. Another tribe, the Chechens identify with them, except for language. Chechen communities are found in Azraq, Zarqa, Ruseifa and Sweileh; they number around 5,000. Other minorities in Jordan include the Turcomans and Bahias, the latter having migrated from Iran shortly after the turn of the century. Since the war in Lebanon, many Lebanese have settled in Amman.

Roughly 40 percent of Jordan's population are Palestinian, many having fled from the West Bank to Jordan as refugees during the wars of 1948 and 1967. Palestinian's welfare is taken care of by the UNRWA (United Nations Relief and Works Agency) which provides basic services such as health, welfare and education. Some of the refugees are still housed in camps in Jordan. Refugees have been granted citizenship by the Jordanian Government and today play an important role in the economic and political life of the country as they occupy many high positions in government and business.⁶

⁴Osborne, Christine. 1981. An Insight and Guide to Jordan.

⁵JPFHS, 1990.

⁶Finlay, Hugh. 1987. Jordan & Syria.

175

Annex III.D.
Social Soundness Analysis

Nearly 15% (or approximately 600,000) of the country's population is Bedouin. The Bedouin people are the original inhabitants who graze camels, sheep or goats. The resettlement of the Bedouin and the improvement of their living standards has been a focus of the government's activities over the last decade, including construction of schools, clinics, houses and the creation of jobs. Bedouin educational levels tend to be below the national average as, historically, children become economically active at an early age, herding goats and performing domestic chores.

The Fellaheen are the village dwellers who live in farming communities cultivating a combination of fruit and olive trees, field crops and vineyards. In addition, they may keep livestock and poultry.

Although Jordan is clearly undergoing rapid social and demographic change, the transitions are far from complete and have proceeded at different paces among different groups mentioned above. The diverse population including a modern, elite class in Amman, Zarqa and Irbid, a large commercial working class in urban areas, refugees living in camps, farmers along the Jordan valley and pastoralists encompass a wide variation in levels of education, standards of living and exposure to new technologies and life styles. Jordan is still a tribal-based society with strong controls exerted by the tribe over individuals and their behavior.

1.1.3 Administrative and Geographic Divisions

Jordan is divided into 8 governorates, which are organized into three regions: Irbid and Mafrq in the Northern region; Amman, Zarqa and Balqa in the Central region; and Karak, Tafileh and Ma'an in the Southern region. Recently, the MOH has adopted a decentralized approach to the provision of health services following this regional differentiation. Conditions vary between each region and this new approach should help insure that health services are tailored to more effectively meet the needs of the population. Accordingly, three regions now each have a Director who is responsible for all hospital and health center services provided within the region.

The geographical distribution of the population is determined mainly by rainfall patterns and methods of cultivation, in addition to business and manufacturing. Overall, more than 80 percent of the population are concentrated in only one-eighth of the total land area.

The Central region is the most densely populated region of the country and has the greatest concentration of public and private medical services. Because of higher levels of education, income, and exposure to different ideas, Central Region residents are often more receptive to new concepts than residents of the other regions. Demand by women for family planning services is higher in the Central Region.

66

Annex III.D.
Social Soundness Analysis

The North is the second most populated region. Infant and maternal mortality are considerably higher in the region as is the unmet demand for contraceptive information and services, particularly among women with no education. However, the number of hospitals is very low and these hospitals are overburdened. Physicians are often too busy in public sector facilities to meet women's health needs.

The South is more rural, tribal, and poor than the other two regions. Women are less educated and tend to have greater numbers of children. At present, for many women in certain social strata, marital security depends on the number of children they bear. Fewer hospitals are available in the South and people must travel greater distances to receive health care services than in other regions.

1.2 Socio-Economic Situation: Determinants of Fertility

1.2.1 Fertility

For a variety of sociocultural and economic factors, large families and short birth intervals have been the norm in Jordan. Currently, the total fertility rate is 5.6. Desired fertility is estimated to be 3.9, however, if all unwanted births were prevented⁷. Levels of fertility previously found among Jordanian women were even higher as seen from the large proportion of women age 45-49 (39 percent) who in 1990 had 10 or more children.

Fertility is much lower in urban areas than in rural areas. The total fertility rate for women in large cities is almost one child lower than for women in other urban areas and more than two children lower than for rural women. The differential in the number of children ever born to women 40-49 are not as large, however, suggesting that the large differences in fertility by residence are a recent phenomenon.

Women's preferences concerning future childbearing serve as indicators of future fertility. In 1990, the majority of Jordanian women (52 percent) considered the ideal family size to be at least 4 children. Only 10 percent of ever-married women stated an ideal family size of two children. Of concern to family planning programs, however, is the fact that 40 percent of women with five or more children have exceeded their ideal family sizes, many by two or more.

In Jordan, high risk fertility behavior is common. Eight out of ten married women are at risk of conceiving a child at increased risk of dying due to age and parity. Two-thirds of married women are at risk because they have already had 3 births, while one-third are at risk

⁷JPFHS, 1990, p. 74.

177

Annex III.D.
Social Soundness Analysis

because they are over age 34. The single most detrimental risk factor is a short birth interval; children born less than 24 months after an older sibling are twice as likely to die as children who are not in any risk category. In Jordan more than half of all births occur less than two years apart.

1.2.2 Educational and Literacy Levels

Jordan has witnessed tremendous progress in the area of education in recent years, with sex differentials in literacy rates, education levels and enrollment rates rapidly disappearing. For females, the literacy rate was estimated to be 73 percent in 1990, up from rates of 59 percent in 1985 and 29 percent in 1970. Male literacy rates have also increased significantly from 64 percent to 89 percent over the same period. Fifty eight percent of women have now attained at least an elementary level education, 17 percent have at least a secondary level education and 1.5 percent have a first or second university degree.

The primary school enrollment for girls has risen from 59 percent in 1960 to 92.5 percent, a rate 2.1 percent higher than for boys. The primary enrollment ratio for boys has remained constant over the same period. Dropout rates among females remain disproportionately high, however, with the estimated rate in 1989 being 3.1 percent for girls versus 2.2 percent for boys. Currently, secondary school enrollment for girls and boys stand at 78 and 80 percent, respectively. In higher education, women now comprise 40 percent of all university students in Jordan and 60 percent of community college students. Finally, 38 percent of women are enrolled in the science faculties compared to 43 percent of males, suggesting a movement of women away from traditional areas such as the social sciences and humanities.

In spite of recent advances in education, about 24 percent of all Jordanian women have never been enrolled in formal education, 23 percent have some primary education, 44 percent have some preparatory or secondary education and 11 percent have more than secondary education. The level of women's education varies greatly by age cohort with the percentage of women with no education or only some primary education increases dramatically with age. For women 15-19 in 1990, only 3.7 percent had received no education while for women 40-44, 45.2 percent had no formal education.⁸

Women in large cities and other urban areas are more likely to have higher education than their rural counterparts. There is a pronounced difference in women's educational attainment by governorate. In the governorate of Amman, 18 percent of all women have no education, whereas, in the South, the proportion is 37 percent. Of the women who have

⁸JPFHS, 1990.

never gone to school, 7 percent declare they can read as compared to 83 percent who have some primary education.

1.2.3 Economic Conditions

Jordan has been experiencing a severe economic crisis since the mid-eighties. It was against this backdrop of recession, harsh structural adjustment measures, high inflation and falling real incomes that the Gulf Crisis struck in August 1990. Virtually overnight, 40 percent of the country's exports disappeared, revenues from tourism dried up, aid from the Gulf countries was completely cut off and workers remittances, previously as much as 20 percent of the national income, plummeted as Jordanians were forced to return home from the Gulf. Total losses attributable to the Gulf crisis in its first six months were estimated at 36 percent of GNP.⁹

The 300,000 returnees from the Gulf have placed an enormous strain on already overstretched social services in the country. The Ministry of Health, in a study issued in September 1990, reported a 34 percent increase in demand for state health care, resulting in a widespread shortage of beds, equipment and medicines, as well as a substantial and still growing budget deficit.

The economic setbacks which have beset the country in the last four years have exacted a tremendous human cost, and have led to the emergence of a new class of urban and rural poor. The major economic indicators that relate to quality of life and purchasing power of families all deteriorated steadily in the four-year period from 1988-1991. The inflation rate, as measured by the official cost of living index, increased by 69 percent over that period, from 106 to 169. Over the same period, the dinar lost approximately 50 percent of its value, and in dollar terms, the average Jordanian family lost about 86 percent of its purchasing power.¹⁰ Household surveys conducted in the squatter areas of Amman indicate the typical squatter family earned less in 1990 than in 1980, while prices rose sharply during this period.

Government surveys showed that around 20 percent of Jordanian families were living below the poverty line before the onset of the 1988 economic crisis.¹¹ At that time, poverty was defined as a monthly family income of 89 JD, or \$135/month. Currently, the absolute poverty line is considered by many to be approximately 150 JD per month or \$220/month. The number of families living in poverty has increased since 1988, but the precise number

⁹UNICEF, 1992.

¹⁰UNICEF, 1992.

¹¹UNICEF, 1992.

Annex III.D.
Social Soundness Analysis

is not well documented and poverty is not precisely defined. Specifically, among the returnees from the Gulf, a recent study by the Ministry of Planning revealed one-third of the families were below the poverty line. The Ministry of Social Development reports that at least 20,000 families live in absolute poverty, without enough food or other essentials. In some regions of the country, the Ministry states that the poverty level reaches 33 percent. The poor are kept alive by assistance provided by government and private societies.

Results from UNICEF's two rapid assessment survey (1990 and 1991) suggest that the most severe pockets of poverty were among the urban poor (especially those living in squatter areas), some refugee camps and those remote rural areas hardest hit by several years of relative drought and the recent economic crisis.

Many poor families are only able to eat one meal a day. Some have resorted to selling jewelry and household goods in order to buy food and other essential goods. Others have increased their indebtedness to local grocers and suppliers. Many families are straining under debts accumulated over the last three years. Accordingly, poor families are reducing their use of education and health systems because they cannot afford even the modest fees charges for school supplies or medicines. Families may postpone taking ill children to health centers in order to save money. The UNICEF survey found that some families are losing confidence in the health system as health providers prescribe medicines that were beyond the families purchasing power, therefore making a visit to the health center meaningless.

The economic decline and increased poverty levels in Jordan have highlighted clearly the unsustainability of the country's current high rate of natural population growth, and thus given renewed importance to family planning and child spacing.

1.2.4 Status of Women

Economic Status

One of the more paradoxical features about women in Jordan is that despite their very high levels of education, particularly among the younger generation, their presence in the labor force remains among the lowest in the world. Working-age men's participation in the labor force is nearly 100 percent. For women, however, the highest level of labor force participation is 20 percent for 20-24 year olds. After the age of 35, women practically disappear from the labor force¹². Eighty-one percent of women who work in the formal sector live in urban areas.

¹²USAID/Amman, 1992.

**Annex III.D.
Social Soundness Analysis**

Fully 76 percent of women who work are employed in community, social and personal services, and only 24 percent are occupied in other branches of the economy. This reflects the concentration of working women in teaching, nursing, activities for which the principal employers are government ministries and agencies. Over half of the working women are also graduates of community colleges or universities. Jordanian women with only secondary education are very unlikely to have a job. In her lifetime, the average woman in Jordan can be expected to hold a job for 3.7 years, compared to 44.8 years for the average male.

Sixty-seven percent of female workers are single compared to 39 percent of male workers. Most single women who work do not work after getting married, although this is slowly changing.

Wages for women in the formal sector are lower than those for men indicating both wage discrimination and males longer time employed which allows them access to promotion, training and allowances.

Legal Status

The legal context under which Jordanian women live has tremendous implications for their socioeconomic welfare. Jordanian women face a highly structured legal system steeped in religious law and social traditions which affect every aspect of their lives. A women's upbringing in the home, education, employment, marriage, marital relations, divorce, retirement and inheritance are all strictly defined within the civil law and the personal status law (derived from religious law and customary practices governing most aspects of private life). A woman's legal status and capacity to act as an individual are restricted by the imposition of both civil and personal status law.

Women in Jordan are largely unaware of their rights under law and the procedures in place to enforce those rights. Additionally, certain laws in Jordan still discriminate against women. For example, the civil service retirement law mandates retirement for women after 15 years of service but after 20 years for men. Entitlement to health insurance benefits is passed on to a man's children but not to a woman's. Inheritance laws give a disproportionate share of property to brothers as opposed to sisters. Nationality law allows a Jordanian man to pass on nationality to his children but restricts a woman's right to do so.

Regulations promulgated under these laws also reinforce inequitable treatment of women. A woman must obtain the permission of a legal male guardian (Be it father, brother, or husband) to obtain a passport whereas a man has no such restriction. The overwhelming majority of women are rarely declared heads of households, a significant classification given the government's use of the family registration book to obtain all benefits and entitlement.

Annex III.D.
Social Soundness Analysis

Without the family registration book, a woman cannot register her children for school, obtain a drivers license or obtain social assistance from any government agency.

In addition to de jure discrimination, de facto discrimination occurs in the inequitable application -- or nonapplication -- of certain laws. For example, despite constitutional provisions mandating the equal rights of both women and men to work, employment advertisements routinely request that only male candidates need apply.

Women received the right to vote in 1974. However, there has never been a female member of Parliament.

Social Status

Jordanian society is strongly patriarchal, with male children being a source of social prestige for the parents. Males maintain the family lineage according to a hierarchy based on age and traditionally assume responsibility for the family, supporting parents in old age as well as unmarried, divorced or widowed sisters.

Being a patriarchal society, after marriage, many couples live with the husband's parents until they have earned enough money to buy or rent their own separate home. Within the household, the new daughter-in-law gains status and thus authority in the family and her husband's kin, in general, through a number of channels: the financial resources she controls, the number of children she has and the quality of her relationship with her husband.

A heavy workload and lower status of younger women in extended families does not allow them to seek medical care, even if they feel the need for it. Upon marriage, many young women are must submit to the wishes of her husband's family, especially to her mother-in-law. The mother-in-law is a powerful influence in a woman's life. In many cases where the couple lives in the parent's house, the son continues to turn his wages over to his mother; his wife if she does not work may have no control over financial expenditures at all. After the birth of her first child, the new mother may be given very little freedom to decide how to raise the child, such when to seek medical care or what to feed the infant and when. The mother-in-law and the whole extended family can be very involved in the upbringing of the child and may perpetuate old less than healthy child care traditions. As the new wife grows older, her role begins shifting as she gain more status and power within the family, her workload is reduced and is replaced by the more managerial tasks of running the household. Even in those cases where the newly married couple has adequate resources to begin their married life in their own house, the husband's family still retains a great deal of control over their activities.

Health Status

No comprehensive study of maternal mortality and morbidity or women's reproductive health has been conducted in Jordan to date. Consequently, little data is available on the actual health status of women. What is known is that many women do not receive adequate antenatal and few seek postpartum care.

Women often place their personal needs after those of their children, husbands and, sometimes, other family members. It is not surprising that women who have been culturally conditioned to put themselves last on the priority order are reluctant to admit to health ailments or seek medical advice, especially if the ailment is considered personal and shameful, as is often the case with reproductive health.

Women tend to internalize ailments such that "pain and discomforts emanating from their reproductive and sexual roles are accepted as the very essence of womanhood".¹³ No biological event has more significance for society than pregnancy and its outcome. It is regarded as a "rite of passage" through which most women will pass. Many girls in the Middle East are taught from an early age to endure physical malaise and suffering associated with the reproductive function, in menstruation, pregnancy or childbirth since this is related to fertility, which is the overriding symbol by which many women gain their socioeconomic status within the family and community.¹⁴

Many women lack informed knowledge on health and the importance of birth spacing for a variety of reasons. Few opportunities exist for formal and informal networking of women outside the family by which women can learn of the realities surrounding their reproductive and health. Schools provide very little general health education and even less on reproductive health, specifically. The majority of public sector health professionals either do not have the time to provide basic health information or feel it is not their role.

1.2.5 Age at Marriage

The Jordan Family Rights Law of 1976 sets the minimum age at marriage for males at 18 years and for females 16 years. However, the average age at first marriage for women currently is at 24.7 years, up from 22.6 years in 1979. The average age differential between husband and wife is now a relatively short 3.2 years, reflecting a more egalitarian power structure within the marriage than previously.

¹³Dixon-Mueller and Wasserheit, 1991.

¹⁴Khattib, 1992.

Annex III.D. Social Soundness Analysis

In Jordan, almost all births occur within marriage; thus, the age at first marriage is an important indicator of exposure to the risk of pregnancy and childbirth. While recent decline in fertility has been attributed to increased use of contraception, the decline in fertility in the 1970s has been attributed to higher age at first marriage.¹⁵

There is little variation in age at first marriage by place of residence (urban/rural) or region. Women marry at about the same age in all groups, although urban women and women in Balqa marry at slightly older ages than rural women and women in other governorates. Education, however, plays an important role in determining women's entry into marriage. The improvement of education opportunities for girls has resulted in their staying in school longer, and subsequently pushing the age at first marriage upward. Women who have attended more than secondary school tend to marry almost 6 years later than those with no education or primary education. Women who have attended primary education marry younger than women who have no formal schooling because they are more favored by potential husbands than illiterate women.

The practice of polygamy is rapidly decreasing in Jordan due primarily to increased education levels, urbanization, economic pressures and a generalized shift from extended to nuclear families. According to the 1987 Health, Nutrition, manpower and Poverty Survey, the rate of polygamous marriage is 2.9 percent, down from eight percent during the 1960s. The rate is 5 percent for rural and 1.4 percent in urban areas.

1.2.6 Infant Mortality

Infant mortality has decreased dramatically over the past three decades in Jordan. The infant mortality rate (IMR) has fallen from 135/1,000 live births in 1960 to 37/1,000 in 1990.¹⁶ The neonatal mortality rate accounted for 60 percent of infant mortality at 22/1,000 in 1990.

The pace of decline in infant and child mortality in Jordan varies, however. Neonatal mortality shows little, if any, decline, while mortality among children 1-4 years has declined rapidly. This suggests that factors affecting infant mortality are different from those affecting child mortality. According to the 1990 JPFHS, infant health is more likely to be influenced by factors such as antenatal and postnatal care and the length of the birth interval. UNICEF states that critical to reducing neonatal mortality are improved antenatal

¹⁵World Bank, 1993.

¹⁶UNICEF, 1992.

201

Annex III.D.
Social Soundness Analysis

care, including systems of risk detection and referral, and delivery care. Low birth weights, prematurity, congenital abnormalities and acute respiratory infections are also major factors behind neonatal mortality which need to be addressed.

The 1990 JPFH Survey found a degree of regional disparity in infant mortality levels. Infant mortality ranges from 45 in the northern governorate of Irbid to 36 in the urban governorate of Amman. Elevated infant mortality levels were also seen in the Southern Region.

Not captured in the 1990 JPFHS are the large disparities which are thought to exist in infant mortality rates in the greater Amman area, where the bulk of the country's population is concentrated. The 1976 Jordan Fertility Survey showed infant and child mortality differentials by place of residence for age cohorts born between 1960 and 1974 to be 77 for Jordan as a whole, 73 for Amman city, 70 for the outer fringes of Amman and the cities of Salt and Zarqa, and 90 for the fringes of the Amman metropolitan area.

The same survey reported IMR ranges in the greater Amman area from 55/1,000 in the more developed areas to 77/1,000 in relatively less developed areas of the city. Experts at the Urban Development Department state that if further disaggregation had been carried out, it would likely have revealed rates as low as 12 to 18/1,000 in the western part of the city. Accordingly, rates in the poorer sections of Amman would have been significantly higher.

1.2.7 Maternal Mortality

Data on maternal mortality in the countries of the Middle East are deficient; reliable, national level figures do not exist. No comprehensive study on maternal mortality has ever been conducted in Jordan. Civil registration of deaths is inadequate and cause of death information recorded on death certificates is considered highly unreliable. Hospital statistics, where they exist, are not representative of the whole population. Additionally, many of the maternal deaths occurring in the hospital may not occur in obstetric wards and therefore are not necessarily registered as a maternal death. It is estimated that in 1970 maternal mortality was 130/100,000. Estimates for 1990 indicate a reduction in maternal mortality to 40 deaths per 100,000¹⁷

¹⁷Shammout, Hani, Bassam Hijawi and Hind Al-Khatib. c.1990.

1.4 Use of Health Services and Family Planning

1.4.1 Use of Health Services

Jordanians of all socio-economic categories place a high value on the maintenance of good health for family members; the majority also value active use of western (allopathic) medical facilities, either private or public. Current patterns of medical facility usage reflect the desires of Jordanians to seek curative care for both perceived ill health and culturally defined circumstances which require medical intervention, such as the onset of labor in pregnant women.

The use of medical facilities for preventive medical attention or for the maintenance of good health is a relatively new social concept in Jordan. As such, changes in health care seeking behavior to include preventive medicine have occurred for only a few special medical events to date: immunizations, diarrheal episodes and birth spacing, the latter to a limited extent. Specifically, in Jordan:

- Over 90 percent of households now have accepted immunization as a means of safeguarding a child's future health;
- Over 60 percent of households now recognize diarrheal episodes as a potentially health threatening event for infants and regularly utilize oral rehydration therapy during such episodes;
- Thirty-five percent of married couples of fertile age currently practice birth spacing (27 percent use modern methods and 8 percent use traditional methods).

In spite of increases in the use of preventive health care resulting from mass public health campaigns by the MOH and changes in popular demand, a strong bias towards curative care still exists in Jordan. This bias leads many Jordanians to bypass primary health care centers and go directly to the outpatient or inpatient care sections of secondary or tertiary health facilities, even when primary levels of care offer the necessary treatment(s).

The CPP Project is designed to build upon the existing patterns of health care seeking behavior in Jordan. The Project strives to create a system with a strong preventive care component linking hospital, CHC and MCH center services, in order to provide pregnant women comprehensive pregnancy care, including family planning, and continuity from the antenatal through the postpartum periods. The Project will provide postpartum family planning and other services to the mother simultaneously with her newborn's well-baby check-up for monitoring growth and development in order to improve breastfeeding

600

Annex III.D.
Social Soundness Analysis

practices, encourage birth spacing, provide a range of appropriate modern contraceptives and improve maternal health and well-being. Additional activities such as promoting better nutritional practices, monthly self-breast exams, identification and treatment of anemia and postpartum depression and application of pap smears may also be provided.

1.4.1 Use of Family Planning

The 1990 Jordan Population and Family Health Survey found the following use rates for different family planning methods in Jordan among currently married women:

<u>Method</u>	<u>Percent</u>
IUD	15.3
Female sterilization	5.6
Pill	4.6
Condom	0.8
Vaginal methods	0.6

Over half (51.7 percent) of all currently married women already have used one of the modern contraceptive methods. Virtually all (99 percent) of currently married women know about at least one modern method of contraception. Ninety-four percent also know a source for a modern method.

1.4.2 Characteristics of Acceptors

Current use of family planning increases with the number of living children, ranging from less than 1 percent among currently married women with no children to 48 percent among those with four or more children. Use of modern methods increases sharply with an increasing number of living children from 0.3 percent for currently married women with no children to 33.8 percent for women with more than 4 living children.

Women in the Amman area had the highest level of current modern contraceptive use in the country at 33.8 percent of currently married women. In the North, the percentage drops to between 20.9 and 25.6 percent. The Southern region has the lowest current use of modern contraception at 20.7 percent. Current contraceptive use varies more dramatically between urban and rural areas. In the large urban areas, modern contraceptive use is twice that in rural areas (34 percent and 17 percent respectively).

187

1.4.3 Attitudes Towards Family Planning

Many people in Jordan emphasize that the term "family planning" is too sensitive and, thus, prefer the term birth spacing. While 74 percent of women express interest in having either no more children or spacing their next birth by at least two years, many women have negative attitudes towards modern contraception. Reasons given include: husband's attitude, health concerns, religion and a fatalistic view. Anecdotal evidence reveals a great deal of misinformation and fears of side effects, as well.

Little data exists on Jordanian male attitudes toward family planning. If the DHS collected such information, analyses of the data would prove invaluable in determining the messages most appropriate for men. Anecdotal evidence indicated that some men seem to feel their virility is proven through the number of children they have, while others believe that family planning is against the Islamic religion. However, Islamic Hospital and other organizations with religious affiliations have worked with the Islamic Affairs Department of the Government to get a reading on the interpretations of family planning according to the Koran. The Koran encourages women to delay their next pregnancy for 2 years and support breastfeeding. Islamic Hospital has taken this to mean they can provide family planning for spacing. The view concerning limiting is less positive. Islamic Hospital, however, does provide sterilization for health reasons.

To maximize the CPP project success, males attitudes will be taken into account and IEC strategies and materials targeting men will be developed. The involvement of men is especially important in light of the role of men as decision-makers in the family. Generally, women will not be able to act on their own views concerning family planning, if they do not have their husband's support.

1.5 Institutional Context

The provision of health care in Jordan is characterized by a diversity of providers categorized into two major groups-government and private. The government directly funds and runs two major channels of health care: the Ministry of Health and the Royal Medical Services. Both provide the full range of primary, secondary and tertiary care.

The Ministry of Health operates a total of over 900 health centers. Of these, outpatient MCH services are available from a network of over 225 health centers and clinics. MCH services provided by the MOH are available free of charge to all citizens of Jordan. The MOH operates 20 hospitals throughout the country.

501

Annex III.D.
Social Soundness Analysis

The RMS also provides MCH and delivery services. In contrast, however, the Royal Medical Services were restricted historically to military personnel and their dependents. This situation has changed as approximately 80 percent of the population currently served by the RMS are civilians. Overall, the RMS provides services for a total 1.3 million people annually, or roughly one-third of the population at 7 hospitals. The RMS operates as a health insurance program; nonmembers pay a minimal fee for service. In the Southern Region, two hospitals built by the MOH have been turned over to be run by the RMS. In Tafileh and Aqaba, the RMS facilities are the only public hospitals in the area and thus serve the entire surrounding population.

Both the RMS and MOH hospitals provide antenatal and limited postpartum and family planning services at their outpatient clinics. Together, their Maternity Wards provide delivery services for approximately 65% of the assisted birth annually. Both have pediatric outpatient clinics. While both provide well-baby services, monitoring of growth and development is not routinely promoted or provided. The RMS does not provide any immunizations. All immunizations in the public sector occur at MOH facilities.

Private health care is provided from variety of sources: for-profit and charitable/non-profit. The major for-profit source of health care are the individual medical practitioners which account for nearly half of all physicians practicing in Jordan. Currently, there are 27 private hospitals, many of which are located in Amman. Many of the private sector physicians provide exceptionally high quality of care to their clients. Delivery fees and office visits charges are often high in the private sector. Thus, private sector care through pregnancy and delivery may not be a viable option for many women as it is too expensive.

The most important source of non-profit health care is that provided through the United Nations relief and Work Agency (UNRWA) for the approximately 680,000 Palestinian refugees living in Jordan. Only refugees and their dependents are eligible to receive UNRWA services. UNRWA has placed emphasis on MCH care in their polyclinic in Amman and some 14 MCH clinics located in the refugee camps.

The Jordan University Hospital also provides MCH and family planning services. The JUH is funded partly from a government grant and partly from fees charged for services provided.

Various NGOs also provide selected MCH and family planning services in their clinics. Overall, approximately 90 NGO are involved in health services, reaching over 170,000 people. The Jordan Association for Family Planning and Protection (JAFPP) currently provides approximately one-third of all family planning in the country. In 1992, JAFPP served close to 62,000 clients at 11 clinics staffed completely with female service providers.

Family planning is also available through commercial channels in Jordan, as well.

2. BENEFICIARIES OF PROJECT ACTIVITIES

2.1 Institutional Participants

The CPP Project will be implemented through four health care service delivery channels:

- governmental health service systems (the Ministry of Health and the Royal Medical Service);
- independent institutions such as medical schools and research institutes;
- non-governmental organizations involved in maternal and child health services delivery;
- private medical organizations and individual practitioners.

Twelve institutions have been identified to participate in the CPP Project: 6 MOH hospitals; 3 RMS hospitals; the Jordan University Hospital, Islamic Hospital and the Soldier's Welfare Society Clinic. Each of these will develop postpartum services following the comprehensive approach to postpartum, well-baby and family planning services, as designed by the project. The 11 hospitals and one NGO clinic were selected based on their number of annual deliveries, the existence of outpatient clinics, the potential for on-site training, political will and commitment to voluntary and informed family planning service provision, availability of space and staff, client demand and other windows of opportunity.

Within these institutions, individual service providers identified for reassignment to the CPP Center and those who will continue to provide services in the antenatal-Ob/Gyn outpatient clinic, pediatric outpatient clinic and delivery ward will also be Project beneficiaries.

2.2 Project Beneficiaries

As the CPP Project is primarily a service delivery activity, mothers and infants who use the new comprehensive postpartum services will benefit directly from the Project. The geographic distribution of project beneficiaries is expected to mirror the distribution of births throughout the country. In 1991, the majority of deliveries (58 percent) occurred in the Midland region of Amman and Zarqa, followed by the Northern region (26 percent), and the Southern region (16 percent). Additionally, as roughly 70 percent of Jordan's population live in urban areas, the bulk of the beneficiaries will be urban residents.

901

**Annex III.D.
Social Soundness Analysis**

The husbands and families of women utilizing the new package of services and the community at large will also benefit from the Project. Specifically, men will benefit due to their increased awareness and knowledge about safe motherhood and the impact of child spacing on maternal and child health.

In addition to those people directly benefiting from the constellation of family planning, maternal and child health education and services offered by the CPP project, additional people will benefit from the project in two ways. First, the materials

In general, the beneficiaries targeted by the CPP Project to receive comprehensive postpartum services include the 350,000 married women of reproductive age and the 125,000 children under one year of age in Jordan. The targeted beneficiaries of information and education activities in Jordan are the 806,000 women and 856,000 men between the ages of 15 and 49. It is not foreseen that any group will be adversely affected by this Project.

3. PARTICIPATION

3.1 During Project Development

The CPP Project design effort incorporated known data on client preferences and health care seeking behavior among the general population of Jordan. Specific concerns and preferences among the women targeted to receive the comprehensive postpartum services was assessed via focus groups and an interview survey conducted in both rural and urban areas. The results have been incorporated into the project design and implementation plan. Members of the project design team also interacted with potential beneficiaries directly in selected hospitals and clinics.

The CPP Project was designed with the participation of all the potential implementing groups in Jordan. More specifically, the project design team collaborated during all phases of project design with the Ministry of Health (including the Minister of Health, the Secretary General and the Directors of the Maternal and Child Health and Health Education Directorates, Regional Directors and the Ob/Gyn and Pediatric Specialists), the Royal Medical Service (including the Director), Jordan University Hospital and the directors of various private and government hospitals, and clinics.

Visits were paid by members of the project design team to many of the public and private hospitals which were considered for inclusion in the Project. Two individuals from the University of Jordan, one from the Department of Community Medicine, the other from the Department of Ob/Gyn at the University Hospital also acted as consultants to the project design effort.

194

Annex III.D.
Social Soundness Analysis

Field visits were made to MOH hospitals, comprehensive health centers and MCH centers, RMS hospitals, Jordan Association of Family Planning and Protection clinics, NGO health care clinics, NGO headquarters and private hospitals. Discussions were held both with management and implementing personnel at these institutions.

The project goals of improving postpartum care for women by treating the mother and child as an essential unit and increasing the availability of family planning methods during the postpartum period were widely shared by the various service provider constituencies, although some diversity of opinion existed concerning the appropriate approach and constellation of postpartum and well-baby services to provide.

3.2 During Project Implementation

In-depth focus groups will be held to obtain the views of women who are potential beneficiaries of the project in order to tailor the appropriate constellation of MCH services to be provided alongside postpartum family planning which will meet client needs and help motivate them to return for care. As client-centered services and satisfaction are an important focus for the project, ongoing assessments of beneficiaries' needs and satisfaction will be undertaken. In this way, Project activities will be responsive to the needs and preferences of beneficiaries. Flexibility built into the Project will allow for continuous modifications in order to maximize effectiveness in providing wanted services.

The views of providers will also be taken into account during protocol development, training and supervisory activities, while technical, managerial and motivational skills are being honed. All technical assistance contractors will work with Jordanian counterpart institutions and individuals. The Project depends on a wide variety of persons and institutions for its implementation. As the body overall in charge of the Project, the MOH will collaborate with relevant government agencies, as well as, private organizations and individuals during project implementation. Although the Jordanian public health system is essentially a 'top-down' decision-making organization, it has been recognized that all levels of the system must be encouraged and 'taken into confidence' in order for effective performance. The project will attempt to widen the sphere of consultation to include key constituencies and NGOs and other organized local groups.

Throughout the implementation and evaluation phases of the CPP Project, the Mission and Cooperating Agencies will continue to work very closely with the MOH, RMS, the two universities, private sector hospitals and service providers and NGOs.

4. SOCIOCULTURAL FEASIBILITY OF THE PROJECT

4.1 Suitability of Proposed Interventions

4.1.1 Within the Social and Ideological Context of Beneficiaries

Family planning in Jordan has been hampered by societal traditions that have emphasized the importance of children, particularly sons, for a variety of social purposes. However, increasing access to family planning from within the context of maternal and child health interventions allows the benefits of spacing and limiting births to be put into a more acceptable frame of reference.

However, women's health is generally considered to be of lower priority by both women themselves and their families than is child health. In Jordan, only 80 percent of women seek at least one antenatal visit, despite the coverage of over 94 percent of all infants by the immunization services provided through the same clinics. Focus groups and discussion with women indicated the reasons women do not seek care are poor quality of care, poor communication with health staff and the inability or unwillingness of health providers to listen. Interviews indicated that if women have the opportunity to receive a high quality of care for themselves that is free or inexpensive at the same time as services for the infant, they will take advantage of it. However, some concerns were raised about women's ability to accept family planning, if their family does not support the idea.

Thus, the Project has been designed to raise awareness, not only among women, but also among the general public, men, grandparents, policy makers and health providers, of the importance of maternal and child health and birth spacing. Creating awareness will be followed by information, education and communication of health messages. The messages should assist women and their families to understand women's health needs and reorganize their orders of priority with regards to maternal and child health while motivating them to seek postpartum care. Also, the Project stresses the importance of utilizing female providers for the provision of services to enhance utilization.

4.1.2 Within the Economic Context of Beneficiaries

The current economic situation in Jordan, including the high rate of inflation, high unemployment, and declining purchasing power is sharpening the focus on issues of rapid population growth and the benefits of smaller families. Thus, the stage is set for educational and motivational campaigns that stress the economic benefits of smaller families, and the health benefits to mothers and children of spacing births, as the project intends to do. The focus of the Project on birth spacing is particularly appropriate to assist families in having children when they want to ensure quality care and survival of the children born.

4.1.3 Within the Available Organizational Context

Jordanian women often complain of lack of communication with health service providers (especially at the free public health clinics and hospitals). They feel that physicians do not give them enough time to talk about how or what they feel and rarely lend a listening ear, show interest or concern. This attitude of physicians can be partially accounted for by the pressures of workload and time. However, cultural differences and gender interference undoubtedly inhibit more open communication. These cultural differences reinforce the culture of silence, discouraging further visits to the health centers and hospitals.

Physicians and health service professionals have not been educated to be sensitive to the social conditions of women's lives. Traditional medical education program focus on patients as clinical cases in a vacuum. This lack of sensitivity to the socioeconomic and cultural context of their patients' lives is widespread and can lead to unrealistic treatment practices and hampers the development of effective preventative strategies at the community level.

The training component of the CPP Project will directly address service providers biases which preclude a client-centered approach by providing counseling and health education training. Physicians, nurses and midwives will be exposed to the concept of personalizing care to meet client needs and preferences which in turn should improve utilization of services by women.

4.1.4 Within the Prevailing Administrative Context

While no formal population policy exists, the Government of Jordan is supportive of efforts to slow the rapid rate of population growth the country is experiencing. Both the Ministry of Health and Royal Medical Service administrations have been very supportive of the CPP approach and have worked extensively with the PP team to design the Project in such a way as to maximize utilization and effectiveness. Hospital administrators from the other selected sites have also been very enthusiastic and willing to cooperate.

4.1.5 Within the Extant Technological Context

Several of the family planning methods to be promoted in the project (condoms, combined and progestin-only pills, IUDs and sterilization) are currently available through various channels in Jordan. However, problems of misinformation, poor quality, poor motivation and delivery skills and poor management have plagued distribution of these methods. The Project aims to rectify these problems at the hospital level by improving IUD and sterilization skills, prescription of oral pills, especially progestin-only pills during lactation, referral and follow-up of recently delivered women. In addition, contraceptive choices will be expanded to include immediate postplacental insertions of IUDs, Norplant and

Annex III.D.
Social Soundness Analysis

injectables. The new choices will be provided only in those sites which guarantee appropriate screening and counseling, proper insertion and follow-up.

4.2 Possible Implementation Obstacles

Potential constraints to participation in the CPP Project can be divided into three main categories: social, economic and political. Social constraints include the status of women in Jordan, the curative bias in health care seeking behavior and attitudinal biases within the male-dominated health system. Economic constraints on participation in the Project can be subdivided into inadequate funds for infrastructure, medical facilities and training and the low income of potential beneficiaries. Political constraints on participation of beneficiaries in the Project include unclear national policy on family planning and possible opposition by certain political/religious groups toward dissemination of information regarding family planning.

The above constraints have been addressed during Project design as the Project seeks to increase acceptability and desirability of women's health services by educating women and their families about the need for women's health care and birth spacing and integrating the currently undervalued postpartum services with the highly valued well-baby services. The Project will provide training in family planning service delivery and counseling both to physicians and nurses both to upgrade their level of knowledge and skills and to counteract biases and practices which inhibit the provision of quality services.

Various social, economic and political factors are expected either to facilitate or to constrain the participation of individuals and institutions in CPP project activities and objectives. The main factors facilitating participation in the Project include the following:

- a. **Willingness of government officials and private sectors to participate.** Almost without exception the medical community believes the program is needed for the health of the mother and child as well as for the economic/social development of the country.
- b. **Inherent desire of a new mother to provide optimal newborn care.** Because of this the mother will bring her baby for immunizations at which time postpartum services and counseling will be offered to her.
- c. **Relatively high literacy rate.** Provided clear and accurate information, most families will appreciate the value of fewer children, recognize the need to educate them, and also come to understand that rapid population growth rates are impeding national, as well as family welfare.

5. IMPACT OF PROJECT

It is estimated that, over the life of the CPP Project, approximately 224,600 women will have benefitted directly from its services, at a minimum by having received information, education and materials about maternal and infant health and family planning at the 12 project sites. These are the women who come to these facilities for delivery (based on 1992 delivery figures).

Not all of these women can be expected to come to the CPP centers for postnatal care and family planning, however, because some will live too far away to return for a visit and others will simply not be interested in such care. For purposes of this project, it is anticipated that, at each site, 35 percent of women delivering will return for postpartum care in the first year, rising to 60 percent by the fourth year. Applying this formula, approximately 115,500 women could be expected to return for postpartum and infant care over the life of the project.

It is estimated that about 67,100 women will accept a modern contraceptive method at the project sites, either while they are in the hospital for delivery or when they return for a postpartum check-up. This figure is based on five percent of women who deliver at these sites accepting a modern method immediately postpartum in the first year of operation at each site, rising to 20 percent in the fourth year; and 30 percent accepting a method at the CPP center in the first year, rising to 50 percent in the fourth year.

The above figures summarize the number of people benefiting from specific services over the life of the project. However, since the number of service sites and knowledge of the availability of services will be building up slowly over the life of the project, the true benefits will only be felt as the project is ending. By the end of the project, when services are up and running, it is estimated that almost 62,700 women a year will benefit, 36,500 (?) will receive postpartum care and almost 27,800 will adopt a contraceptive method.

The figures above reflect only the services provided at the 12 project sites. However, through the project's training and IEC activities, it is hoped that the concept of comprehensive postpartum care will be well on the way to being integrated into medical practice in Jordan beyond these centers, into other public and private hospitals. This could significantly increase the project's impact. In addition, virtually every Jordanian will have been touched by the project's IEC activities.

It should also be noted that the figures on contraceptive acceptors do not take into account users of the Lactational Amenorrhea Method (i.e. proper breastfeeding practices that protect against pregnancy during the extended postpartum period)--a method that will be actively promoted at the CPP centers.

601

**Annex III.D.
Social Soundness Analysis**

The methodology for the calculations on postpartum visits and contraceptive acceptance, as well as detailed tables for the 12 project sites are included as Appendix II.G.

Projected Impact on Fertility

Using its Target-Cost Model and data provided by the design team on the projected number of acceptors and method-mix, the Options Project (Futures Group) calculated the estimated impact of the project on various indicators related to fertility. This model, which is used around the world, takes into account a wide variety of considerations such as contraceptive discontinuation rates, desire to become pregnant, cumulative impact of long-term methods, etc. In the case of Jordan, key data from the 1990 Population and Family Health Survey, such as the method mix, were also used.

Using this model, it was estimated that 40,200 births might be averted over the life of the project. Contraceptive prevalence (modern methods only) could be expected to increase--from 26.9 percent to an estimated 33.9 percent among currently married women--and the total fertility rate could decline from 5.6 to 4.9 per woman. This would be a major step toward Jordanian women's desired fertility of 3.9 children per woman. Again, to the extent the comprehensive postpartum approach is adopted beyond the project sites, the impact could well be greater.

By the end of the project, approximately 18,800 births per year would be averted through the 12 project sites alone, amounting to over 15 percent of the 120,000 reported births in 1991.

It should be noted, however, that these figures do not take into account that a certain number of acceptors in the project are likely to be women who would have obtained contraception even in the absence of the CPP centers. Thus, they are likely to be somewhat over-estimated.

While the impact of the project on health indicators such as maternal and infant mortality have not been calculated, these could be significant. For example, scientists project that if all Jordanian births were at least 24 months apart, the infant mortality rate would fall by 40 percent (or 4,000 infant deaths/year) and maternal mortality would drop by 29 percent.

The calculations concerning the number of beneficiaries and the memorandum from The Futures Group with the data on the potential impact of the project on fertility are attached as Appendix II.G.

197

5.2 On Beneficiaries

Project beneficiaries will reap dramatic benefits from the CPP Project. Not only will family planning services be offered within a meaningful and convenient context for women, but quality of care will be improved and range of choice will be expanded. The anticipated shift in service provider knowledge, attitudes and practices towards a more client-focused approach should allow women and their families access to the information and services they need and in an atmosphere more conducive to behavioral change. The emphasis on provision of postpartum services by women physicians, where possible, will also benefit many women attending the CPP Centers as they will be more comfortable discussing family planning and reproductive health concerns woman to woman. Additionally, the education provided at the Center

5.3 Risks

In the implementation of the Project, there are both provider-related and beneficiary-related risks. On the side of providers, the Project assumes that training, improved skills and management will bring about positive changes in attitudes towards the provision of family planning services and enhance provider motivation. This is not an unreasonable assumption but, as in all human resource development efforts, there is a likelihood of 'winning some and losing some'. Bringing about changes in attitudes and practices among providers in established systems is never easy. Ultimately, the success of the project will depend on the individual efforts of providers and on the establishment of a collective, critical mass of people devoted to family planning provision.

Another assumption is that people can be educated and motivated (through IEC strategies, improved quality and comprehensiveness of services, etc.) into forms of behavior that go against tradition and the religious and socioeconomic reasoning established over centuries.

6. ISSUES

This section summarizes the issues that derive from the information and analysis presented above.

6.1 Social Issues Bearing on the Project

6.1.1 Status of Women

Women in Jordan are often viewed as "reproducers" with little recognition of their productive roles particularly if the latter refer to domestic or subsistence production. Hence, society and families place a premium on high fertility, ensuring it through the

01 ↓

Annex III.D.
Social Soundness Analysis

pressure to conceive and bear a child soon after marriage and repeatedly thereafter. In addition, the greater value placed on bearing sons places pressure on women to produce several children to ensure at least two sons.

There are several ways out of this cycle. Perhaps the most effective is the provision of female employment as the availability of work and incomes draws women out of the home into an arena where awareness increases and a powerful incentive exists for the family at large to reduce her burden of pregnancy. Another is female education, which serves to delay marriage and increases the chances that women will work and have access to paid work. This is a long-term route but Jordan has made significant strides in this area. A third is the provision of proper health services for women and children within which family planning services are also offered. This will help ensure the health and survival of children and improve their own health. Increasing awareness of family planning and positing it as a means of achieving these goals can encourage women to accept it. Spacing children better and having fewer of them can help women improve their health status, increase their productivity and thereby enhance their overall status. The project fits into this approach, focusing on making family planning more available, more acceptable and of better quality.

6.1.2 Access to Health and FP Services

However, there is a "catch 22" situation at work here. Because of their low status, women may have limited access to health service providers; and if they have limited access, how can they avail themselves of services to improve their status? Families may not allow women to travel without supervision to health centers or approach unknown male providers. Women are conditioned to bear pain and illness. If postpartum care and family planning require traveling and interactions with strangers or male service providers, it is unlikely to be sought, particularly since it is "preventative" rather than "curative".

6.2 Issues Requiring Special Attention during Project Implementation

The three most significant socio-cultural issues which will require special attention during implementation of the service delivery component of the Project are:

- The difficulties women experience in approaching family planning providers, including the sex of the provider, distance, time-costs and monetary costs of obtaining services.
- The attitudes of husbands and the extended family towards desired family size and family planning and the decision-making control which creates major barriers against the exercise of choice by women themselves.

Annex III.D.
Social Soundness Analysis

- **The attitudes of service providers towards women and the poor.**

6.3 Additional Information Needs

In the initial phase of the Project, additional information should be sought on the following topics in order to design socially-sound program strategies:

- **Information on the attitudes of hospital-based Ob/Gyns, pediatricians, nurses and midwives to family planning, to their clients (i.e. women), to their jobs, etc. in order to design training and motivational programs to facilitate the work of the important group of providers. Also, a systematic study of infrastructural, administrative and any further equipment/supply needs should accompany the KAP study so that work situations can be improved side by side retraining.**
- **Male attitudes towards family planning.**

6.4 Project Activities to Ensure Participation

6.4.1 Availability of Sex-desegregated Data

The Project will collate data on the gender of maternal health service managers and providers at all sites participating in the Project and review these data on an annual basis. It will also collect data from the non-governmental organizations participating in outreach activities and in the NGO grant program.

6.4.2 Analysis of Women's Participation

The research component of the Project includes a series of focus groups to investigate women's preferences in family planning and the constraints they face in accepting contraception. This will provide information about "what women want", in terms of postpartum health services for themselves and their infants, including family planning. The focus groups will also provide information concerning "why women do not come back" for postpartum care and how their return could be facilitated/encouraged. Results from the focus groups will be utilized to design the range and packaging of postpartum, infant health and family planning services appropriate for the comprehensive postpartum centers. Results will also be utilized to conceptualize a theme, logo and identity for the Project. Additionally, operations research studies would usefully include approaches to overcoming women's constraint's in order to strengthen program design to increase women's participation and utilization of the CPP Center services. Results from research focused on the issues of women clients' preference for women service providers could be useful in

177

**Annex III.D.
Social Soundness Analysis**

helping debunk the myth prevailing among many male Ob/Gyn specialists that gender is not an issue in the provision of medical services in Jordan. Such results would be especially useful in developing and implementing policy changes if the results indicated women's utilization of family planning and health services would be increased if clients had greater access to female providers.

6.4.3 Measurement of Women's Participation

Women's participation can and should be measured in terms of:

- the number of women who fill managerial positions related to the Project (as described above);
- the number of women providers trained in the Project;
- the quality of the training and the quality of workers' performance, with attention to the 'women-sensitivity' of both;
- the number of women coming for postpartum services for themselves and their infants;
- the number of women reached by outreach activities; and, ultimately,
- the increase in family planning acceptance by women in Project centers.

The effectiveness of Project strategies in reaching women beneficiaries will be measured primarily on the basis of monitoring data collected at the CPP Centers. These data as well as more qualitative information collected through specific studies, such as the proposed intercept/continuation and client satisfaction studies, can be analyzed and utilized to continuously improve women's participation in Project activities.

ANNEX III.E.

ADMINISTRATIVE ANALYSIS

During the course of the project, USAID will be collaborating with several public and private Jordanian institutions. The organizational structure and functional capacity of these indigenous institutions are therefore relevant to the success of the project.

Ministry of Health

Primary care: The MOH operates a vast array of Village Health Clinics (VHCs), Primary Health Care Centers (PHCs), and Maternal and Child Health Care Centers (MCHs), most of which are now integrated with PHCs. With about one center per 6,000 population, and with an average patient travel time to the nearest clinic of 30 minutes, this represents a high density system by international standards. However, many of these centers are underutilized because a large proportion of patients seek primary care at MOH hospitals. Outpatient departments are filled to capacity with self-referred clients, leading to a high outpatient ratio of 300 per 1000 population per year. Patient preferences for hospitals over PHCs and MCHs reflects a widely held belief that hospitals are better, and a concern that non-specialist physicians are less competent than specialists at hospitals.

Hospital care: The MOH provides hospital care through its 18 MOH hospitals. In areas where it has less coverage, particularly the South, the MOH has entered into agreements with the Royal Medical Services (RMS) to try to increase access for public sector patients. In terms of the total number of hospital beds per 10,000 population, the Northern Region is substantially underserved, having 11 beds per 10,000 relative to 17 for the Central Region and 15 for the Southern Region (World bank, 1992). The opening of the new MOH hospital in Irbid is likely to offset some of this inequity, although it will not do so entirely.

In 1991, the 18 MOH hospitals have an official inpatient bed capacity totalling to more than 2000 beds. During 1991, MOH hospitals provided 462,197 inpatient days of service and over 1.75 million outpatient and emergency visits. In 1992, they employed over 6,800 personnel and in 1992 expended approximately JD31 million on recurrent costs and an additional JD16.5 million on capital items - a total budget for the year of over JD47 million, or 62 percent of the total MOH budget of JD76.2 million (World Bank, 1992).

Planning and Policy-Making: In principle, the MOH is responsible for setting health priorities for the Kingdom. In practice, however, it tends to operate reactively and as one among several day-to-day service providers. One result that has been noted in the project paper is the lack of norms for health care during the antenatal, delivery and postpartum periods.

211

Annex III.E.
Administrative Analysis

Management Capacity of the MOH: The World Bank determined in 1992 that the MOH was suffering from serious organizational and management deficiencies which in turn led to inefficient and low quality service provision. The report determined that MOH management was over-centralized at headquarters in Amman, despite the existence of local health directorates. Even within headquarters, decision-making was centralized at the level of the Secretary General and the Minister, making the multitude of departments essentially obsolete. Little accountability and delegation of authority was found below the Secretary or the Minister; the report indicated that the Minister personally approved the hiring of any staff with earnings of over JD90. Management information and accounting systems were found to be weak; most accounting procedures were (and continue to be) manual and computers are scarce even in financial departments. In sum, the Bank found that the MOH's decision-making environment was slow and ineffective.

The World Bank is presently working with the MOH to try to reorganize its management. The Bank's objective is to *"enable the MOH to become an effective policymaking, management and planning agency, and to devolve day-to-day operation of MOH services to the regional level."* Thus far, the reorganization has led to the creation of three Regional Health Authorities, each under the responsibility of a Regional Assistant Secretary General. The reorganization has also led to the establishment of the Maternal-Child Health Directorate, a move that has been praised by donors and Jordanians alike, particularly given the growing need for a preventive focus in the MOH's service delivery.

The mandate of the MCH Directorate is to strategically plan oversee all of the MOH's MCH activities, not just those located at the level of MCH or PHC centers. This is a fundamental change from before, in which care given at hospitals, including antenatal, delivery, and postpartum care, was under the mandate of a different unit. The new organization will improve continuity of care for mothers and babies alike, as well as facilitate the administration of the CPP project within the MOH. However, because it is a new directorate in a system under transition, it is somewhat weak. Thus, this project paper calls for the presence of a senior resident advisor (RA) who will assist the Directorate implement CPP activities more effectively. It is also hoped that the RA's presence will strengthen the Directorate by facilitating the institutionalization of sound management and decision-making skills.

Royal Medical Services (Public)

The Royal Medical Services (RMS) has nine hospitals, seven of which have maternity wards. It offers maternal and child health services through its outpatient clinics.

203

Annex III.E.
Administrative Analysis

The RMS is administratively more sound than the MOH, principally because of its strong emphasis on the military chain of command. Thus, having the support of the system's chief ob/gyn and pediatrician is vitally important to successful implementation. The project design team has enjoyed the full support of the chief obstetric and pediatric personnel, who have all but guaranteed an effective implementation and administration of the project in CPP centers supported by AID. Furthermore, they have expressed interest in setting up other centers at their own cost.

Jordan University Hospital (Quasi-governmental)

Like the administrative management of the RMS, JUH is less complex than the MOH. Basically, the JUH is a nearly autonomous organization with no subordinate hospitals to administer. It has a cadre of health professionals with post graduate training in various arenas, including management. The project team anticipates few problems in the administration of the CPP center there.

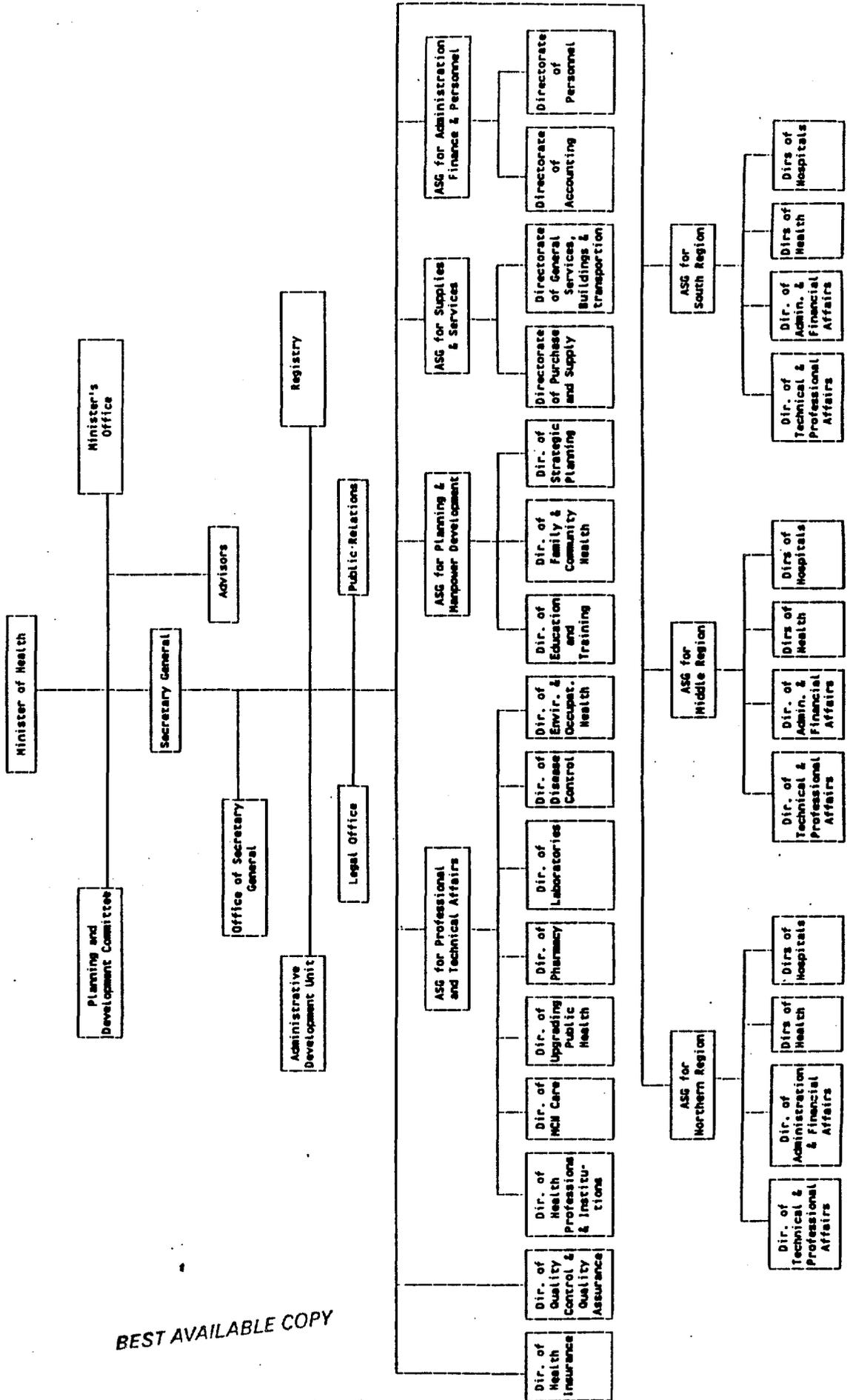
The Islamic Hospital (Private)

The Islamic Hospital is governed and partially funded by a private foundation. However, it coordinates closely with the MOH and JUH in training residents. It has demonstrated sound administrative and managerial practices in a variety of ways, one of which is knowing how to market services to its clients. In recognition of female clients' desire for female providers, it limited its training program to female ob-gyn residents only. It also is highly regarded in the scientific and Islamic communities.

USAID

This project along with its companion projects, FHS and MBS, will be sited in USAID's Office of Population, Family and Health. This office is staffed with a well-trained HPN officer experienced in project management, who in turn is supported by a highly qualified staff of two Jordanian physicians, one with an NGO background and the other with a strong background in public sector health management. Notwithstanding the foregoing, it is strongly recommended that an additional staff member who would have very strong skills in data gathering, analyses and USAID project management be recruited. This person would be highly useful for the FHS and MBS projects and essential to the monitoring and evaluation requirements of the CPP project.

Annex III.E.
Ministry of Health Organizational Chart



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205