



The **POLICY** Project

Reproductive Health
Case Study

JORDAN

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in collaboration with

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**The Centre for Development and
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Executive Summary

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified worldwide focus on reproductive health policies and programs. Many countries have worked to adopt the recommendations from the ICPD *Programme of Action* and to shift their population policies and programs from an emphasis on achieving demographic targets for reduced population growth to improving the reproductive health of their population. The POLICY Project has conducted eight country case studies to assess each nation's process and progress in moving toward a reproductive health focus. The purpose of the country reports is to describe the policy environment for reproductive health and the role of the 1994 ICPD in sparking and shaping policies and programs in reproductive health. The field work for the Jordan Reproductive Health Case Study was carried out from August 9 to 22, 1997. Interviews were conducted with 34 persons involved in reproductive health programs in Amman.

In 1973, Jordan established the National Population Commission (NPC); since the 1970s, Jordan's development plans have contained references to population issues. The first *National Population Strategy*, drafted in 1992 and approved in 1996, served as the basis for the report of Jordan's delegation to the ICPD. The *National Population Strategy* does not incorporate all of the recommendations from the ICPD *Programme of Action*; however, at the time of the case study, the NPC was revising the strategy to reflect the recommendations of the ICPD. The *National Population Strategy*'s eight domains are comprehensive, although the document does not specify priorities.

In Jordan, population and reproductive health policymaking at the national level takes place through the NPC and its members. In addition to government ministries and agencies, NPC members include three nongovernmental organizations (NGOs) and representatives of public and private universities. Overall, Jordan has made strides in policy formulation by following what one respondent called a "low-key technical approach," making cautious advance through the work of small expert groups according to what is politically and socially acceptable within the country and subsequently building wider consensus.

Jordan has not adopted the ICPD definition of reproductive health for its policies and programs. Some staff in the Ministry of Health and Health Care (MOHHC), while aware of reproductive health, do not endorse it as a new approach for the ministry. Support for family planning and maternal and child health activities is growing among national political leaders, MOHHC staff, religious leaders, and the public. While there is no organized support for reproductive health in Jordan, there is no organized opposition either.

Reproductive health services in Jordan are available throughout the public, NGO, and private sectors. The public sector provided 28 percent of family planning services in 1990; NGOs provided 26 percent of services and the private sector (including private providers and hospitals) 46 percent. Despite the availability of some integrated services, comprehensive reproductive health services are not the norm in Jordan.

Jordan faces challenges in increasing awareness and acceptance of the broader concept of reproductive health; improving the NPC's monitoring and coordination functions; increasing financial resources; improving the use of data in decision making; strengthening the service delivery infrastructure and the capability of personnel; expanding participation; increasing donor involvement; and planning for implementation of the *National Population Strategy*.

Abbreviations

AIDS	acquired immune deficiency syndrome
CPP	Comprehensive Postpartum Project
ESCWA	United Nations Economic and Social Commission for Western Asia
FAMEPPD	Forum of African and Middle East Parliamentarians on Population and Development
HIV	human immune deficiency virus
ICPD	International Conference on Population and Development
IEC	information, education, and communication
IPPF	International Planned Parenthood Federation
IVF	in vitro fertilization
JAFPP	Jordan Association for Family Planning and Protection
JICA	Japanese International Cooperation Agency
KAP	knowledge, attitudes, and practice
MCH	maternal and child health
MOE	Ministry of Education
MOHHC	Ministry of Health and Health Care
MOP	Ministry of Planning
NGO	nongovernmental organization
NPC	National Population Commission
NPCPD	National Parliamentarian Committee on Population and Development
ob-gyn	obstetrics and gynecology
RH	reproductive health
RMS	Royal Medical Service
RTI	reproductive tract infection
STD	sexually transmitted disease
UNFPA	United Nations Population Fund
UNRWA	United Nations Relief Works Agency for Palestine Refugees
USAID	U. S. Agency for International Development

1. Introduction

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified worldwide focus on reproductive health policies and programs. Many countries have worked to adopt the recommendations from the ICPD *Programme of Action* and to shift their population policies and programs from an emphasis on achieving demographic targets for reduced population growth to improving the reproductive health of their population.

The POLICY Project has conducted eight country case studies to assess each nation's process and progress in moving toward a reproductive health focus. Case studies were conducted in Bangladesh, Ghana, India, Jamaica, Jordan, Nepal, Peru, and Senegal. The purpose of the country reports is to describe the policy environment for reproductive health and the role of the 1994 ICPD in sparking and shaping policies and programs in reproductive health. A report summarizing experiences across the eight countries and examining trends in the development and implementation of reproductive health policies and programs accompanies the country reports.

Based on their epidemiological significance and recommendations from the ICPD *Programme of Action*, reproductive health care in these case studies is defined as including the following key elements:

- prevention of unintended pregnancy through **family planning services**;
- provision of **safe pregnancy services** to improve maternal morbidity and mortality, including services to improve perinatal and neonatal mortality;
- provision of **postabortion care services** and safe abortion services where permitted by law;
- prevention and treatment of reproductive tract infections (**RTIs**) and sexually transmitted diseases (**STDs**) and **HIV/AIDS**;
- provision of **reproductive services to adolescents**;
- improvement of **maternal and infant nutrition**, including promotion of **breastfeeding programs**;
- screening and management of **specific gynecological problems** such as **reproductive tract cancers**, including **breast cancer**, and **infertility**; and
- addressing of **social problems** such as prevention and management of harmful practices, including **female genital mutilation** and **gender-based violence**.

The country case studies were conducted through in-depth interviews with key individuals in the areas of population and reproductive health. Respondents included representatives from government ministries, parliaments, academic institutions, NGOs, women's groups, the private sector, donor agencies, and health care staff. Not all groups were represented in each country case study. The interview guide included the definition of and priorities for reproductive health; how reproductive health policies have been developed; the committees or structures responsible for reproductive health policy development, including the level of participation from various groups; support of and opposition to reproductive health; the role of the private sector and NGOs; how services are implemented; national and donor funding for reproductive health; and remaining challenges to implementing reproductive health policies and programs. Interviews focused on the sections of the interview guide where the respondent had knowledge and expertise. POLICY staff or consultants served as interviewers for the case studies.

Interviews were carried out with 34 people from 19 different organizations from August 9 to 22, 1997. Additional information was gathered in Washington, D.C., where discussions were held with several representatives of technical assistance organizations based in the United States. Appendix 1 lists the organizational affiliations of respondents.

2. Background

Jordan is situated in the Middle East on the East Bank of the Jordan River. It is bordered by Syria to the north, Saudi Arabia to the south, Iraq to the east, and Israel and the West Bank to the west. Jordan's population has grown rapidly due to a high rate of natural increase and a history of in-migration of refugees from Palestine in 1948, from Israel in 1967, and from the Gulf War in 1991, including returning Jordanian nationals. The 1952 population of 586,000 grew to 4.4 million by 1996. Between 1979 and 1994, Jordan's population grew at an annual rate of 4.4 percent. In 1994, 79 percent of the population was urban, and 41.4 percent was under age 15. The per capita gross national product in 1995 was US\$1,510 (World Bank, 1997).

Fertility has been declining in Jordan since the mid-1970s. The total fertility rate was 7.4 in 1976 and 4.3 in 1997 (DOS and IRD, 1998). The contraceptive prevalence rate among currently married women was 52.6 percent in 1997, with mostly modern method use (37.7 percent) (DOS and IRD, 1998). According to respondents, the decrease in fertility is a function of increased age at marriage and increased contraceptive use, especially in more modern urban areas. In addition, the poor economic situation of past years and resultant high cost of caring for children have influenced couples to change their ideas about large families and to accept family planning. Jordanians are well educated, and a high proportion of girls attend school. In 1990, over 90 percent of men and over 80 percent of women had had some schooling; for those under age 25, the gender gap in schooling disappears (DOS and IRD, 1992). In 1994, the illiteracy rate was 8 percent for men and 21 percent for women. Only 13 percent of Jordanian women are economically active (DOS, 1997).

Marriage is almost universal in Jordan and divorce is rare. Only 3.3 percent of women were not married by the end of their reproductive years (Almasarweh, 1997b). The Jordan Family Rights Law of 1976 set the minimum age at marriage at 18 for males and 16 for females. Median age at first marriage (women age 25 to 49) was 21.5 in 1997, although early marriage still occurs in rural areas (DOS and IRD, 1998). Several respondents noted that sexual relations are limited to marriage; in fact, pre- and extramarital sex are illegal (Al-Ma'aitah, 1997). Respondents cite these factors as responsible for the low perceived prevalence of STDs and HIV/AIDS in Jordan and the lack of adolescent reproductive health services (although most note that reproductive health education for youth is essential).

Partly owing to the influence of Islam, Jordanian society is socially conservative. In 1990, 96 percent of the population was Muslim and approximately 4 percent Christian. The family structure is traditional; men tend to be the major decision makers in all aspects of family life, including the use of contraception and the number of children. Women place great importance on fertility, and, in some instances, infertility or fertility limitation may cause a husband to seek a new wife. Several respondents noted that violence against women is not part of Jordanian culture, although others noted that it exists but that women do not report it "for the sake of the kids and the family." Respondents did not perceive gender-based violence as a priority reproductive health problem in Jordan. Men rarely use contraception themselves. Among currently married women in 1997, 2.4 percent reported use of condoms and none reported male sterilization (DOS and IRD, 1998). According to respondents, men may be concerned that vasectomy might inhibit their sexual ability.

The maternal mortality ratio was 44.1 in 1996 (Nsheiwat and Al-Khalidi, 1997), and the most recent estimate of the infant mortality rate is 32 (World Bank, 1996). These relatively low rates are partially attributable to the high proportion of attended deliveries. In 1995, trained providers attended over 90 percent of deliveries, and home deliveries constituted 13 percent of all deliveries (Al-Ma'aitah, 1997). According to a 1992 Ministry of Health and Health Care (MOHHC) study, complications of pregnancy and delivery (including abortion) for all women ages 15 to 44 represented 4.6 percent of all health

problems, 20 percent of all admissions to public hospitals, and 10 percent of admissions to private hospitals. Jordanian women experience the shortest birth intervals in the world, with 50 percent of births within less than 24 months of the previous birth. The brief intervals are due to the short duration of exclusive breastfeeding with a mean of less than two months (DOS and IRD, 1992). In 1996, 23 percent of women age 15 to 19, 26 percent of women age 20 to 29, and 35 percent of women age 30 to 39 were anemic. Breast cancer represented 19.3 percent and urinary and reproductive cancers 5.9 percent of all cancer cases, according to a 1995 MOHHC study. A total of 145 HIV/AIDS seropositives were diagnosed in Jordan between 1986 and February 1997 (Al-Ma'aitah, 1997). No national studies on STD prevalence have been conducted in Jordan. Infertility is estimated at 4 percent (DOS and IRD, 1992).

Regarding the political structure of Jordan, the 1952 Constitution states that Jordan is a constitutional monarchy with a representative government. The monarch is King Hussein, who has reigned since 1952. The King appoints the 40-member Senate of the National Assembly (or upper house of Parliament) and the people democratically elect the 80-member House of Representatives (or lower house of Parliament). The first full elections since 1967 were held in November 1989, at which time women voted for the first time.

3. Policy Formulation

A. Evolution of Policies from Family Planning to Reproductive Health

In 1973, Jordan established the National Population Commission (NPC) in response to a United Nations Economic and Social Council recommendation that each country establish a population commission. NPC membership included representatives from government and NGOs. In 1976 the NPC's membership was enlarged, but the committee remained inactive. In 1980, the MOHHC began to offer family planning services—eight years after the Jordan Association for Family Planning and Protection (JAFPP), which is an International Planned Parenthood Federation (IPPF) affiliate, initiated family planning services in Jordan.

Since the 1970s, Jordan's development plans have contained references to population growth rates, internal migration, and age structure; however, it was not until the mid-1980s that Jordan became more aware of population concerns as a consequence of an acute economic crisis (Almasarweh, 1997a). In his statement to the 1984 International Population Conference held in Mexico City, King Hussein emphasized the link between population and economic development. In subsequent speeches, he and Crown Prince Hassan called for a policy to balance population growth with natural resources. In 1984, the NPC was restructured and its membership increased to include broader representation (Almasarweh, 1997a). Despite these developments, however, Jordan failed to develop an explicit population policy.

At the initiative of Princess Basma bint Talal, King Hussein's sister, the NPC was reorganized in 1988 to include a General Secretariat, whose goal was to develop a national population strategy. In 1993, the NPC formulated the *National Birth Spacing Policy*, which reflected the government's desire to consider population variables in development planning. The policy focused on increasing birth intervals to ensure the health of mothers and children but specified no quantitative goals (Almasarweh, 1997a). Also in 1993, the Maternal and Child Health (MCH)/Family Planning Unit of the MOHHC was upgraded to an independent directorate, demonstrating the government's commitment to strengthening MCH and family planning training and services (Al-Ma'aitah, 1997). Jordan's 1993–1997 five-year development plan included population issues, to be addressed through the delivery of family planning programs based on birth spacing and the introduction of population issues into school curricula.

Another development in 1993 was the formulation of the *National Strategy for Women* by the National Committee for Women. While not intended as a comprehensive reproductive health or reproductive rights document, the strategy incorporated issues later addressed by the 1994 ICPD and the 1995 Fourth World Conference on Women in Beijing. It contains a health domain that calls for health services for all stages of a woman's life span; birth spacing and MCH; educating women on health; and encouraging women to participate in the medical professions and positions in the health field (JNCW, 1993).

In 1992, the NPC began to draft Jordan's first *National Population Strategy*, which served as the basis for the report of the Jordanian delegation to the ICPD in 1994. In 1994, the NPC's membership was enlarged to include 20 members (one member was added in 1995) from the government and nongovernment sectors. In March 1996, the Council of Ministers, or Cabinet, approved the strategy. Even though the document does not incorporate all the ICPD *Programme of Action* recommendations, the Cairo conference did have an effect on the final product. For example, the strategy addresses issues such as women in development and reproductive rights for families. At the time of the case study, the NPC had appointed a task force to revise the *National Population Strategy* to reflect the recommendations of the ICPD *Programme of Action*.

B. Structures for Policymaking

The NPC is the main structure responsible for population and reproductive health policy formulation and implementation at the national level in Jordan. Largely owing to their membership on the NPC, other agencies and organizations in the government and nongovernment sectors also participate in national policymaking.

Overall, Jordan has made strides in policy formulation by following what one U.S. technical assistance organization respondent called a "low-key technical approach," making cautious advance in policy issues through the work of small expert groups according to what is politically and socially acceptable within the country and subsequently building wider consensus. Such an approach does not foster broad participation in initial policy development; nonetheless, consensus building occurs expeditiously. A respondent from a U.S. technical assistance organization said, "This approach is successful: pressing forward and building consensus after the fact. This is a reasonable approach for Jordan." This approach to policy formulation is discussed further in conjunction with participation and support for reproductive health.

Government Agencies

National Population Commission

Chaired by the Minister of Labor, the NPC is the main coordinating and monitoring agency for population and reproductive health issues in Jordan. As of 1995, the NPC had 21 members from government, NGOs, and universities (see Appendix 2 for a list of members of the NPC). The NPC's objectives are to establish the basis for a national population strategy; determine population policy components in cooperation with concerned government and NGOs; coordinate national efforts in population projects and activities; create public awareness about population issues; provide population information for decision making and planning; and develop and sustain cooperation between the NPC and other national, Arab, and international organizations (JNPC, n.d. (a)).

Since its reorganization in 1988, the NPC's primary task has been to develop and implement a national population strategy for Jordan (see Appendix 3 for policies pertaining to reproductive health). Before drafting the *National Population Strategy*, the NPC undertook research, conducted workshops at the local, regional, and international levels, and included a broad base of participants in discussions. The

Cabinet approved the strategy in 1996. The final document contains eight domains and an “institutional framework” that describes the mechanism for implementation of the strategy (JNPC, n.d. (b)). The eight domains include maternal and child care; family care, family planning, and birth spacing; population information and communication; women and development; education; population and labor force; population, the environment, and natural resources; and population and housing.

To revise the *National Population Strategy* to ensure consistency with the ICPD recommendations, the NPC will take advantage of newly available data to update population priorities, set new goals and targets, and specify the means to achieve the goals (Almasarweh, 1997a). The NPC will also take into consideration the goals of other national strategies, such as the *National Strategy for Women* and the *National Strategy for the Environment*. In line with the “low-key technical approach,” the NPC has appointed a five-member task force of national experts (demographers and public health specialists) to undertake the revision. Upon completion of the revision, the NPC will generate support for the updated policy. A donor respondent was optimistic about the revision of the *National Population Strategy*. “Reproductive health is not yet included in the *National Population Strategy*. It is more general. I hope with our efforts and donors in the country, it will be updated. It looks like it’s going in the right direction.”

The NPC is also responsible for ensuring that national social and economic plans address population issues. The NPC General Secretary is a member of the Committee on Labor, one of the sectoral committees formed to prepare the 1998–2002 five-year development plan. That plan focuses on four sectors: water, population, environment, and export promotion. According to a government respondent, the inclusion of the NPC General Secretary in sectoral committee meetings is a new and important development.

As already noted, the NPC is charged with coordinating and monitoring implementation of the *National Population Strategy*. While the strategy’s “institutional framework” is not an action plan for implementation, it sets out the NPC’s broad responsibilities in fostering dialogue and interaction among all organizations concerned with population; gathering and processing data on population issues; conducting relevant studies; supporting educational activities, such as workshops and seminars; and evaluating progress toward implementation of the *National Population Strategy* (JNPC, n.d. (b)). The NPC General Secretariat, established to coordinate the functions of the NPC, uses several means to monitor implementation progress. First, the General Secretary coordinates with the members of the NPC. Several respondents noted, however, that the NPC does not convene meetings regularly or frequently enough to ensure that its members are aware of and involved in its activities (generally, the NPC meets one to three times a year). Neither do NPC members regularly report on their progress. In addition, coordination between the NPC and other organizations appears to go no deeper than the designated member of the NPC. For example, the Secretary General of the MOHHC (who is a member of the NPC) is knowledgeable of NPC activities, but other high-level MOHHC officials and the rest of the MOHHC bureaucracy do not seem to be familiar with NPC activities or goals.

A second mechanism for monitoring implementation is the technical committees. The NPC forms the committees to develop implementation strategies for each domain of the *National Population Strategy*. At this time, the only functioning committee is the information, education, and communication (IEC) task force, which has developed a National IEC Strategy for population. Task force members represent ministries, donors, NGOs, and private universities. According to an NPC staff member, even though the IEC task force is at the height of its work, it is not incorporating reproductive health issues other than family planning into the National IEC Strategy; however, it has highlighted these issues in its 1998–1999 workplan.

At the sectoral level, all ministries, institutions, universities, and voluntary organizations concerned with population issues are charged with implementing that part of the *National Population Strategy* directly relating to their area of specialization—whether or not they are members of the NPC. In response, the NPC has created a third monitoring mechanism whereby it has appointed liaison officers to follow up their respective organizations' implementation efforts. According to a respondent from a U.S. technical assistance organization, liaison officers' roles have not been clearly defined, and officers do not regularly report to the NPC. One NPC staff member said, "We are too busy to really work with them. We must make this a priority issue for us and them." Several government, NGO, and donor respondents reported that, so far, progress in implementing the *National Population Strategy* has been slow.

Several donor and U.S. technical assistance organization respondents concurred that the main reason for lack of progress in implementing the *National Population Strategy* is that the document is not a detailed implementation plan. According to a respondent from a U.S. technical assistance organization, the strategy "does not say what the government should do to reach the goals." A United Nations Population Fund (UNFPA) reproductive health assessment recommended development of a comprehensive implementation and monitoring plan to translate the strategy's goals into well-defined actions for all parties involved (Almasarweh, 1997a). Formulation of the action plan should be the responsibility of the NPC, according to donor and U.S. technical assistance organization respondents. Respondents did not mention whether the revised strategy would serve as an action plan for implementing agencies.

Ministry of Health and Health Care

The MOHHC is involved in population and reproductive health policymaking at the national level through its membership on the NPC and its leadership of numerous national health committees, including the Safe Motherhood Committee, the HIV/AIDS Committee, and the National Breastfeeding Committee. These committees formulate national policies for their respective health topics under the direction of the MOHHC, not the NPC. Coordination between the committees and the NPC is informal and occurs mainly through reciprocal membership.

The MOHHC is the most important implementing agency for the *National Population Strategy*; however, government, donor, and U.S. technical assistance organization respondents noted that coordination between the NPC and the MOHHC could be stronger. One MOHHC respondent voiced doubts about the usefulness of the NPC and argued that the MOHHC should become the agency responsible for population policymaking and implementation efforts. He stated, "The NPC has no influence. Policy should be made through the MOHHC. Family planning is under primary health care [in the MOHHC]."

Other Government Agencies

The Ministry of Planning (MOP), which develops social and economic plans for Jordan, coordinates all foreign donor assistance. It determines if proposed donor projects coincide with Jordan's five-year development plans and consults with other government agencies, such as the MOHHC, the NPC, and the National Committee for Women, on donor plans for population and reproductive health. The Ministry of Information and the Ministry of Education (MOE) work on some aspects of population IEC, although UNFPA's work with the MOE is completed and no further projects are envisioned. At present, the NPC and the Ministry of Youth do not coordinate efforts simply because the *National Population Strategy* makes no reference to adolescent issues.

Parliamentarian Committees

Following the ICPD, JAFPP conducted a meeting with parliamentarians and media representatives to increase awareness of reproductive health and population issues and to discuss implementation of the

ICPD recommendations. Participants at the meeting recommended the establishment of a population committee in Parliament. Thus, in 1996 the National Parliamentarian Committee on Population and Development (NPCPD) was established with UNFPA support, furthering the ICPD recommendation to promote population and reproductive health awareness among legislatures (Almasarweh, 1997a).

The NPCPD comprises representatives of the Upper and Lower Houses of Parliament. At the time of the case study, the NPCPD was not a permanent committee of Parliament. According to a donor representative, the committee was too newly established to be effective; nonetheless, some members have demonstrated “good attitudes” concerning population and reproductive health issues.

After the ICPD, the Forum of African and Middle East Parliamentarians on Population and Development (FAMEPPD) was formed as a regional United Nations population organization. The forum includes Jordanian representatives; an office will be located in Amman. Several respondents noted that the establishment of a FAMEPPD regional office in Amman will favorably influence the promotion of population and reproductive health issues in Jordan.

NGOs

All NGOs in Jordan must register with the government and obtain approval of their bylaws from the Ministry of Social Development. The Ministry ensures that the objectives of the NGOs are consistent with Jordan’s legal system (i.e., given that abortion is illegal, an NGO may not provide abortion services). Donor agencies, including UNFPA, USAID, and the Japanese International Cooperation Agency (JICA), among others, support NGOs.

JAFPP, which is a member of the NPC, is the chief NGO involved in population and reproductive health. JAFPP’s main objectives are to provide high-quality family planning and reproductive health services to the community and to increase public awareness about family planning and sexual/reproductive health (JAFPP, n.d.; Al-Ma’aitah, 1997). JAFPP considers itself an example of an NPC member that began implementation of the *National Population Strategy* before the strategy gained the approval of the Council of Ministers. A JAFPP respondent noted, “We have been working for years with family planning and reproductive health. Therefore, we are ahead of the *National Population Strategy*.”

Five NGOs overseen by Princess Basma wield considerable influence: the National Committee for Women, the National Forum for Women, the Queen Alia Fund, the Queen Zein Complex for Development, and the Princess Basma Women’s Resource Center.¹ Because these NGOs are connected to the government, they are housed in government buildings. Moreover, with staff seconded from other government positions, the government pays their salaries. Although established with distinct objectives, the NGOs often coordinate with one another on overlapping issues. The National Committee for Women is most closely involved in population and reproductive health policy at the national level, whereas the National Forum for Women works with grassroots projects. The director of the National Committee for Women is a member of the NPC, thereby ensuring that women’s issues are incorporated into the *National Population Strategy*.

Being associated with Princess Basma confers a unique status on these NGOs. On the one hand, they are sponsored by Princess Basma and thus benefit from her influence in the government. For example, because Jordan does not have a Ministry for Women, the NGOs can promote women’s issues in general and their agendas in particular with less opposition than faced by private NGOs. They can also exert more influence at higher levels of government. On the other hand, they may not act as freely as they would without such close ties to the government. This ambiguity may, in fact, help the NGOs further

¹ Princess Basma also oversees the NPC.

their agendas, as noted by a donor representative. “My opinion is that when they want to be NGOs, they are NGOs, and when they want to be government, they say they are government.” A representative from a U.S. technical assistance organization noted that the NGOs may have small staffs, but they are run by dynamic women and have great influence in promoting change for women in Jordan.

A government official pointed to the need for more formal coordination between all of the NGOs connected to the government. For example, the health component of the *National Strategy for Women* may affect the revised *National Population Strategy* and its focus on reproductive health issues. If coordination is deficient, the two documents may set forth conflicting objectives. Housed in the same complex, the Queen Alia Fund and the National Committee for Women enjoy informal coordination. Thus, by virtue of their proximity and their work on similar issues, these two NGOs have had influence on the NPC General Secretariat.

Participation in Policy Formulation

Population and reproductive health policymaking at the national level takes place through the NPC and its members. In addition to government ministries and agencies, NPC members include three NGOs as well as representatives of public and private universities. Women’s interests are represented directly by the National Committee for Women and indirectly by other members (e.g., JAFPP, which incorporates women’s issues into its programs). The private sector is not explicitly represented on the NPC. In fact, one respondent from a U.S. technical assistance organization noted that the NPC’s private university member, a population specialist, is the only private sector representative. Accordingly, that respondent doubted that the NPC membership reflects private sector interests.

Commenting on the “low-key technical approach” to policy formulation, several respondents noted that the strategy translates into narrow participation in some NPC activities. For example, the five-member NPC task force revising the *National Population Strategy* does not include broad representation. Task force members are researchers and trained demographers rather than representatives of grass roots organizations. Some respondents believed that the revision process should be open to wider review. In particular, one respondent from a U.S. technical assistance organization noted the trade-off between opening the process to wider review and rapid development of the *National Population Strategy*: “The NPC is charged with getting the strategy done. It is reluctant to open the process up too much because it could really slow it down.”

“We have regular contact with them [the NPC]. We attend their activities and workshops. We share research and publications.”

NGO respondent

At the national level, the largest NGOs wield the greatest influence, including JAFPP and the NGOs connected to the government. A donor respondent pointed out, “Some big [NGOs] have influence.” Perhaps because they are accustomed to a situation wherein the government has great influence on politics and society, respondents did not appear concerned that JAFPP is the only private NGO involved with the NPC. Most viewed the participation of the NGOs

connected to the government as a positive step toward participation. Respondents’ views may be shaped by the fact that the government-connected NGOs, as opposed to the smaller and less influential private NGOs, are highly instrumental in supporting women’s issues in Jordan.

While certainly influential, religious and community leaders are not directly involved in policymaking, except when individuals serve as advisors to NPC or MOHHC committees. Nonetheless, a respondent from a U.S. technical assistance organization noted that the NPC does take religious and community leaders’ views into consideration when formulating policies and programs. In this way, the respondent believed that the NPC does acknowledge local community views.

C. Definition of Reproductive Health

Jordan has neither developed a consensus definition of reproductive health nor adopted the ICPD definition of reproductive health for its policies and programs. While respondents understood that reproductive health is a term that covers several different health components, they frequently equated it with family planning. Questions about reproductive health policies and programs usually generated a discussion of family planning policies and programs. Respondents provided information about other elements of reproductive health, such as STDs, HIV/AIDS, and safe pregnancy, only when asked specific questions about such matters. As one respondent from a U.S. technical assistance organization commented, “People have a vague idea of what reproductive health means.” Some NGO and donor respondents spoke broadly of reproductive health as defined by the ICPD. Mentioning that the concept of family planning was too limited, most welcomed the broadened view of reproductive health.

“Before ICPD it was ‘family planning.’ After 1994, the definition is expanded to ‘reproductive health,’ including sexual education, youth, women’s rights. Everything about the reproductive life... ‘Reproductive health’ is a wider concept. ‘Family planning’ was too limited.”
NGO respondent

A donor respondent pointed out, however, that some program managers do not support the reproductive health concept for fear that greater emphasis on the health of mothers will dilute the focus on infant and child health. Respondents in the MOHHC were aware of the concept of reproductive health and its connection to the ICPD, but some did not embrace reproductive health as a new approach to the organization and delivery of services. Some MOHHC respondents considered family planning a broader concept than reproductive health. An MOHHC respondent said, “We were not involved in the Cairo conference. We know about it though. The term ‘reproductive health’ is recently introduced. We changed our terminology from ‘family planning’ to ‘reproductive health’... In practicality, we still deliver MCH/family planning.” Still, as described below, Jordan offers an array of reproductive health services—services are just not linked under the term “reproductive health.”

Rationale for Population Programs

According to more than one-half of the respondents, population growth is still the principal rationale behind Jordan’s population programs. Government officials, donors, and respondents from U.S. technical assistance organizations spoke of population growth as a problem and noted the consideration of population variables in development planning as a goal.

Several respondents linked population growth to economic development. They noted that Jordan faces several problems, including diminishing water resources and per capita income, and agreed that population growth has exacerbated them. They also mentioned that the recent influx of immigrants has contributed to population growth. One donor stated, “We need to correct the myth that population is not so important. Water is a problem, but it still depends on population growth.” Nonetheless, the government still promotes family planning as a means to improve the health of mothers and children. Respondents said that the public more easily understands concepts based on individual health versus the more complex associations with economic development.

Several respondents noted that the ICPD occurred only three years ago and therefore policymakers, program managers, and the public are not yet knowledgeable about reproductive health. One NGO respondent commented, “Others start to see the new definition. It will take time. It’s not easy to convince people in two to three years. It took 20 years for family planning!” Respondents noted that

family planning still triggers considerable opposition. New ideas are introduced slowly in Jordan, and thus the concept of reproductive health will take time to be understood and accepted.

Priorities

While its support for family planning and birth spacing has increased over the past several years, the government of Jordan has not yet established clear priorities in population and reproductive health. The *National Population Strategy's* eight domains are comprehensive, but they do not specify priorities. When questioned about priorities for their respective organizations, about one-fifth of respondents mentioned family planning alone or in combination with safe pregnancy, well-baby care, and maternal and infant nutrition programs. Only one NGO respondent mentioned reproductive health elements other than family planning (STDs and cancer) as priority areas. Two respondents noted that their organizations were in the process of undertaking reproductive health assessments in order to determine reproductive health priorities.

Within Jordanian society, the elements of the ICPD *Programme of Action* concerned with reproductive rights and women's rights have found less acceptance than those associated with health. Several respondents expressed the view that Jordan is not ready to address some of these elements or that the elements themselves simply do not represent problem areas for Jordan. Respondents agreed that reproductive health elements not addressed by Jordan include HIV/AIDS and STDs (few cases), violence against women (either not present or not brought to the attention of authorities), and female genital mutilation (not practiced in Jordan). An MOHHC official noted, "Social life does not permit free contact out of the family, so STDs are not very common. They come from outside [from visitors or migrants to the country]."

"The number of AIDS cases is probably too low to be a priority. The level of effort here is not high enough because it is not thought of as a chronic issue. But you need to work on it beforehand, [before it becomes a widespread problem]."

U.S. technical assistance organization respondent

MOHHC respondents noted that the ministry uses data to determine its priorities, but that its studies are generally not of high quality. One respondent from a U.S. technical assistance organization commented that the ministry does not make good use of the available data, including service statistics. In response to limitations of data, the MOHHC is developing a cause-of-death registry pilot project and a logistics database. The database will help inform national priority setting, although it will not incorporate statistics from the private sector, which delivers a large share of reproductive health services in Jordan.

D. Support and Opposition

While support for family planning is growing among policymakers, religious leaders, and the public, support for broader reproductive health remains weak because of lack of widespread understanding of the concept. Respondents concurred and pointed out that, although there is no organized support for reproductive health in Jordan, there is no organized opposition either.

National Political Leaders

With respect to the elements of reproductive health, high-level political leaders demonstrate the greatest support for population and family planning. One optimistic NGO respondent argued that the government has undertaken some activities post-ICPD to show its commitment to reproductive health. He

commented, “After ICPD, the concept of reproductive health is now accepted... The government has adopted and announced family planning and reproductive health. The Council of Ministers asked all ministries to cooperate and promote the concept. It formed the NPC and increased its membership. All this was helped by the Cairo conference. Before, people were afraid to talk about family planning and reproductive health, although they knew about it. Now we have the [green] light.” Still, respondents appeared concerned about the need to continue strengthening support for population and family planning rather than reproductive health more broadly.

One respondent from a U.S. technical assistance organization noted that the King selects progressive leaders. Respondents were optimistic that these leaders, including the Prime Minister and members of the Council of Ministers and the Upper House of Parliament, although presently concerned with population’s effect on economic growth, would embrace reproductive health over time if they were educated about the benefits of a reproductive health approach. Several donor respondents reported that the previous Prime Minister was the former Minister of Labor and Chair of the NPC and, therefore, was a strong supporter of family planning. He “learned population knowledge and brought this with him as Prime Minister.”

Several respondents commented on an apparent lack of support for reproductive health among representatives in the Lower House of Parliament. Elected by the public, Lower House representatives tend to be more conservative than their counterparts in the Upper House. A respondent from a U.S. technical assistance organization commented, “They are not supporters of reproductive health. They are not opposed, they are simply not interested. And they are not worried about health as an issue.” Respondents agreed, however, that the members of the NPCPD are strong supporters. One donor respondent noted, “The commitment is high even though it is a new committee.” While Parliament does not promulgate policy, the support of Parliament may not be as crucial as that of the Council of Ministers, which approves the *National Population Strategy*. Nevertheless, Parliament does play a role in funding decisions that can influence population and reproductive health programs.

“Who should be targeted? We need parliamentary approval. We must convince the ministers concerned [with population and reproductive health] and then they can try to convince the Cabinet.”
Donor respondent

Ministry of Health and Health Care

Some MOHHC representatives interviewed for this case study did not support the new approach to reproductive health; furthermore, these same respondents did not believe that the lower levels of the MOHHC bureaucracy would readily accept the concept. In addition, they pointed to the conservatism of some regional directors and physicians in remote areas and noted that a lack of understanding of the issues or disapproval of family planning has left these administrators and practitioners unconvinced even of family planning. Still, family planning is provided in all MOHHC facilities, and 28 percent of family planning clients are served by MOHHC facilities. One NGO respondent said of the MOHHC, “Some managers of MCH are not convinced by reproductive health concepts. They are not trying to promote it or provide these services or even cooperate with us.”

Religious Leaders

Social conservatism in Jordan is closely linked to religion, and religious leaders and their opinions are highly respected and valued. Therefore, gaining the support of Jordan’s religious leaders is critical for the acceptance of reproductive health policies and programs. One-third of the respondents gave positive assessments of religious leaders’ support for family planning, and some believed that religious leaders would support reproductive health in time as well. A donor respondent mentioned that religious leaders

can use verses from the Koran both to support and oppose family planning; however, support is greatest when family planning is viewed as a “health” issue.

At present, religious leaders are open to education on reproductive health matters for both themselves and the public. One NGO respondent reported that some religious leaders support the general concept of reproductive health. “After ICPD, the concept of reproductive health is now accepted. Nobody before would believe that the Ministry of Religious Affairs would promote reproductive health and talk about STDs!” Respondents were optimistic that more religious leaders would spread positive messages about family planning and reproductive health in their Friday speeches in mosques and during private counseling sessions. Despite some active promotion of family planning by religious leaders, the NPC and others are continuing to focus on educating the leaders about the benefits of family planning and reproductive health. For example, JAFPP runs a training course for religious teachers in reproductive health, family planning, STDs, and sexual counseling. Offered in cooperation with the Ministry of Religious Affairs, the course has trained 90 religious leaders to date. The NPC organized a trip to Cairo in 1997 for 10 high-level religious leaders, including two women, to observe the Egyptian Population Program. The NPC has also undertaken a knowledge, attitudes, and practice (KAP) survey of religious leaders in Jordan—the first of its kind. The survey results will provide additional information about religious leaders’ attitudes toward family planning and reproductive health and help determine priority areas for educating them.

The Public

After 20 years of advocacy, the public is increasingly understanding and accepting family planning. Respondents commented that views change slowly in Jordan. One government respondent noted, “In the past, we worried if communities would accept family planning. Now the idea is becoming normal.” Generally speaking, however, the public has little knowledge of reproductive health, although some respondents envisioned little opposition once people understood the separate elements of reproductive health. An MOHHC official was optimistic. “There is no opposition in the communities to reproductive health, except for the liberalization of abortion [which is illegal in Jordan].”

“This awareness [of reproductive health] is not just because of Cairo. Awareness in Jordan is better. People are willing to know more. There is more media coverage. All these factors contribute to awareness.”

Donor respondent

Two respondents involved in service delivery observed that, since the ICPD, clients have begun to ask for more services. One provider noted, “Post-Cairo, people are asking for more help with pregnancy spacing, lactation, family planning. They ask about different methods of family planning.

Jordanian families are relatively educated and read a lot and see TV [therefore are aware of the Cairo conference and reproductive health issues].” Thus, in a general sense, the ICPD has had an effect on the public’s attitudes, but the public has no specific knowledge of its recommendations. Respondents remained optimistic that the public will accept the concept of reproductive health over time. One donor stated that the people are open to new ideas, such as reproductive health, and remarked that “the opinions of people and the conception of the world are changing.”

4. Policy Implementation

A. Operational Policies and Plans

Jordan lacks a formal process for translating national policies into operational policies for MOHHC service delivery, and, until recently, lacked operational guidelines for family planning and reproductive health. Moreover, a comprehensive set of national guidelines for all sectors does not exist. One representative from a U.S. technical assistance organization observed, “All policies and guidelines [at the MOHHC] are informal and we [donors] are trying to encourage them to make policies.” The same respondent reported that the MOHHC faxes new policies to the directorates as they are drafted, but does not compile them into an official guideline manual.

The absence of formal operational policies has encouraged donors to develop guidelines through their projects with the MOHHC and JAFPP, which in some cases has resulted in an initial duplication of effort, according to some respondents. For example, UNFPA and the MOHHC developed a training guide and participant’s handbook in reproductive health and worked with JAFPP on counseling guidelines. Through the Comprehensive Postpartum Project (CPP), USAID worked with the MOHHC to develop national training guidelines for MCH, family planning, and counseling. Now, however, all UNFPA, JICA, and USAID projects use the same MOHHC guidelines. A JAFPP respondent noted that the organization has developed its own guidelines for its clinics and has adopted IPPF service delivery guidelines. A JAFPP respondent said, “We do not go by MOHHC guidelines.” It is not possible to assess progress in implementing MOHHC operational guidelines, as they have only recently been developed and have not yet been disseminated to all levels of service delivery.

Several respondents observed that many physicians, particularly in rural areas, still voice opposition to family planning and thus impede policy implementation and service delivery. For example, one respondent from a U.S. technical assistance organization noted that heads of rural health directorates often refuse to implement MOHHC policies if they do not support them. Further, the staff of rural health centers often take local physicians’ nonconforming directives as formal policy. For reasons such as these, respondents stressed the need to develop a single set of service guidelines for all sectors.

B. Service Delivery Structure and Implementing Agencies

Reproductive health services are available from the public, NGO, and private sectors (see Appendix 4 for services offered by sector). The public sector, consisting of the MOHHC and Royal Medical Service (RMS), provided 28 percent of family planning services in 1997. NGOs (primarily JAFPP) provided 24 percent of family planning services in the same year. The private sector consists of private hospitals (including the University of Jordan Hospital), clinics, and practitioners; it provided 48 percent of family planning services in 1997 (DOS and IRD, 1998). In addition, the United Nations Relief and Works Agency for Palestinian Refugees (UNRWA) provides services for Palestinian refugees living in Jordan.

Ministry of Health and Health Care

The MOHHC is Jordan’s largest provider of primary and secondary health care and one of the country’s largest MCH/family planning providers. It offers three levels of primary health care: comprehensive health centers, primary health centers, and peripheral health centers (also known as village clinics). Hospitals are at the apex of the system of curative services. MCH and family planning services are not available at the peripheral health centers.

“We are touching almost every aspect [of reproductive health]. Violence is not a part of our culture. We touch each one, although we are not digging in so deep to each.”
MOHHC respondent

The MCH Directorate covers most of the reproductive health services available from the MOHHC at MCH centers. After the establishment of the directorate in 1993, the MOHHC has nearly completed the integration of all MCH centers, which were previously stand alone centers, into comprehensive health centers.

The MCH centers provide antenatal, postnatal, and child care; delivery service (although most deliveries are performed in hospitals); child vaccination; health and nutrition services; family planning services; and general health and nutrition education (Al-Ma’aitah, 1997). Most services are free. STD services and postabortion care are available at hospitals, although there has been no specialized training in postabortion care. The Planning and Projects Management Directorate of the MOHHC oversees family planning services and donor projects. HIV/AIDS and STDs fall under the Disease Control Directorate. The Health Safety Directorate is responsible for IEC activities. Infertility, gender-based violence, and adolescent services (except for married adolescents) are not available under the MOHHC structure.

The MOHHC has not adopted a reproductive health approach to service delivery as a result of the ICPD. An MOHHC respondent said, “There is no difference in the offering of services before and after ICPD. We offer the same services now as then. We need the infrastructure [to incorporate new services].”

Royal Medical Service

The RMS provides health care for members of the Jordanian armed forces and their dependents, all of whom account for 1.2 million people, or 30 percent of the population. Reproductive health services cover family planning, antenatal care and delivery, postabortion care, STDs, HIV/AIDS, nutrition, reproductive tract cancers, and infertility. The services are free, except for cost sharing for in vitro fertilization (IVF). Respondents from the RMS reported that RMS services are better than MOHHC services.

United Nations Relief and Works Agency for Palestinian Refugees

Established in 1950, UNRWA is the health, education, and social service agency for Palestinian refugees residing in Jordan, Lebanon, Syria, the West Bank, and the Gaza Strip. With 1.3 million registered refugees in Jordan, UNRWA offers limited family planning services in addition to antenatal, delivery, postnatal, and nutrition services. It provides no STD or HIV/AIDS services, but does offer educational programs for selective reproductive health issues, especially for youth.

Jordan Association for Family Planning and Protection

Most NGOs (mostly smaller, local NGOs) are involved in information and education with regard to reproductive health; only a few NGOs provide services. The government-connected NGOs provide some reproductive health services, but only at local clinics and not on a large scale. Noting that NGOs are instrumental in providing services to Jordan’s underserved populations, respondents specifically mentioned JAFPP—the largest NGO involved in reproductive health care.

JAFPP provides family planning services through its 17 permanent and two mobile clinics. Shortly after the ICPD, JAFPP began introducing reproductive health services, including STD screening and management, early detection of breast and cervical cancer, and limited infertility counseling. JAFPP focuses on providing high-quality services such as counseling (including later age/menopause counseling), a women’s hotline, and education and awareness campaigns for youth and women and in rural areas. JAFPP is planning a pilot project to address men’s reproductive health issues.

JAFPP charges minimal fees for reproductive health services. Respondents from JAFPP explained that clients are willing to pay for services because they recognize the high quality of care they receive. Overall, JAFPP has achieved 30 percent cost recovery, with some clinics at full cost recovery.

In the past several years, the MOHHC began to play a larger role in the provision of reproductive health services, especially family planning. Respondents voiced different opinions as to whether the services of the MOHHC and JAFPP are complementary or competing. A few MOHHC respondents said that the MOHHC should provide all reproductive health services and expected the ministry to be able to meet demand in the next few years. Most other respondents believed the services of the MOHHC and JAFPP are complementary. They also noted that demand is so great, especially in rural areas, that even together the MOHHC and JAFPP cannot meet it. A JAFPP respondent commented, “We offer the same services [as the MOHHC]... We are not in competition with the MOHHC. We are providing quality services. We have good cooperation with the MOHHC. Our two mobile clinics use the MOHHC infrastructure of the MCH centers in rural areas. We provide where services are lacking.”

“JAFPP works in areas where the government does not. In the last five years the government has expanded to overlap. But JAFPP still has the biggest number of clients. The government cannot provide for the large numbers.”
JAFPP respondent

University of Jordan Hospital

The University of Jordan Hospital is a private provider of reproductive health services through its ob-gyn clinic in Amman. Most patients are covered by private insurance; however, the public sector refers some patients to the clinic. The hospital provides family planning, safe pregnancy, postabortion, STD, reproductive cancer, and nutrition services. In the area of infertility, it presently provides only counseling and testing.

Private Sector

The private sector is responsible for a large proportion of reproductive health services in Jordan. Respondents reported that the private sector handles most abortion complications and STD/HIV cases. In the absence of government barriers to the private sector, the market for private health care is flourishing despite fees for all reproductive health services. Respondents commented that most private physicians are responsible and relatively progressive. Private sector services are generally more efficient than those in the public sector. In addition, private providers offer more personal care and more flexible hours and spend more time with patients. Some respondents noted, however, that some practitioners offer services of questionable quality.

Donor Projects

Several donor projects work with the public sector to offer high-quality, integrated reproductive health services. For example, USAID sponsors the CPP, which offers family health, postnatal care, and family planning services in centers lodged in public sector hospitals (including the RMS). The USAID-funded Quality Assurance Project cooperates with the MOHHC Quality Control Directorate to integrate family health care with family planning at 12 model centers throughout the country. The centers concentrate on safe pregnancy, family planning, and maternal and infant nutrition. The Social Marketing for Change (SOMARC) Project trains private sector physicians and pharmacists in contraceptive technology and the health benefits of contraception and birth spacing. JICA is beginning a three-year project to introduce reproductive health services and income-generation activities for women in one area in southern Jordan.

At the time of the interviews for this case study, the project was gathering baseline information on women (including girls and postmenopausal women) as part of a needs assessment in advance of the design of program interventions.

Almost all donor and U.S. technical assistance organization respondents noted no change in their projects as a result of the ICPD. Reasons include the inability to change projects in mid-cycle (and the lack of funding to do so) and the belief that projects embodied reproductive health issues even before the ICPD. Most respondents were optimistic that any new projects would address additional reproductive health issues, especially if the necessary funds were available.

C. Integration

Despite the existence of some integrated services, comprehensive reproductive health services are not the norm in Jordan. Moreover, the ICPD did not recommend specific institutional mechanisms for integrating population issues into development policies and programs. Thus far, policymakers and program managers in Jordan have not worked out a consensus definition of integrated services on their own (Almasarweh, 1997a).

The MOHHC assigns various reproductive health services to its several directorates, although family planning and MCH are located in the same directorate. Nonetheless, the MOHHC is still in the process of linking MCH and family planning. Most women in Jordan deliver in a hospital; thus, linking prenatal and antenatal care and family planning services (located in MCH centers) with delivery services (in hospitals) remains a challenge. The CPP, located in several hospitals, aims to integrate these services. Linkages between MCH and family planning services and STDs or HIV/AIDS are nonexistent. One MOHHC official did not see the need to integrate these services. “HIV/AIDS has nothing to do with family planning. Our efforts are to control the disease. The Disease Control Department in the MOHHC follows the cases... STDs are handled through the Disease Control Department. [Family planning is handled by the MCH/Family Planning Directorate.]”

In contrast to the MOHHC, NGOs, the private sector, and some donors are moving toward a reproductive health approach; however, none of these organizations is offering services in the comprehensive, integrated manner envisioned by the ICPD. Respondents from several sectors reported that services are

“We practice all these things [reproductive health services], but not in an organized fashion. We have six clinics in Amman, and we treat whatever comes in.”

Royal Medical Service respondent

integrated in the sense that providers treat “whatever comes in.” Such may be the case for the RMS, UNRWA, and the University of Jordan Hospital, which, for example, operates a few facilities that treat all conditions. The UNRWA respondent reported that the agency was providing integrated reproductive health services before ICPD. “We integrate services all

together... We were doing reproductive health before the Cairo conference!” The MOHHC experiences a different problem. Clients go directly to the hospital for care, bypassing local clinics and MCH centers. For example, a donor respondent said, “People can go with STDs to the hospital or MCH center whenever they want. We are trying not to have everything in the hospitals.” Although referral systems between services and providers are an effective strategy for improving integration if all services are not available at each level of health care (Hardee and Yount, 1995), no sector appears to have a formal referral system, particularly for reproductive health services.

All sectors have made efforts to introduce integrated reproductive health services despite the absence of a comprehensive reproductive health policy or operational guidelines. As a result, the various sectors are pushing forward with different approaches to integration. Numerous respondents have noted duplications of effort and the repetition of mistakes. One NGO, the Family Health Group, is undertaking a reproductive health assessment in a lower income area of Amman for the purpose of developing a model for reproductive health interventions. Clearly, Jordan is still working out an integrated approach to providing comprehensive reproductive health services.

“People don’t now how to integrate. They are asking for a model. It is not just physical integration, but system integration. Gender issues should be addressed, too.”
NGO respondent

D. Constraints

NPC Monitoring and Coordination

Respondents concurred that improved coordination among the NPC, the MOHHC, and other relevant organizations would help foster implementation of the *National Population Strategy*. Overall, respondents admired the achievements of the NPC—especially given the General Secretariat’s limited staff and resources—and believed that the commission has built a solid foundation for future progress.

Respondents noted that monitoring by liaison officers could be a potentially effective approach to improving coordination between the NPC and other organizations. Respondents also believed that the NPC should be better informed about donors’ population and reproductive health projects and involvement in implementing the *National Population Strategy’s* objectives. One NGO representative suggested that the NPC could bring donors and local NGOs together to discuss their projects and coordinate efforts.

Respondents felt that in order to monitor implementation of the *National Population Strategy*, the NPC should convene more frequent meetings. NPC members should disseminate the activities of the Commission within their respective organizations to gain even deeper support for their work. In addition, many respondents commented that NPC staff members need support through training in data use, communication skills, technical skills, and the addition of staff and equipment in general.

One of the greatest challenges facing the NPC relates to its work with the MOHHC. Some MOHHC respondents believed that the MOHHC should assume responsibility for the population policymaking process and oversee donor funds for project activities.

Financial Resources

Several respondents reported that financial constraints make implementation of population and reproductive health programs difficult. In particular, a government official noted the limited amount of donor funding, while a donor noted that contraceptives are totally funded by donors. Respondents called for greater financial commitment to population and reproductive health on the part of government, donors, and NGOs.

“Everyone can say there is a lack of resources. This is the first thing. It’s a big issue. People under-estimate how much effort is needed.”
MOHHC respondent

Use of Data for Decision Making

Respondents said that the NPC and MOHHC should make better use of data for program design, monitoring, and evaluation. Some respondents thought that higher-quality data were needed to convince policymakers of the importance of population and reproductive health problems. A donor respondent, noting that data could be used more effectively for policymaking, remarked that “numbers make a big difference if they are presented right.”

Infrastructure and Trained Personnel

Even though Jordan enjoys good access to health care (98 percent coverage [Al-Ma’aitah, 1997]), the country is overly reliant on hospital services, with greater access in urban versus rural areas. Respondents noted that these problems constrain integration and delivery of reproductive health services. Moreover, a shortage of health care providers, particularly female gynecologists, affects all specialty areas within the MOHHC. In addition, 75 percent of practicing nurses are female and 10 percent of physicians are female. Respondents pointed to a great need for female physicians and nurses (male nurses cannot enter the treatment room of a female patient), especially in rural facilities. Finally, a lack of administrative and management skills with regard to reproductive health and family planning services (Al-Ma’aitah, 1997) undermines integration.

Need for Broader Participation

Several respondents called for wider participation in the policymaking process; although aware of the “low-key technical approach,” they also see the benefits of broader participation in initial policy development. In general, respondents appear optimistic about the involvement of NGOs and women’s groups in policymaking and service delivery. They view the NGOs connected to the government as particularly influential in the policy process. Nonetheless, inclusion of smaller, community-level NGOs and the private sector in policymaking would improve stakeholder representation.

Sociocultural Context

Jordan is a conservative, predominantly Islamic society. Men tend to be the decision makers in most aspects of family life, including use of family planning and reproductive health services. There is no widespread perception that Islam forbids the use of contraception; however, other reproductive health elements are sensitive subjects in Jordan, including postabortion care, STDs, and gender-based violence. This sociocultural context provides a challenge for policy formulation and provision of comprehensive reproductive health services. For example, one NGO respondent said, “There is even a need to have a postabortion care policy. This is not easy in Muslim countries.” The NPC is recruiting religious leaders to promote family planning and reproductive health, and NGOs are initiating pilot projects aimed at increasing male involvement.

5. Resource Allocation

A. Funding Levels for Reproductive Health

The government provides most of the funding for family planning and reproductive health through the MOHHC. The MOHHC budget accounts for 5.2 percent of the total government budget and 2.2 percent of the gross domestic product (Almasarweh, 1997a). With the exception of family planning, no information is available on funding and expenditures for reproductive health as a whole or for most

elements. Preliminary estimates from a family planning funding and expenditures study (Winfrey and Almasarweh, 1998) indicate that, for 1995, spending on family planning in Jordan totaled approximately US\$5.7 million, including public (MOHHC and RMS), NGO, UNRWA, and University of Jordan Hospital sources (the private commercial sector was not included). According to the study, the major funders of the family planning program include the government of Jordan (47 percent), major donors such as USAID, UNFPA, IPPF, and the European Union (38 percent), UNRWA (4 percent), and self-funding through cost recovery and user fees (11 percent).

Regarding the outlook for future funding, a respondent from a U.S. technical assistance organization commented, “Funding levels are not bad now, but in the future they may be different with the new implementation plan [for the *National Population Strategy*].” Offering broader reproductive health services as envisioned by the ICPD may be expensive.

B. Major Donors

The major population and reproductive health donors in Jordan are USAID, UNFPA, the European Union, JICA, and IPPF (which supports JAFPP). Respondents noted that UNFPA concentrates on reproductive health, whereas USAID concentrates on water, microfinance, and population issues, with a focus on family planning. An MOHHC respondent who commented that donors place too much emphasis on family planning projects believes that funds should be allocated to other areas of health as well.

According to several respondents, Jordan is highly dependent on donor funds not only for service delivery, but also for support of organizations and policy development activities. Except for the facility provided by the Queen Alia Fund (Almasarweh, 1997a), which is supported by donor funds from UNFPA and USAID, the NPC General Secretariat receives no domestic funding from public sources. The Secretariat is approaching the Ministry of Finance to secure funds in the government budget.

Several respondents said they did not see strong evidence of donor coordination; however, two donor respondents noted that donor coordination is strong—even to the extent of co-funding some training and logistics activities.

6. Challenges

“Jordan has nice policies; the question is, Will they be implemented?”

MOHHC respondent

Jordan has experienced tangible changes since the ICPD including the introduction of awareness-raising activities and the revision of the *National Population Strategy*. Abstract changes have taken the form of more favorable attitudes toward reproductive health among policymakers and the public. Many respondents said that the ICPD had a positive influence on policy

dialogue; whether the dialogue can be translated into a comprehensive reproductive health document and subsequently implemented remains to be seen. A respondent from a U.S. technical assistance organization commented, “ICPD made a big difference with policy debate, but it is questionable if it affected implementation and what will happen with implementation.”

Awareness Raising

The NPC, JAFPP, and others have underwritten several activities aimed at generally increasing knowledge and support for population activities, and, in particular, increasing awareness of the

reproductive health approach endorsed by the ICPD *Programme of Action*. Jordan has made progress in working with religious leaders, policymakers in Parliament and the population field, and the public. Respondents commented that awareness-raising activities should continue to be targeted to policymakers. All levels of the MOHHC—from high-level officials to rural service providers—need to develop a greater awareness of the benefits of a reproductive health approach. Awareness activities should also be directed to private sector providers. Respondents concurred that the public needs to be further educated about population and reproductive health issues, noting that a special effort is needed to convince men of family planning benefits and to educate women about their legal rights.

Donor Involvement

Donor involvement has been important in the formulation and implementation of population and reproductive health policy in Jordan. In particular, respondents noted that donor support has been crucial to the establishment and continued operation of the General Secretariat of the NPC, to Jordan's involvement in the ICPD, and to the institution of operational guidelines at the MOHHC. In addition, donor organizations have supported NGOs. Donor support and influence is critical to advancing the reproductive health agenda in Jordan and financing reproductive health services.

Planning for Implementation

To meet the potential demand for reproductive health services and allocate resources efficiently, Jordan needs to assign priority to its reproductive health problems and develop well-conceived implementation plans that include monitoring and evaluation. Several respondents called for formation of a detailed action plan for implementing the *National Population Strategy*. With respect to priorities, many respondents perceived that HIV/AIDS, STDs, gender-based violence, abortion complications, and adolescent reproductive health issues are not priorities or even issues in Jordan. Although not validated by a systematic reproductive health assessment, such beliefs continue to influence policymaking. Therefore, a reproductive health assessment should be completed to determine priority issues.

Maintaining Momentum with the Low-Key Approach

The policy formulation and implementation process in Jordan is a gradual one. One donor observed that “the tempo is very slow.” The incremental pace can be attributed to the conservatism of Jordanian society, the influence of religion, and the structure of policymaking. In any event, the “low-key technical approach” appears to be working in Jordan. While some respondents wished for policymaking at a more rapid pace and society's more ready acceptance of sensitive reproductive health elements, most acknowledged the need to work within the realities of the Jordanian context. A National Committee for Women representative noted that the committee uses a similar approach to ensure success in its work. “There is no opposition to us. This is my feeling. Because we moderate our sayings. We don't go for extremes. There are cultural, religious, social norms. We work within our [Jordan's] nature. Our ideas don't come from outer space.” These attitudes underscore the importance of contextual factors in developing reproductive health policies and programs.

Family planning through birth spacing is gaining increasing acceptance after 20 years of advocacy. Thus, with only three years elapsed since Cairo, Jordan's strides toward reproductive health policies and programs should be seen as positive steps leading to desired social and economic change.

Appendix 1

Organizations Represented in the Interviews

Government Organizations	Ministry of Health and Health Care; Royal Medical Service; Ministry of Planning; National Population Commission
Nongovernmental Organizations	Jordan Association for Family Planning and Protection (JAFPP); Family Health Group; National Committee for Women
Donors	United Nations Population Fund (UNFPA); United Nations Economic and Social Commission for Western Asia (ESCWA); United Nations Relief and Works Agency for Palestine Refugees (UNRWA); Japan International Cooperation Agency (JICA); United States Agency for International Development (USAID)
Technical Assistance Organizations	Pathfinder International; John Snow, Inc.; The Futures Group International; Johns Hopkins Population Communication Services; University Research Corporation
Academic Institutions	University of Jordan Faculty of Nursing
Service Providers	University of Jordan Hospital

Appendix 2

Members of the Jordanian National Population Commission

Minister of Labor, Chairman
Queen Alia Fund for Social Development Representative, Vice-Chairman and Secretary General
Secretary General, Ministry of Social Development
Secretary General, Ministry of Education
Secretary General, Ministry of Planning
Secretary General, Ministry of Health and Health Care
Secretary General, Ministry of Information
Secretary General, Ministry of Awqaf and Islamic Affairs and Holy Places
Secretary General, Civil Service Bureau
Director General, Department of Statistics
Director General, Passports and Civil Status Department
Director General, Radio and Television Corporation
Director General, Housing and Urban Development Corporation
Representative of the University of Jordan, Population Studies Department
Representative of Yarmouk University, Journalism and Mass Communication Department
Representative of Mu'tah University, Population Specialist
Representative of Private Universities, Population Specialist
Representative of Jordan's Armed Forces, Moral Guidance and Planning Specialist
Representative of the Jordanian National Committee for Women
Representative of Noor Al-Hussein Foundation
Representative of Jordan Association for Family Planning and Protection

Appendix 3

Policies Covering Reproductive Health Elements in Jordan, 1997

Element of Reproductive Health Policy	Policy and Year
Family Planning	National Birth Spacing Policy, 1993 National Population Strategy, 1996
Postabortion Care	n/a
Safe Pregnancy	National Population Strategy, 1996
RTIs	n/a
STDs	n/a
HIV/AIDS	n/a
Reproductive Health Services for Adolescents	n/a
Maternal and Infant Nutrition	National Birth Spacing Policy, 1993 National Plan of Action for Childhood, 1993 National Population Strategy, 1996
Cancers of the Reproductive Tract	n/a
Infertility	n/a
Female Genital Mutilation	n/a
Gender-Based Violence	n/a
Other: Reproductive Rights*	National Population Strategy, 1996

*Reproductive rights are for *families*, not couples or individuals.

Note: The National Strategy for Women in Jordan does not address any of these elements in particular.

Appendix 4

Reproductive Health (RH) Services Delivered by Sector in Jordan, 1997

RH Element*	MOHHC	RMS (Ob-Gyn Clinics)	University of Jordan Hospital (Ob-Gyn Clinic)	UNRWA	JAFPP	Private Sector**
Family Planning	YES Not all methods available in all MCH centers; initiated in 1980	YES Available in each hospital, not clinics	YES	YES Not comprehensive until 1993	YES Initiated in 1972	YES
Safe Pregnancy	YES	YES	YES	YES	YES	YES
Post-abortion Care	YES Only in hospitals; not free	YES	YES	NO	NO	YES
RTIs/STDs	YES STD services in hospitals only (except syphilis detection); otherwise, counseling and education	YES Prevalence low, however	YES Prevalence low, however	NO Education, especially youth	YES Introduction of screening and management; education and training-of-trainers for youth	YES Most clients served here
HIV/AIDS	YES Education	(no cases?) Prevalence low, however	NO (only one case from blood transfusion)	NO Government covers these services; education, including adolescents	NO Education for youth	YES Most clients served here
RH Services for Adolescents	NO	NO	NO	NO Education	NO Education campaigns for STDs, HIV/AIDS	?
Maternal and Infant Nutrition	YES	YES	YES	YES	YES Nutrition services limited	YES
Cancers of the Reproductive Tract	YES Pap smear not free	YES Oncology clinic	YES	NO?	YES	YES
Infertility	NO	YES First IVF program in the country	YES Testing and counseling; trying to establish IVF program	NO?	NO Counseling only (tried program in past, but too expensive)	YES
Gender-Based Violence	NO Counseling and social workers	?	NO	NO Counseling if client requests	NO	?

Other		Hormone replacement therapy			Gender program, including reproductive rights; menopause counseling; male issues	
Integration and Extent of RH Services Offered and at What Level	LOW MCH centers do not offer STD and HIV/AIDS programs and services; not delivered at village level, rather at MCH center level	LOW/MEDIUM Many RH elements offered but not in integrated manner; several ob/gyn clinics are integrated CPP centers; national for RMS	LOW/ MEDIUM Many RH elements offered but not in integrated manner; urban Amman	LOW/ MEDIUM MCH services are integrated; national (for all Palestinian refugees)	MEDIUM Program contains most elements; pilot male involvement; education programs for some elements; national (including mobile clinics)	MEDIUM? Most RH services offered; indeterminate if integrated; national

*Female genital mutilation not included in table; not applicable to Jordan.

**Based on reports of respondents from other sectors; private sector physicians were not interviewed; information and statistics on coverage and services delivered by private sector are lacking in Jordan.

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