

Primary Health Care Initiatives (PHCI) Project  
Contract No. 278-C-00-99-00059-00  
Abt. Associates Inc.

PHCI Technical Report

## **Building A National Research Agenda**

**Volume II:**

## **Developing a National Research Agenda for Reproductive Health and Family Planning in Jordan**

*June 7, 2001*

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*Submitted to:*

**Ministry of Health, Jordan**

**USAID/Jordan**



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## ***Mission***

*Primary Health Care Initiatives will demonstrate that improvements in quality of care can be achieved and sustained at both facility and household levels by establishing an integrated model of family care, in which family preventive and curative health needs, including reproductive health, are satisfied by a family health provider team, in a holistic manner.*

**June 7, 2001**

This report is Volume II in a series of four PHCI/MOH Research Agenda reports, *Building a National Research Agenda*:

- Volume I: Developing a National Research Agenda for Primary Health Care in Jordan
- Volume II: Developing a National Research Agenda for Reproductive Health and Family Planning in Jordan
- Volume III: Matrix of Existing Research in Reproductive Health and Family Planning in Jordan
- Volume IV: Summaries of Existing Research in Reproductive Health and Family Planning in Jordan

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# Table of Contents

Table of Contents.....	iii
Acronyms .....	v
Acknowledgements.....	7
1. Introduction.....	9
1.1 Primary Health Care Initiatives Project (PHCI) .....	9
1.1.1 Framework for PHCI Implementation.....	9
1.1.2 PHCI Mission.....	10
1.1.3 PHCI Strategic Framework.....	10
1.1.4 Partnership with Counterparts and Stakeholders.....	11
1.1.5 PHCI Commitment to Applied Research.....	11
1.2 Objective of Establishing a National Research Agenda.....	14
1.3 Methodology .....	14
1.3.1 Participatory Approach – An Introduction .....	14
1.3.2 Preliminary Research.....	15
1.3.3 The RH/FP Research Roundtable .....	16
2. Identifying RH/FP Research Topics.....	17
2.1 Presentations.....	17
2.2 Research Topics by Category .....	18
Quality of Care .....	19
Adolescent Reproductive Health .....	19
Adolescent Reproductive Health .....	19
3. Existing RH/FP Knowledge.....	27
3.1 Systems Related Research.....	27
3.1.1 Policy Environment for Reproductive Health and Family Planning .....	27
3.1.2 Financing .....	29
3.1.3 Integration of RH/FP into Primary Health System.....	30
3.1.4 Referral System.....	30
3.1.5 Donor Coordination.....	31
3.1.6 Data Issues .....	31
3.2 Demand Related Research.....	33
3.2.1 Fertility .....	33
3.2.2 Contraceptive Prevalence Rate (CPR).....	35
3.2.3 Unmet Need for Family Planning .....	38
3.2.4 Contraceptive Continuation .....	40

3.2.5 Method Mix .....	42
3.2.6 Client Attitudes and Behaviors .....	43
3.2.7 Integration of RH/FP into Primary Health System.....	45
3.2.8 Community Participation.....	46
3.2.9 Specific Target Populations .....	46
3.2.10 Reproductive Health Status .....	47
3.3 Supply Related Research.....	49
3.3.1 Integration of RH/FP into Primary Health System.....	49
3.3.2 Access.....	49
3.3.3 Quality of Care.....	49
3.3.4 Role of NGOs in the Provision of RH/FP.....	50
3.3.5 RH/FP Specific Information, Education and Communication.....	50
3.3.6 Target Populations.....	51
3.3.7 Access.....	51
3.3.8 Provider Issues .....	52
4. Next Steps.....	55
4.1 Prioritize Research Questions.....	55
4.1.1 RH/FP Research Working Group.....	55
4.1.2 Dissemination of Prioritized List .....	56
4.1.3 Continuing Dialogue Among Stakeholders .....	56
5. PHCI Role in Conducting Research.....	58
Annex A: List of Participants .....	59
Annex B: Agenda for RH/FP Roundtable .....	61
Annex C: RH/FP Roundtable Handout .....	62
Annex D: RH/FP Roundtable Presentations.....	64
Annex E: Matrix of Relevant RH/FP Research Studies .....	83

## Tables and Figures

Figure 1.1: A Research Model -- Purpose, Process and Stakeholders .....	13
Table 2.1: Illustration of Potential Issues within Selected Research Framework .....	18
Table 2.2: Matrix of Main RH/FP Research Topics within Framework .....	19
Table 2.3: Matrix of Specific RH/FP Research Questions within Framework.....	20
Table 3.1: Stock Distribution Conversion Factors to Obtain CYP .....	32
Figure 4.1: PHCI/MOH Prioritization Criteria .....	55

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# Acronyms

<b>ADRA</b>	Adventist Development and Relief Agency
<b>CA</b>	Cooperating Agency
<b>CBR</b>	Crude Birth Rate
<b>CBS</b>	Community Based Services
<b>CE</b>	Continuing Education
<b>CEDPA</b>	Center for Development and Population Activities
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CHC</b>	Comprehensive Health Center
<b>COP</b>	Chief of Party
<b>CPP</b>	Comprehensive Post Partum
<b>CPR</b>	Contraceptive Prevalence Rate
<b>CTO</b>	Cognizant/Contracting Technical Officer
<b>DET</b>	Directorate of Education and Training at the Ministry of Health
<b>DG</b>	Director General (at the Governorate level)
<b>DHS</b>	Demographic Health Surveys (Macro International)
<b>DMPA</b>	Depot Medroxy-Progesterone Acetate (Depo-Provera)
<b>DOS</b>	Department of Statistics
<b>DPHC</b>	Directorate of Primary Health Care
<b>DPP</b>	Directorate of Planning and Projects
<b>EU</b>	European Union
<b>FH</b>	Family Health
<b>FP</b>	Family Planning
<b>GDP</b>	Gross Domestic Product
<b>GFR</b>	General Fertility Rate
<b>GOJ</b>	Government of Jordan
<b>HC</b>	Health Centers
<b>HCM</b>	Health Communications and Marketing
<b>HMIS</b>	Health Management Information Systems
<b>HTT</b>	Health Team Trainer
<b>IEC</b>	Information, Education and Communication
<b>IPPF</b>	International Planned Parenthood Federation
<b>IUD</b>	Intrauterine Device
<b>JAFPP</b>	Jordan Association for Family Planning and Protection
<b>JAFS</b>	Jordan Annual Fertility Survey
<b>JFPA</b>	Jordan Family Planning Association
<b>JHFS</b>	Jordan Husbands' Fertility Survey
<b>JHU/PCS</b>	Johns Hopkins University/Population Communication Services
<b>JICA</b>	Japan International Cooperation Agency
<b>JNPC</b>	Jordan National Population Commission
<b>JPFHS</b>	Jordan Population and Family Health Survey
<b>KAP</b>	Knowledge, Attitudes and Practices
<b>LAM</b>	Lactational Ammenhoreah Method
<b>MCH</b>	Maternal and Child Health
<b>MIS</b>	Management Information System
<b>MOH</b>	Ministry of Health

<b>MRO</b>	Market Research Organization
<b>NGO</b>	Nongovernmental Organization
<b>NPS</b>	National Population Strategy
<b>OC</b>	Oral Contraceptive
<b>PES</b>	Policy Environment Score
<b>PHC</b>	Primary Health Care or Primary Health Center
<b>PHCI</b>	Primary Health Care Initiatives project
<b>PHR</b>	Partnerships for Health Reform
<b>PIR</b>	Performance Improvement Review
<b>RH</b>	Reproductive Health
<b>RMS</b>	Royal Medical Services
<b>QA</b>	Quality Assurance
<b>QI</b>	Quality Improvement
<b>QIP</b>	Quality Improvement Program
<b>SES</b>	Socioeconomic Status
<b>STI</b>	Sexually Transmitted Infection
<b>STTA</b>	Short-term Technical Assistance
<b>SOW</b>	Scope of Work
<b>TA</b>	Technical Assistance
<b>TFR</b>	Total Fertility Rate
<b>TOT</b>	Training of Trainers
<b>UN</b>	United Nations
<b>UNDP</b>	United Nations Development Program
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>UNRWA</b>	United Nations Relief and Works Agency for Palestine Refugees in the Near East
<b>USAID</b>	United States Agency for International Development
<b>WHO</b>	World Health Organization

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# 1. Introduction

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## 1.1 Primary Health Care Initiatives Project (PHCI)

In cooperation with the Hashemite Kingdom of Jordan, USAID/Jordan developed a comprehensive program to improve the provision of primary and reproductive health care in the public sector. The Primary Health Care Initiatives (PHCI) project is a five-year bilateral project designed to meet the needs of the Ministry of Health (MOH) in achieving their goal of improved primary health care in Jordan. The goals of the project are to improve access to and quality of reproductive and primary health care services through an integrated family health model. These goals are to be achieved through six key interventions:

- Quality Assurance
- Primary Health Care Training and Continuing Education
- Health Management Information Systems (HMIS)
- Renovation and Equipment
- Research and Evaluation
- Health Communications and Marketing (HCM)
- Management Strengthening

The project is expected to contribute towards the achievement of USAID/Jordan's Strategic Objective SO3: Improve access to and quality of reproductive and primary health care; and to assist the MOH achieve its Primary Health Care (PHC) strategy. The Project activities correspond with two intermediate results that are part of the USAID Mission's strategic framework:

IR3.1: Improved knowledge of contraceptive methods and reproductive health.

IR3.2: Increased availability of reproductive and primary health care.

The project, which began in 1999, is being implemented throughout the country and aims to improve the performance of the existing primary care network of public facilities.

### 1.1.1 Framework for PHCI Implementation

Jordan's demographic and epidemiological profile makes it vitally important to incorporate reproductive health into a model of restructured and improved primary care. Experience and lessons learned have shown that throughout the world, providing reproductive health (RH) services through primary health care (PHC) facilities responds to strong client preference to receive care in one location and from familiar providers. Integrating reproductive health services provides a number of benefits, not only to clients, but also to the health delivery system as a whole. Some of the benefits include continuity of care, reduction of missed opportunities, more

cost effective improvements in quality of management and clinical services and, most importantly, improved coverage due to increased client demand.

### **1.1.2 PHCI Mission**

*PHCI will demonstrate that improvements in quality of care can be achieved and sustained at both facility and household levels by establishing an integrated model of family health care, in which family preventive and curative health needs, including reproductive health, are satisfied by a family health provider team, in a holistic manner.*

### **1.1.3 PHCI Strategic Framework**

Abt Associates Inc. and its partners are collaborating with the MOH, as well as other ongoing projects, to implement a model of family health care in which reproductive health, child health, adult health and health promotion will be delivered by a family health provider team as an integrated package of services. The PHCI project interventions will be implemented simultaneously in order to produce maximum and sustainable impact.

The integrated approach consists of the following components:

#### **Supply Improvements**

- Clinical Training
- Management Development
- Health Management Information Systems (HMIS)
- Facility Renovation
- Provision of Essential Equipment

#### **Demand Improvements**

- Demand Creation
- Management of Customer Expectations
- Customer Feedback
- Community Outreach

#### **Quality Improvements**

- Quality Standards
- Performance Improvement
- Monitoring and Feedback
- Staff Improvement

#### **Applied Research**

- Quality Improvement
- Service Delivery
- Access
- Demand Sustainability

#### 1.1.4 Partnership with Counterparts and Stakeholders

To promote partnership and coordination with the Ministry of Health, PHCI specified the creation of a project Steering Committee. This Steering Committee is composed of primary health directors at the directorate level of the MOH and is chaired by the Undersecretary of the MOH. It is charged with providing advice and counsel to the project team, as well as to monitor project implementation.

The PHCI team works closely with a group of appointed MOH counterparts and other local experts in all aspects of project implementation. Each technical component works concurrently with a designated counterpart team, and technical working groups provide invaluable assistance in the implementation of the project. This collaborative PHCI/MOH team –comprised of project staff and MOH counterparts – plans, designs and implements activities according to the project goal of improving primary health care in Jordan.

#### 1.1.5 Commitment to Applied Research

One of the project’s major components is Research and Evaluation. In the project’s *Annual Workplan - Project Year Two*, the PHCI/MOH Research Team proposed to coordinate efforts to develop national research strategies in primary health care and reproductive health and family planning.

To place this effort into context, it is important to recall the general mandate of the project. PHCI is tasked with assisting the MOH achieve improvements in access to and quality of primary health care and reproductive health in Jordan. To fully achieve this objective, the project needs to undertake applied research to better inform both the project’s implementation, as well as broader decision making in Jordan. In other words, PHCI intends to undertake research that will improve the success of the project as well as improve the ability of other stakeholders including the MOH, other Ministries, donors, implementing agencies, universities, etc. to make decisions regarding health care in Jordan. PHCI’s research process model and its expected outcomes is shown in Figure 1.1 on the following page.

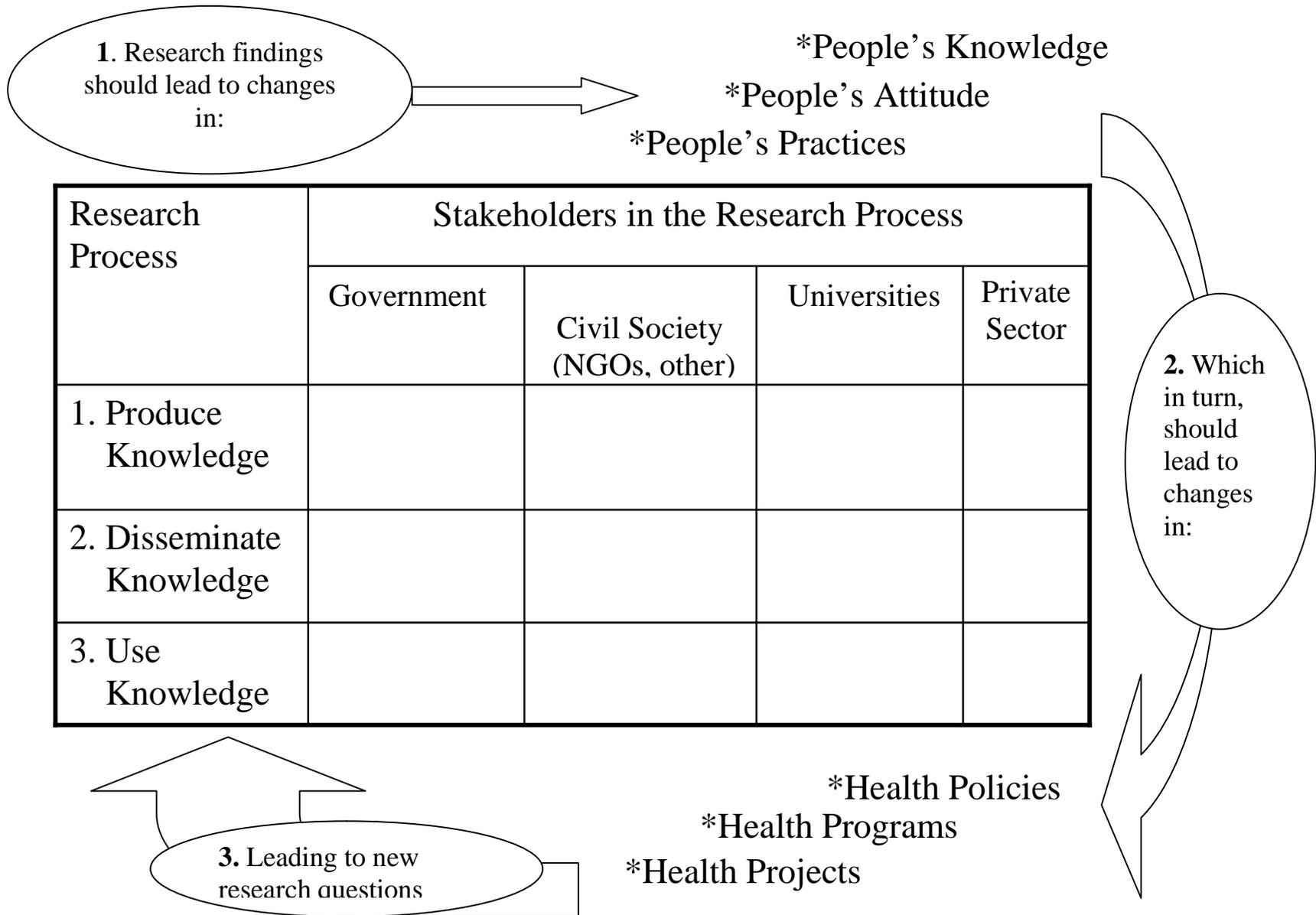
As stated in the Research component section of the PHCI Annual Workplan PY2, PHCI planned for the following activities to support the project objective of *conducting research to support quality improvements in reproductive and primary health care*.

Coordinate RH/FP Related Research Activities among the Family Planning Community. Although much research has been conducted on different family planning and health topics, many questions still remain suggesting gaps in our understanding of RH/FP and health trends. Moreover, there have been minimal efforts to synthesize the different research to create a common understanding of the FP situation that would point to strategic directions to address the stalled contraceptive prevalence rate (CPR). PHCI proposes convening a meeting among CAs, counterparts and Jordanian researchers working on RH/FP issues to: a) determine what current research exists on RH/FP, b) identify gaps in the research, and c) coordinate which group and agency will conduct the needed research. In addition, the participants will discuss dissemination

strategies to foster greater understanding and consensus on RH/FP priorities.

Collaborate with other PHCI Technical Components on Targeted Research Activities. As noted in the workplan, each of the technical areas has identified research activities that will help shape their technical strategies, provide additional information on RH/FP and PHC issues and evaluate the impact of their activities. The Research Technical Advisor will assist them to carry out these research activities.

**Figure 1.1: A RESEARCH MODEL – Purpose, Process and Stakeholders**



Source: Dr. Richard Yoder

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## 1.2 Objective of Establishing a National Research Agenda

The primary purpose of developing a national RH/FP research agenda was to build a set of research questions to guide reproductive health research activities over the next three to five years. With this set of prioritized research questions, the MOH, universities, donors, and others can select questions that are consistent with their mandate for implementation. A second purpose was to initiate a process of dialogue among stakeholders around critical health sector issues.

Thus, the aim of establishing a national research agenda is to identify issues that deserve attention, determine the adequacy of existing research findings on issues of importance to stakeholders, decrease the duplication of efforts among stakeholders, and serve as a mechanism to support collaborative efforts in research endeavors in Jordan.

This is the first national research agenda to be developed in Jordan. It is crucial that strong partnerships be developed and maintained to ensure that the resulting collaborative associations are lasting.

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## 1.3 Methodology

The methodology for this process was similar to that used to initiate the development of the PHC research agenda (see separate report). PHCI realized that it would be extremely helpful in the long run to provide support in the development of a *national* research agenda, rather than strictly defining a *PHCI* research agenda<sup>1</sup>. The project desired to promote a collaborative environment in which various groups could come together to discuss the health issues in Jordan and determine the most pressing research needs for the country. A participatory approach was thus utilized to encourage the involvement of a wide range of stakeholders.

### 1.3.1 Participatory Approach

PHCI/MOH believes that participatory approaches are essential and productive methods to accomplish sustainable end results. Participatory approaches in development work have been widely successful over the past two decades in determining needs, designing programs, evaluating projects and reaching consensus.

"Participatory development stands for a *partnership* which is built upon the basis of a *dialogue* among the various actors (stakeholders), during which the 'agenda' is set jointly, and local views and indigenous knowledge are deliberately sought and respected. This implies *negotiation* rather than the dominance of an externally set project agenda. Thus people become actors instead of being simply beneficiaries"  
(Evaluation of Programs Promoting Participatory Development and Good Governance: Synthesis Report, OECD/DAC 1997)

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<sup>1</sup> Note: PHCI will eventually define its own research plan based upon the results of this process, in accord with its mandate and the expectations of USAID.

PHCI/MOH hoped to ensure that a wide range of stakeholders was able to participate in this first phase in the process of developing a national RH/FP research agenda in Jordan. Participation of a variety of stakeholder groups – including the MOH, USAID, other donors, implementing agencies, universities, private sector – permitted varying perspectives, knowledge, experiences and ideas to influence discussions. Including local experts and those involved in RH/FP ensures that extremely important information regarding the Jordanian context – such as social structure, economic environment, conditions, traditions, perspectives and attitudes – is considered throughout the process. Such perspectives are critical in developing national frameworks and in defining priorities that are important to a large multidisciplinary group of stakeholders.

'Participatory development stands for **partnership** which is built upon the basis of dialogue among the various actors, during which the agenda is jointly set, and local views and indigenous knowledge are deliberately sought and respected. This implies negotiation rather than the dominance of an externally set project agenda.' (OECD, 1994)

### 1.3.2 Preliminary Research

To best prepare for the development of a national RH/FP research agenda, it was first necessary to assess which research questions had already been adequately answered in Jordan and highlight gaps in existing research. PHCI contacted donors, implementing agencies, the MOH, and others involved in RH/FP activities in order to collect existing studies on RH/FP in Jordan. In addition, the project conducted literature reviews and collected other published reports including a limited number of relevant studies conducted in other countries.

The products developed during the preliminary stages of developing national research agendas in PHC and RH/FP resulted in a series of reports. Volumes III and IV of this series present summarized findings from collected RH/FP research. Volume III contains a consolidated matrix that briefly summarizes the findings from the collected studies and Volume IV comprises a set of summaries that document the objectives, methodology, findings and recommendations for each study collected. It is hoped that the research community will utilize these resources in the process of prioritizing the research agenda, as well as for planning future research efforts.

In addition to the collected research are recent findings from data analysis conducted by PHCI. Marilyn Wilkinson (Abt Associates) documented that “the contraceptive prevalence rate for both all methods [modern *and* traditional] and modern methods has remained constant in recent years (since 1997/1998), although a larger absolute number of married Jordanian women are using contraception given the increasing number of women marrying and entering their reproductive years.” While PHCI can make assumptions regarding the reasons behind the leveling off of the CPR, such as the notion that those women likely to use FP have already adopted a method (as seen in Mexico), the precise reasons for this trend have not been fully determined. This is of particular concern to USAID, which aims to work with the Government of Jordan to achieve an overall modern contraceptive prevalence rate of 43.7 percent by 2004.

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### **1.3.3 The RH/FP Research Roundtable**

In the spirit of participation, the PHCI/MOH team decided that the most appropriate approach to initiating the process of developing a national RH/FP research agenda would be to hold a roundtable consultation. Various stakeholders were invited to this session to allow for open and productive discussion of important RH/FP issues. In addition, seven professionals with extensive backgrounds in RH/FP were invited to make presentations.

The following sections of this report detail the outcomes of the RH/FP research roundtable, highlights the extent of previous research conducted on certain topics, and presents optional next steps to further develop the agenda. The agenda of the Research Roundtable is attached as Annex B.

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## 2. Identifying RH/FP Research Topics

The Research Roundtable IV: Building a Research Agenda for Reproductive Health and Family Planning was held on April 10, 2001 at the Amra Hotel in Amman. A list of participants is provided in Annex A.

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### 2.1 Presentations

As mentioned, seven professionals were asked to make presentations at the roundtable. The presenters, listed below, were selected in an effort to provide extensive representation of different perspectives, levels of experience in RH/FP research and knowledge of vital RH/FP needs in Jordan. The presenters were asked to reflect on and respond to the issue of why the contraceptive prevalence rate (CPR) is leveling off and to identify specific research questions arising from their reflections.

The presenters included:

- Dr. Mohammed Batayneh, Director, Maternal and Child Health, MOH
- Mr. William Goldman, Director, Population and Family Health, USAID
- Dr. Adnan Abbas, Chair, Jordan Public Health Association
- Dr. Ra'eda Al Qutob, Advisor, Childhood and Public Health, Office of Her Majesty Queen Rania Al-Abdullah
- Mr. Abdur Rahim Al Ma'aytah, National Population Commission
- Dr. Amal Dagestani, Coordinator, Futures Group International
- Dr. Richard Yoder, Research Advisor, PHCI

Following each presentation (included in Annex D), the floor was open for questions and comments. Sincere dialogue representative of the various stakeholders' perspectives and missions resulted and helped to guide to subsequent discussions. Individual comments, questions and concerns reflected the various perspectives, experience and opinions of those present.

In addition to the open exchange of ideas during discussions, a handout was provided to each participant (Annex C). PHCI/MOH designed this handout with a basic matrix to allow participants to record in writing any topics or questions, by category of research, that were not stated formally during the roundtable. These handouts were collected by PHCI at the end of the consultation and the written comments were included in the consolidated list of research topics (see Section 2.2).

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## 2.2 Research Topics by Category

To organize and summarize the results of the research roundtable, PHCI worked to consolidate the research topics identified by the presenters and participants. The categories selected for organizational purposes include **systems**, **demand** and **supply**.

Ideally, each topic and the related questions would be placed within only one category. Given the complexity of the health care market, however, this is not possible. There is a great deal of overlap among the three categories and the types of corresponding questions.

**Table 2.1: Illustration of Potential Issues within Selected Research Framework**

<b>Systems</b>	<b>Demand</b>	<b>Supply</b>
Referral systems	Client attitudes	Service delivery
Logistics	Client practices	Provider practices
Insurance	Care seeking behaviors	Effects of quality
Management	Knowledge	User fees
Etc.	Etc.	Etc.

### *Categorization of Identified Research Questions within Research Framework*

The following pages present the research topics and questions identified by stakeholders within the framework presented above.

**Table 2.2: Matrix of Main RH/FP Research Topics within Framework Identified at the RH/FP Roundtable**

<b>Systems</b>	<b>Demand</b>	<b>Supply</b>
<i>Integration of RH/FP into PHC</i>	<i>Integration of RH/FP into PHC</i>	<i>Integration of RH/FP in PHC</i>
Policy	Fertility Demand	Access and Availability
Regulatory Environment/Laws	Contraceptive Prevalence Rate (CPR)	<i>Quality of Care</i>
Financing	Unmet Need for Family Planning	Role of NGOs
Referral Systems	Continuation of Family Planning Methods	Information, Education and Communication
Overlap among Donors	Contraceptive Method Mix	Community Participation
Data Collection	Client Attitudes and Behaviors (including the effects of <i>quality of care</i> on demand)	<i>Adolescent Reproductive Health</i>
	Care-Seeking Behaviors (including the effects of <i>quality of care</i> on demand)	Insurance
	Determinants of Fertility	Provider Attitudes and Behaviors
	Target Populations	Provider Training
	<i>Adolescent Reproductive Health</i>	Provider Preferences
	Health Status Issues	Provider Motivations

\* Research topics that are repeated in more than one category are represented in *italics*.

**Table 2.3: Matrix of Specific RH/FP Research Questions within Framework Identified at the RH/FP Roundtable**

<b>Systems</b>	<b>Demand</b>	<b>Supply</b>
<p><b>Policy</b></p> <ul style="list-style-type: none"> <li>• Family Planning considered as a component of reproductive health/women' s health. Need for or presence of a policy for reproductive health/women' s health in Jordan.</li> <li>• Political commitment for population policy exists that is inclusive of family planning.</li> <li>• Family planning used as a mean to improve women' s health status or an end to achieve a demographic goal.</li> <li>• Awareness of policy makers regarding reproductive health rights and extent that awareness is translated into action.</li> <li>• Existence of policies that ensure equity in the provision of FP services.</li> <li>• Impact of the frequently changing government on population policy/family planning and overall sustainability of the policy commitment.</li> <li>• Responsibilities for setting RH/FP policies and incorporation of gender perspective.</li> <li>• Effects of prolonged maternity leave policies on fertility and birth spacing.</li> </ul>	<p><b>Fertility Demand</b></p> <ul style="list-style-type: none"> <li>• Utility of children in Jordan.</li> <li>• "Economic model" to measure the relative demand for children.</li> <li>• Factors contributing to the relatively large ideal family size.</li> <li>• Interventions that could change the desire for large families.</li> </ul>	<p><b>Integration</b></p> <ul style="list-style-type: none"> <li>• Effect of integration of RH/FP into PHCs vs. vertical programs.</li> <li>• Acceptability of integration for the PHC staff.</li> <li>• Barriers at integrated centers for RH/FP utilization.</li> </ul>
<p><b>Regulations/Laws</b></p> <ul style="list-style-type: none"> <li>• Existence of laws and regulations that effect RH/FP/women' s health.</li> <li>• Awareness of couples and providers regarding rights.</li> <li>• Role of public sector in regulating and monitoring FP service provision in the private sector to ensure access, equity and quality.</li> <li>• Extent that the private sector is involved in setting policies/strategies related to RH/FP.</li> </ul>	<p><b>Determinants of Fertility</b></p> <ul style="list-style-type: none"> <li>• Determinants of fertility.</li> <li>• Impact of women' s economic participation on fertility and contraceptive use. Interaction with education and women status indicators.</li> <li>• Comparison of socioeconomic characteristics of high fertility and low fertility couples</li> <li>• Impact of complimentary measures (non-direct FP) on contraceptive use:</li> <li>• Status of women (education, financial independence, access to credit, decision making roles, employment, etc.)</li> <li>• Size and distribution of income and wealth</li> <li>• Improvements in quality of PHC system</li> <li>• Impact of an integrated Family Health model of PHC on fertility</li> </ul>	<p><b>Access and Availability</b></p> <ul style="list-style-type: none"> <li>• Adequacy and maintenance of volume at PHCs.</li> <li>• Consequences of premature cost recovery.</li> <li>• Methods for cost containment with individual providers.</li> <li>• Availability of condoms in STD clinics.</li> <li>• Clinics' role in attracting clients for services.</li> </ul>

Systems	Demand	Supply
<p><b>Financing</b></p> <ul style="list-style-type: none"> <li>• Financing of FP services.</li> <li>• Means to improve sustainability of FP.</li> <li>• Effects of user fees on the use of RH/FP services.</li> </ul>	<p><b>Contraceptive Prevalence Rate (CPR)</b></p> <ul style="list-style-type: none"> <li>• Factors leading to the leveling off of the CPR in Jordan.</li> <li>• Characteristics of non-user (contraceptive) groups.</li> <li>• Reasons for variation in distribution of contraceptives from month to month (especially for IUD insertion).</li> <li>• Effect of distribution variation on overall fertility rate in Jordan.</li> </ul>	<p><b>Quality</b></p> <ul style="list-style-type: none"> <li>• Effect of quality at MCH centers on utilization.</li> </ul>
<p><b>Integration</b></p> <ul style="list-style-type: none"> <li>• Optimal level (model) of integration for RH/FP within the MOH.</li> <li>• Sustainability of integrated services as compared to vertical programs.</li> </ul>	<p><b>Unmet Need for FP</b></p> <ul style="list-style-type: none"> <li>• Contributing factors to the high degree of unmet need for FP in Jordan.</li> <li>• SES characteristics of couples with unmet needs.</li> <li>• Possible interventions to decrease unmet need (policy, system or services).</li> </ul>	<p><b>Role of NGOs</b></p> <ul style="list-style-type: none"> <li>• Role of NGOs in the provision of RH/FP services.</li> <li>• Need for expansion of NGOs' roles.</li> </ul>
<p><b>Referral Systems</b></p> <ul style="list-style-type: none"> <li>• Needs for RH/FP referrals (conditions and volume at PHCs).</li> <li>• Status of current referral system.</li> <li>• Effectiveness of approaches to improving the referral system (TBD).</li> </ul>	<p><b>Continuation</b></p> <ul style="list-style-type: none"> <li>• Continuation rates for contraceptive methods.</li> <li>• Characteristics of discontinuers.</li> <li>• Factors contributing to discontinuation.</li> <li>• Means to improve continuation rates.</li> </ul>	<p><b>IEC</b></p> <ul style="list-style-type: none"> <li>• Effectiveness/adequacy of IEC efforts for RH/FP.</li> </ul>

<p><b>Overlap over among Donors</b></p> <ul style="list-style-type: none"> <li>• Extent of overlap among various donors.</li> <li>• Feasibility of eliminating overlaps.</li> <li>• Donors and unwarranted expectations.</li> </ul>	<p><b>Method Mix</b></p> <ul style="list-style-type: none"> <li>• Reasons for IUD preference.</li> <li>• Factors contributing to the apparent lack of acceptance of new contraceptives (e.g., Norplant and injectables) versus more established methods in Jordan.</li> <li>• Effectiveness of introducing new methods in Jordan (Norplant, injectables). Effectiveness of “pushing” methods that are not highly utilized, such as condoms.</li> <li>• Effectiveness/viability of careful client-sensitive controlled introduction of injectables.</li> <li>• Factors making traditional methods attractive to clients and ways in which programs can take advantage of these preferences.</li> <li>• Probability that users of traditional methods can be converted to modern methods and ways to best serve traditional users’ interests.</li> <li>• Possibility that mothers could be influenced to change from breastfeeding to LAM,.</li> <li>• Costs of condoms and the effect of cost on usage.</li> <li>• Condom use rate among married men.</li> <li>• Feasibility of introducing vasectomy as part of the method mix.</li> </ul>	<p><b>Community Participation</b></p> <ul style="list-style-type: none"> <li>• Community participation in planning, designing, implementing FP services.</li> <li>• Community interests in participating in planning, implementing FP programs.</li> <li>• Cost-effectiveness of CBS program and feasibility of nationalizing training, materials and incentives.</li> <li>• Feasibility that condom use be campaigned through projects designed and implemented by male partners in a community-based activity.</li> </ul>
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<p style="text-align: center;"><b>Systems</b></p> <p><b>Data Collection</b></p> <ul style="list-style-type: none"> <li>• Appropriate mechanism to collect information regarding RH/FP (Annual Fertility Survey, DHS, etc.).</li> <li>• Correct conversion rates in Jordan to estimate the CYP from the distribution of contraceptives.</li> </ul>	<p style="text-align: center;"><b>Demand</b></p> <p><b>Client Attitudes and Behaviors</b></p> <ul style="list-style-type: none"> <li>• Level of social acceptance of FP.</li> <li>• Indicators of quality according to the patient.</li> <li>• Effect of religion on client behavior in FP.</li> <li>• Presence of changes in demand for contraceptives in the months prior to Ramadan and reasons why.</li> <li>• Attitudes and opinions regarding the use of oral contraceptives among patients.</li> <li>• User barriers to increased use of oral contraceptives.</li> </ul>	<p style="text-align: center;"><b>Supply</b></p> <p><b>Adolescent Reproductive Health</b></p> <ul style="list-style-type: none"> <li>• Adequacy of school health programs for adolescents’ needs for reproductive health information.</li> <li>• Factors contributing to the success of UNRWA services for youth.</li> </ul>
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**Care-Seeking Behaviors**

- Factors influencing the decision regarding where clients seek RH/FP services.
- Factors causing changes in trends regarding source of RH/FP services.
- Primary location of where clients seek care and type of provider (doctors, midwives, pharmacists).
- Client perceptions of nurses and midwives.
- Relationship between male providers and contraceptive use.
- Client population's preferred source of information about RH/FP.
- Care-seeking behavior of females in Jordan for STI services.

**Insurance**

- Extent that private insurance schemes include FP methods and services in their packages.
- Ways to motivate insurers to include FP.

**Systems**

**Demand**

**Supply**

	<p><b>Integration</b></p> <ul style="list-style-type: none"> <li>• Factors encouraging usage at freestanding MCH centers. Qualitative research examining why FP services appear to be under-utilized in PHCs, as well as to determine barriers to FP/RH.</li> <li>• Acceptability of integration for the clients.</li> <li>• Effect of integration on utilization rates of RH/FP services.</li> </ul>	<p><b>Provider Attitudes</b></p> <ul style="list-style-type: none"> <li>• Factors causing health providers to have misconceptions about contraceptive use and preferences for certain methods over others.</li> <li>• Attitudes and opinions regarding the use of oral contraceptives among health care providers.</li> <li>• Provider barriers to increased use of oral contraceptives.</li> <li>• Effects of provider misinformation/misconception on contraceptive choices made by clients.</li> <li>• Effectiveness of counseling practices of physicians and the practicality that physicians be counselors.</li> <li>• Adequacy of FP counseling given to couples by health providers and ways to improve quality.</li> <li>• Characteristics of providers who fail to provide appropriate FP counseling (conservative, undertrained).</li> <li>• Factors causing a drop in contraceptive use in the months prior to Ramadan, and ways providers can play a role in eliminating the decrease.</li> <li>• Perceptions and attitudes of physicians towards nurses and midwives, especially with regard to the integration of FP into PHCs and the possibility of expanded roles (e.g., IUD insertion).</li> </ul>
	<p><b>Target Populations</b></p> <ul style="list-style-type: none"> <li>• Identification of underserved populations.</li> <li>• Ways to target the population aged 15-25 to increase their demand for contraceptives.</li> <li>• Ways to target newly married couples for FP.</li> <li>• Contraceptive practices among mothers with children aged 0-3.</li> <li>• Ways to improve family planning in polygamous marriages.</li> <li>• Measures to make males more instrumental in sustaining FP services.</li> </ul>	<p><b>Provider Training</b></p> <ul style="list-style-type: none"> <li>• Extent of RH/FP in medical and nursing curricula.</li> <li>• Effects of Academic Health institutions' curricula on perceptions of contraceptives (encourage or create myths and misconceptions).</li> <li>• Need for review and/or update of curricula.</li> <li>• Effective utilization of nurses and midwives in F/P programs and definition of their roles.</li> <li>• Feasibility of the MOH training a certain number of midwives in IUD insertion.</li> <li>• Feasibility of other professionals (university graduates in social sciences in other ministries) who could, after receiving proper training, provide effective counseling.</li> </ul>

	<p><b>Adolescent Reproductive Health</b></p> <ul style="list-style-type: none"> <li>• Reproductive health needs of adolescents (needs assessment).</li> <li>• Extent of adolescents' knowledge regarding STIs.</li> <li>• Psychological effects of adolescence that affect health.</li> </ul>	<p><b>Provider Preferences</b></p> <ul style="list-style-type: none"> <li>• Impact of providers pushing products.</li> </ul>
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Systems	Demand	Supply
	<p><b>Health Status</b></p> <p><i>Reproductive Health</i></p> <ul style="list-style-type: none"> <li>• Prevalence of gynecological and related morbidities among women (</li> <li>• Women's perceptions about their reproductive health status.</li> <li>• Care-seeking behaviors of women with symptoms.</li> </ul> <p><i>Antenatal and Postnatal Care</i></p> <ul style="list-style-type: none"> <li>• Number of antenatal care visits.</li> <li>• Prevalence of hypertension disorders of pregnancy, gestational diabetes mellitus, anemia.</li> <li>• Extent of utilization of postnatal care services (at the national level).</li> <li>• Quality of postnatal care received.</li> <li>• Causes of non-utilization of antenatal and postnatal care.</li> </ul> <p><i>STIs</i></p> <ul style="list-style-type: none"> <li>• Prevalence of STIs among women.</li> <li>• Extent of utilization of health services by women with STI symptoms.</li> <li>• State of knowledge of women about STIs (symptoms, transmission, complications, and prevention).</li> </ul> <p><i>Osteoporosis</i></p> <ul style="list-style-type: none"> <li>• Prevalence of osteoporosis among menopausal women.</li> <li>• Women's awareness of the seriousness of the condition and ways to prevent it.</li> </ul> <p><i>Children with special needs</i></p> <ul style="list-style-type: none"> <li>• Prevalence of deafness among children and common causes.</li> </ul>	<p><b>Provider Motivations</b></p> <ul style="list-style-type: none"> <li>• Motivating factors for providers to provide quality RH/FP services.</li> </ul>



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## 3. Existing RH/FP Knowledge

PHCI made an effort to collect as much existing documentation of previous RH/FP research conducted in Jordan as possible. The following section utilizes information that was readily available to identify which topics have been covered previously and where gaps remain. This report, however, should not be considered as exclusive or exhaustive; without doubt, much relevant research has been completed that was not identified or collected. This document serves to inform stakeholders only of information that was collected by PHCI. Additional resources, including findings from research conducted in other countries, should be sought and taken into consideration when further steps are taken.

The following section details specific research topics and relevant findings that were discovered in the collected resources. The following discussion is illustrative and presents select findings; users of the document are encouraged to refer to the Volume III: Matrix of Existing Research in Reproductive Health and Family Planning in Jordan and Volume IV: Summaries of Existing research in Reproductive Health and Family Planning in Jordan reports for more detailed information regarding each topic. A matrix that links each identified research topic with relevant RH/FP studies included in the matrix and summaries reports in included in Annex E.

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### 3.1 Systems Related Research

#### 3.1.1 Policy Environment for Reproductive Health and Family Planning

Research Questions Related to RH/FP Policy Environment
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| <ul style="list-style-type: none"><li>• Family Planning considered as a component of reproductive health/women's health. Need for or presence of a policy for reproductive health/women's health in Jordan.</li><li>• Political commitment for population policy exists inclusive of family planning.</li><li>• Family planning used as a mean to improve women's health status or an end to achieve a demographic goal.</li><li>• Awareness of policy makers regarding reproductive health rights and extent that awareness is translated into action.</li><li>• Existence of policies that ensure equity in the provision of FP services.</li><li>• Impact of the frequently changing government on population policy/family planning and overall sustainability of the policy commitment.</li><li>• Responsibilities for setting RH/FP policies and incorporation of gender perspective.</li><li>• Effects of prolonged maternity leave policies on fertility and birth spacing.</li></ul> |
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There are many active players at the policy level in Jordan. One major organization in the RH/FP policy environment is the Jordan National Population Commission (JNPC), which was founded in 1973 as a body to advise the government on population issues. Its current objectives include advocating for the development and adoption of population and reproductive health policies and increasing public awareness regarding the social and economic development impacts of population issues in Jordan. While this organization has been in existence for nearly 20 years and

works to promote progress in RH/FP, the existence of and support for population policies in Jordan was lacking until recently.

In the past, policy and programmatic approaches have focused more on maternal and child health (MCH) services than family planning services (*“Respect for Religion and Tradition: Key to Family Planning in Jordan”*, 1990). This emphasis on MCH was referred to as a creative means to reducing birth rates, since it avoided sparking opposition to FP (based on religious beliefs) by emphasizing birth spacing as a health benefit to mothers and children.

The POLICY Project – implemented by the Futures Group International, the Center for Development and Population Activities (CEDPA) and the Research Triangle Institute (RTI) – is another major player in considering issues related to RH/FP policy in Jordan. In 1998, the project conducted a multi-country comparative study to assess the status of the RH environment since the 1994 International Conference on Population and Development (ICPD, also referred to as the Cairo Conference). The study reports that Jordan’s political support and level of participation in promoting the acceptance of the ICPD agenda was not sufficient. Although the JNPC had made some changes since the ICPD, the overall participation of stakeholders in the policy-making settings was slight. At that time, additional commitment and dedicated resources were necessary to allow for a full implementation of the ICPD recommendations.

In 1998, the *Reproductive Health Case Study – Jordan* was completed by the POLICY Project. It noted that Jordan lacked a formal process for transforming policy dialogue into actual policies. Needs were identified for evidence-based decision-making; broader and active participation of all stakeholders; raising awareness; improving the infrastructure; and training personnel.

In 2000, the POLICY Project completed the second of two Policy Environment Score (PES) reports in Jordan (*Measuring the Degree to Which the Policy Environment in Jordan Supports Effective Policies and Programs for Reproductive Health*). Overall, it appears the RH environment has been improving since the last PES assessment completed in 1997. These findings show that the policy environment for FP is good, improvements were needed in the use of data in programming, the participation of the private sector in policy development and the involvement of other ministries in implementation.

At present, political support seems to be rather strong for reproductive health and family planning. Moreover, the political environment lacks many barriers to comprehensive RH programs including the absence of severe limitations on the use of media, high commitment and awareness of political leaders and general freedom of providers to supply FP services.

Additional information is likely available from the MOH, JNPC, the POLICY Project and others, and should be examined prior to undertaking additional assessments of the policy environment.

<b>Research Questions Related to Regulations/Laws that Effect RH/FP</b>
<ul style="list-style-type: none"><li>• Existence of laws and regulations that effect RH/FP/women’s health.</li><li>• Awareness of couples and providers regarding rights.</li><li>• Role of public sector in regulating and monitoring FP service provision in the private sector to ensure access, equity and quality.</li><li>• Extent the private sector is involved in setting policies/strategies related to FP.</li></ul>

In the POLICY Project’s 2000 PES Report (see above), the legal and regulatory environment scored less encouragingly than the policy environment, although it is still “respectable.” Overall, Jordan enjoys a reasonably supportive legal atmosphere. There are no limits on the use of IUD, pill or condoms (although services offered by nurses and midwives are limited, see below) and duties are not charged on the importation of contraceptives.

Conversely, there is restricted access to sterilization for both males and females and no formal laws on minimum age at marriage. Additionally, in the *Analysis of Policy and Legal Barriers to Improved Reproductive Health Services in Jordan* (2000), several other serious regulatory barriers were identified. These included the inability of midwives or nurses to insert intrauterine devices (IUD), shortages of funding for community based services (CBS), inadequate RH education in schools, lack of government funding in premarital counseling, and limited dissemination of information on the side effects modern contraceptives.

Note: The *Analysis of Policy and Legal Barriers to Improved Reproductive Health Services in Jordan* report stated that duties were charged on pills and condoms, contrasting the PES study which stated the absence of duties on contraceptives. This existence of duties on contraceptives should be verified.

### 3.1.2 Financing

<b>Research Questions Related to the Financing of RH/FP</b>
<ul style="list-style-type: none"> <li>• Financing of FP services.</li> <li>• Means to improve sustainability of FP.</li> <li>• Effects of user fees on the use of RH/FP services.</li> </ul>

A large amount of donor money is dedicated to RH/FP in Jordan; in 1995, approximately \$5.7 million was spent on FP. In the *Reproductive Health Case Study* report, the POLICY Project noted that while there is data available regarding the financing of FP activities (see below), information is inadequate on the status of RH funding and expenditures. The major funders of FP activities, according to the report, are the Government of Jordan (47 percent), major donors such as USAID, UNFPA, IPPF, and the European Union (38 percent), United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) (4 percent), and self-funding through cost recovery and user fees (11 percent).

The study *Funding and Expenditures within the Jordanian Family Planning Program*, also written in 1998, reported more specific information. The top financier for FP service delivery was the GOJ with the second largest source of funds collected in user-fees paid by clients. USAID provided most of the funding for training (39 percent) and information, education and communication (IEC) (47 percent). Research, evaluation, and policy related activities were funded predominantly by the government (53 percent), followed by USAID (34 percent) and UNFPA (13 percent).

Information related to the effects of user-fees on RH/FP utilization is more vague. It is known that some user-fees exist, as stated above, and that user fees are applied in private and JAFPP clinics. The extent of impact on utilization due to user fees, however, was not discussed in the studies collected and deserves further examination.

### 3.1.3 Integration of RH/FP into Primary Health System

<b>Research Questions Related to the Integration of RH/FP into PHC</b>
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| <ul style="list-style-type: none"><li>• Optimal level (optimal model) of integration for RH/FP within the MOH.</li><li>• Sustainability of integrated services as compared to vertical programs.</li></ul> |
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Since the integration of RH/FP into the PHC system is untested in Jordan, information was not found. Resources should be sought, however, that discuss experiences of integration in other countries.

### 3.1.4 Referral System

<b>Research Questions Related to Referral Systems</b>
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| <ul style="list-style-type: none"><li>• Need for RH/FP referrals (conditions and volume at PHCs).</li><li>• Status of the current referral system.</li><li>• Effectiveness of approaches to improving the referral system (if improvements are implemented).</li></ul> |
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Formal referral procedures are limited in the public health system in Jordan. *The MOH Institutions Medical Referral System for Non-Urgent Cases* describes some inefficiencies and problems of the current MOH system. Largely, the system is ineffective due to insufficient information sharing and a lack of understanding by providers as to the importance of referrals and the documentation of successful referrals.

The Comprehensive Postpartum Project (CPP) attempted to initiate an integrated referral system (among CPP centers, MCH clinics, hospitals, and other facilities). The main problems with the referral system, as stated in the *CPP Operations Research - the Referral System* report, were clients failing to bring referral slips with them to the centers; staff at centers failing to contact the referring center leading to inaccurate records; and other information gaps. Overall, within the CPP context, referrals were not given adequate consideration. Due to a lack of understanding by staff and patients of the importance of referrals and comprehensive record keeping, the system did not function appropriately.

Also reported in the *CPP Brainstorming Results* report, the information provided to both the referral facility and the patient were inadequate. The CPP referral booklet did not contain enough information, for example, for the MCH medical and administrative staff. Patients were not given enough information about the referral center such as location and hours of operation leading to missed/failed appointments. Overall, the CPP referral system required improvements to effectively channel patients from primary to secondary to tertiary care.

Approaches to developing/improving a referral system within the PHC environment, as anticipated in the context of the above questions, have not yet been developed. Evaluative research will be required to assess the effectiveness of any intervention.

### 3.1.5 Donor Coordination

#### Research Questions Related to Overlap among Donors

- Extent of overlap among various donors.
- Feasibility of eliminating overlaps.
- Donors' unwarranted expectations.

It is well known that Jordan receives a large amount of donor funding (see section 3.1.2). The extent of donor overlap was not discussed in any of the reports collected for specific types of activities. This information should be relatively easy to compile, however, by documenting the types of activities being supported by the major donors. Donor expectations were not reported in the studies collected and are probably more difficult to ascertain.

### 3.1.6 Data Issues

#### Research Questions Related to the Collection of RH/FP Data

- Appropriate mechanism to collect information regarding RH/FP (Annual Fertility Survey, DHS, etc.).
- Correct conversion rates in Jordan to estimate couple years of protection (CYP) from the distribution of contraceptives.

The means of collecting data in Jordan are fairly well established. Formal data collection processes include the Jordan Annual Fertility Survey (JAFS), Jordan Population and Family Health Survey (JPFHS), Demographic and Health Surveys (DHS), and others. The needs of the various agencies that manage the collection of data vary, however, and thus it is difficult to state whether or not these approaches are 'appropriate.' While further examination of the data and types of information collected may be warranted, new instruments for data collection may not be necessary. For example, a further examination of the quality of data in the regular surveys may be necessary, as well as an assessment of the adequacy of the range of variables. Discussions with the implementing agencies about the need for additional information, the need to ask questions in a slightly different manner or the need for improved data quality should be considered.

The conversion rates currently used to compute CYP in Jordan are shown below. Marilyn Wilkinson mentioned that discussions regarding the need to modify the conversion factors of CYP in Jordan have occurred in her *Indicator Development and Data Assessment in Jordan* report. A comparison of service statistics using the conversion factors currently used (presented below) with JAFS contraceptive prevalence rate data, however, showed relative consistency. Additional examination of this issue may be deserved to ensure that the calculations of CYP in Jordan are valid and that CYP can be used as a dependable RH/FP indicator.

**Table 3.1: Stock Distribution Conversion Factors to Obtain CYP**

<b>Method</b>	<b>Number for 1 CYP</b>	<b>CYP calculation</b>
Pill	13	Number of cycles distributed/13
IUD	0.3	Number of IUDs inserted/0.3
Condom	120	Number of condoms distributed/120
injectables	4	Number of injections given/4
Vaginal tablets	120	Number of tablets distributed/120
Norplant	0.2	Number of implants/0.2
LAM	2	Number of sessions/2

Source: Marilyn Wilkinson, PHCI Trip Report: Indicator Development and Data Assessment in Jordan

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## 3.2 Demand Related Research

### 3.2.1 Fertility

Research Questions Related to Fertility Demand
<ul style="list-style-type: none"><li>• Utility of children in Jordan.</li><li>• “Economic model” to measure the relative demand for children.</li><li>• Factors contributing to the relatively large ideal family size.</li><li>• Interventions that could change the desire for large families.</li></ul>



An economic analysis of the relative demand for children does not seem to have been completed in Jordan. Resources do exist, however, on economic models used to measure the economic value of children in other developing countries (for example, Gambia, Nepal, Nigeria, Vietnam, and others). It would be useful to acquire such studies to review the methodologies, the appropriateness of such a study in Jordan and the required modifications to established research models. Additional background research should also focus on determining if such studies have been completed in the region to allow for comparison.

Some reports did raise the issue of the “value” of children, although such statements were likely not based on systematic research. The 1990 article *“Respect for Religion and Tradition: Key to Family Planning in Jordan”* stated that children in Jordan are no longer an immediate economic asset. It mentioned that Jordan was no longer a pastoral-agricultural economy with a premium on large families, however that family size had not, at the time of the article, reflected this economic transition. Dr. Ali Othman, advisor to Princess Basma, discussed some changes evident in Jordan in the article:

“Twenty years ago, the cost of having children was small, and it was seen as insurance for the future. Now it is more of a burden than insurance. Children have to be sent to school and college; they want to leave and establish their own families. Instead of being their parents’ pension, they are the dependants! And as a general rule, the more educated the woman, the fewer children she will have.”

These statements are not based on thorough economic analyses, however, and should be taken as possible indications of societal changes that typically impact the economic value of children.

There seem to be several factors that contribute to the desire for a large family. The JNPC and JHU/ CPP study, *Family Planning Knowledge, Attitudes and Practices in Jordan* (1997), discusses issues regarding the value of children and optimum family size. Some Jordanians believe that it is their duty, according to Islamic beliefs, to have many children since children are “gifts from God”. In a CPP Project study, *Rumors and Misinformation Study – Quantitative Research Final Report*, of those women reporting an ideal family size of six or more children, the following justifications for having many children were given: “limitation is forbidden” (31 percent), children are “God’s gift” (31 percent), and children are a “support/pride to their families” (30 percent). Moreover, son preference appears to play a role in a large ideal family size as documented in the above-mentioned JNPC/JHU study.

The preference for large families seems not to be as strong among young Jordanians, as documented in the POLICY Project report *Qualitative Research on RH Knowledge and Needs Among Jordanian Youth*. The findings indicated that the younger generation indeed shows a preference for smaller families and late marriage, which indirectly influences reproductive life periods. The respondents seemed to understand the economic consequences of rapid population growth. An interesting comment was noted in the *CPP Rumors and Misinformation* study that could serve to indicate differing views between the adult population and youth in Jordan. Some adults (of those with 10 or more children) acknowledged the significance of a high birth rate in Jordan but did not seem to feel personally responsible, stating 'it is someone else's fault'. (This study, however, was very limited in sample size and should not be considered as representative of the population).

The *Fertility Preferences and Fertility Regulation Behavior in Jordan* report stated that desired family size seems to be one of the most important correlates of desire for future births and for the intention to use contraception in the future. These desires or intentions are further related to actual use of FP or unmet need of contraception.

<b>Research Questions Related to Determinants of Fertility</b>
<ul style="list-style-type: none"> <li>• Determinants of fertility.</li> <li>• Impact of women's economic participation on fertility and contraceptive use. Interaction with education and women status indicators.</li> <li>• Comparison of socioeconomic characteristics of high fertility and low fertility couples</li> <li>• Impact of complimentary measures (non-direct FP) on contraceptive use.</li> <li>• Status of women (education, financial independence, access to credit, decision making roles, employment, etc.)</li> <li>• Size and distribution of income and wealth</li> <li>• Improvements in quality of PHC system</li> <li>• Impact of an integrated Family Health model of PHC on fertility</li> </ul>

Many articles were published in the mid-1980s regarding determinants of fertility. The analyses resulted from data collected in the World Fertility Survey (1970s) within an already defined economic model (developed by Bongaart) to measure the effects of intermediate variables on fertility. Also reported in the following discussion are results from analyses using national fertility surveys from the early 1980s. The variables affecting fertility in Jordan, according to such studies include:

*Education:* Jordan enjoys relatively high literacy for both men and women. In the recent past, however, females have gained increased access to higher education. As an effect of this improved access, some women have remained in formal educational environments for a longer period of time. It appears that fertility is effected most among women with six or more years of education (those with one to five years of education did not show significant difference in fertility). Increased education has affected age at marriage, which also impacts fertility. Also related to improved educational status of both men and women is an increase in use of modern contraceptive methods. In Jordan, married couples in which both the husband and wife were highly educated have lower fertility than less education couples.

*Age at Marriage:* The average age at marriage in Jordan has increased. When women marry later, their reproductive lives are decreased. In addition, women marrying later have often completed more years of formal education and/or have entered the formal labor force, both of which could improve their status in society. Improved status of women often results in a decline in fertility.

*Occupation:* In Jordan, the husband's occupation was found to have a significant effect on marital fertility. Those families with husbands working in professional and clerical categories had lower fertility than those working in primary industries did. Meanwhile, no relationship was found between women's work status and fertility in another study (see note below). The absence of a relationship was thought to be due to the fact that most employed women, at the time, were engaged in traditional jobs compatible with childcare and breastfeeding.

NOTE: These findings reported above are over 15 years old and should not be relied upon as concrete findings. The environment (social, economic, and political) has changed significantly, and this surely has impacted the variables affecting fertility in Jordan.

The *Family Planning Knowledge, Attitudes and Practices among Currently Married Men and Women in Jordan* study (JNPC) does not directly identify determinants of fertility, but it does allude to factors such as knowledge of FP methods, approval of FP and degree of spousal communication, which significantly influence contraceptive utilization.

### 3.2.2 Contraceptive Prevalence Rate (CPR)

Research Questions Related to Contraceptive Prevalence Rate (CPR)
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| <ul style="list-style-type: none"><li>• Factors leading to the leveling off of the CPR in Jordan.</li><li>• Characteristics of non-user groups.</li><li>• Reasons for variation in distribution of contraceptives from month to month (especially for IUD insertion).</li><li>• Effect of distribution variation on overall fertility rate in Jordan.</li></ul> |
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As mentioned in the introduction, Marilyn Wilkinson documented the leveling off of the contraceptive prevalence rate in Jordan. She suggested that a level contraceptive prevalence rate (CPR) could imply that those women who are likely to use family planning have already adopted a FP method. This would indicate that greater efforts are likely necessary for any additional increases in the contraceptive prevalence rates. Wilkinson mentions that other countries, such as Mexico, have witnessed this trend in their family planning programs. There have been no specific research endeavors in Jordan attempting to determine the factors leading to the leveling off of the CPR, since it was only recently discovered.

The POLICY Project study *Unmet Need and Intention to Use Family Planning Among Jordanian Women* (2000) evaluated reasons for not using FP and also characteristics of non-user groups, as shown in the following tables.

**Table 3.2: Reasons For Not Using Family Planning (%)**

	Want Soon		Want Later		Want No More	
	Do not Intent to use*	Intend To Use	Do not Intent to use*	Intend To Use	Do not Intent to use*	Intend To Use
Fecundity Related	7.2	8.8	5.1	4.8	22.4	10.2
Pregnant or Amenorrheic	5.6	19.6	39.3	72.4	12.2	72.0
Want More Children	76.5	56.8	31.1	12.5	3.5	1.6
Opposition to Use	2.0	6.1	10.2	2.0	12.9	2.4
Lack of Knowledge	--	--	--	--	0.3	--
Health or Side Effects	8.3	8.8	13.3	7.3	44.4	9.6
Accessibility or Cost	--	--	--	--	--	0.6
Other	0.4	--	1.0	0.9	4.2	3.7
Total	100	100	100	100	100	100
# Observations	540	148	196	537	286	510

Source: POLICY Project

**Table 3.3: Demographic Characteristics of Women Across the Different Need Categories Using a Prospective Basis for the Evaluation of All Married Women (%)**

	Not Currently Using Family Planning			Using Traditional Family Planning Methods		Using Modern Family Planning Methods		In-fecund	All Women
	Want Soon	Want to Space	Want to Limit	Want to Space	Want to Limit	Want to Space	Want to Limit		
Age of Women									
15-19	9.5	11.4	1.5	3.5	0.2	3.9	0.2	1.3	3.9
20-24	23.0	35.3	7.1	23.2	3.7	22.1	3.4	4.6	14.6
25-34	43.2	47.6	39.7	61.6	31.7	64.6	34.6	18.1	42.5
35-49	24.3	5.8	51.8	11.7	64.4	9.4	61.8	76.0	39.0
Total	100	100	100	100	100	100	100	100	100
Education Level									
None	7.6	4.6	16.2	3.5	8.7	1.6	8.1	27.0	8.8
Primary	13.1	11.9	20.0	4.8	18.3	8.8	17.8	23.0	15.0
Secondary	56.1	58.0	49.6	57.2	49.0	59.0	54.0	37.8	53.7
Higher	23.3	25.5	14.3	34.6	24.0	30.7	20.2	12.2	22.5
Total	100	100	100	100	100	100	100	100	100
Region									
North	28.0	30.8	27.3	30.9	27.1	28.9	21.3	26.1	26.7
Central	65.2	60.9	64.6	63.8	67.7	65.0	73.5	67.7	66.9
South	6.8	8.3	8.1	5.3	5.3	6.1	5.1	6.3	6.4
Total	100	100	100	100	100	100	100	100	100

Residence									
Urban	51.5	50.6	51.5	50.9	52.2	55.5	60.4	50.3	54.1
Rural	48.5	49.4	48.5	49.1	47.8	44.5	39.6	49.7	45.9
Total	100	100	100	100	100	100	100	100	100
#	734	757	817	375	437	640	1,424	304	5,488

Source: POLICY Project

**Table 3.4: Comparison of Women Who Intend to Use Family Planning in the next 12 Months with Women Who Did Not (%)**

	Want Soon		Want Later		Want No More	
	Do not Intend to use*	Intend To Use	Do not Intend to use*	Intend To Use	Do not Intend to use*	Intend To Use
Age of Women						
15-19	8.2	16.3	13.6	10.8	1.0	1.8
20-24	23.0	20.4	32.8	36.7	1.0	10.6
25-34	41.7	50.3	41.9	49.2	20.1	51.0
35-49	27.1	12.9	11.6	3.4	77.8	36.7
Total	100	100	100	100	100	100
Education Level						
None	8.3	4.0	8.6	3.2	29.5	8.1
Primary	14.1	8.1	17.2	9.7	28.1	15.9
Secondary	53.4	65.8	57.1	58.5	34.7	57.8
Higher	24.1	22.1	17.2	28.7	7.6	18.3
Total	100	100	100	100	100	100
Children Ever Born						
None	42.0	29.1	21.2	16.2	1.4	0.6
1-2	30.7	38.5	40.9	51.3	6.9	20.2
3-4	15.4	20.3	23.2	21.4	17.7	31.0
5-6	7.8	9.5	7.6	8.6	21.9	21.2
More than 6	4.1	2.7	7.1	2.6	52.1	27.1
Total	100	100	100	100	100	100
# of Observations	538	148	198	538	288	510
Pregnant	5.6	15.6	36.4	61.2	7.7	55.9
Amenorrhic	4.6	6.1	15.7	22.1	6.3	22.0

Source: POLICY Project

\* The "Do not intend to use" category includes those women who do not intend to use at any time in the future and women who intend to use at some time in the future beyond 12 months from now.

Further, in Johns Hopkins' report *In Their Own Words: A Qualitative Study of Family Planning in Jordan*, focus group discussions revealed the following barriers to using FP:

- > Family pressures to have a child as soon as possible.
- > Family pressures to have a son (son preference).
- > Lack of communication between husband and wife about family size and FP.
- > Reliance on traditional methods early in marriage.
- > Fear of harmful side effects of modern contraceptives.
- > Lack of knowledge about contraceptives.

Several of these barriers were repeated in the *Blue Circle Brand and Advertising: A Focus Group Study*, a smaller qualitative study, conducted by the Commercial Market Strategies (CMS) project in 2000. CMS also stated the following barriers:

- > Husband wanted more children; husband refusal to use contraceptives or disapproves of FP.
- > Lack of female physicians at health center.
- > Lack of quality care (long wait, too many clients, unpleasant behavior of providers).
- > Late marriage causes need for high fertility.
- > Misconceptions about FP.
- > Mother-in-law pressures.
- > Fear that FP is not acceptable under Islamic tenets.

Finally, the research review did not disclose any studies that looked at variations in the distribution of contraceptives in Jordan (such as before Ramadan) or the impact of such variations on overall fertility.

### 3.2.3 Unmet Need for Family Planning

Research Questions Related to Unmet Need for FP
<ul style="list-style-type: none"><li>• Factors contributing to the high degree of unmet need for FP in Jordan.</li><li>• SES characteristics of couples with unmet needs.</li><li>• Possible interventions to decrease unmet need (policy, system or services).</li></ul>



Unmet need for family planning is the “number or proportion of women currently married or in union who are fecund and who desire to either terminate or postpone childbearing, but who are currently not using a contraceptive method<sup>2</sup>.” The measurement of unmet need for family planning in Jordan varies. Unmet need, according to the 1997 Jordan Population and Family Health Survey, was approximately 14 percent in Jordan. In comparison, the POLICY Project's *Unmet Need and Intention to Use Family Planning Among Jordanian Women* (2000) report stated that unmet need among married women was 18.7 percent (see table below), and USAID's 1999 report, *Maternal Health in Asia and the Near East: An Assessment Report*, reported that unmet

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<sup>2</sup> Handbook of Indicators for Family Planning Program Evaluation. Bertrand, Magnani, Knowles. Pg. 138

need in Jordan was 22.4 percent. The measurement of unmet need for FP in Jordan warrants attention.

The percent of unwanted births in Jordan was reported to be 17 percent (*“Fertility Levels Among Jordanian Women Have Fallen Sharply, But Unwanted Childbearing Remains High”*). Moreover, the ideal number of children has been determined to be 4.2 children while the actual average family size is 4.3. Twenty percent of births in 5 years prior were reported as mistimed, and 17 percent were unwanted. Wanted fertility rate (similar to total fertility rate, but excluding births exceeding the number considered ideal) was 2.9 births per woman, indicating that actual fertility is 50% higher than wanted fertility.

**Table 3.5: Need for Family Planning  
as Defined in the Final Report of the JPFHS 1997**

Need Status	Percent of Married Women
<b>Unmet Need for Family Planning</b>	
Unmet Need for spacing	7.4
Unmet need for limiting	6.8
Method failure	4.5
Total Unmet Need	18.7
<b>Met Need for Family Planning</b>	
Met need for spacing	18.2
Met need for limiting	34.3
Total Met Need	52.6
<b>Menopausal, Infecund, or Want a Child Soon</b>	28.7
<b>Total</b>	100
# Observations	5,337

Source: POLICY Project

The following table shows differences by age, education and place of residence in FP need among married women.

**Table 3.6: Demographic Characteristics of Women Across the Different Need Categories Using a Prospective Basis for the Evaluation of All Married Women (%)**

	Not Currently Using Family Planning			Using Traditional Family Planning Methods		Using Modern Family Planning Methods		Infecund	All Women
	Want Soon	Want to Space	Want to Limit	Want to Space	Want to Limit	Want to Space	Want to Limit		
<b>Age of Women</b>									
15-19	9.5	11.4	1.5	3.5	0.2	3.9	0.2	1.3	3.9
20-24	23.0	35.3	7.1	23.2	3.7	22.1	3.4	4.6	14.6
25-34	43.2	47.6	39.7	61.6	31.7	64.6	34.6	18.1	42.5
35-49	24.3	5.8	51.8	11.7	64.4	9.4	61.8	76.0	39.0
Total	100	100	100	100	100	100	100	100	100
<b>Education Level</b>									
None	7.6	4.6	16.2	3.5	8.7	1.6	8.1	27.0	8.8
Primary	13.1	11.9	20.0	4.8	18.3	8.8	17.8	23.0	15.0
Secondary	56.1	58.0	49.6	57.2	49.0	59.0	54.0	37.8	53.7
Higher	23.3	25.5	14.3	34.6	24.0	30.7	20.2	12.2	22.5
Total	100	100	100	100	100	100	100	100	100
<b>Region</b>									
North	28.0	30.8	27.3	30.9	27.1	28.9	21.3	26.1	26.7
Central	65.2	60.9	64.6	63.8	67.7	65.0	73.5	67.7	66.9
South	6.8	8.3	8.1	5.3	5.3	6.1	5.1	6.3	6.4
Total	100	100	100	100	100	100	100	100	100
<b>Residence</b>									
Urban	51.5	50.6	51.5	50.9	52.2	55.5	60.4	50.3	54.1
Rural	48.5	49.4	48.5	49.1	47.8	44.5	39.6	49.7	45.9
Total	100	100	100	100	100	100	100	100	100
# Observations	734	757	817	375	437	640	1,424	304	5,488

Source: POLICY Project

As mentioned above, *the Fertility Preferences and Fertility Regulation Behavior in Jordan* report stated that desired family size seems to be one of the most important correlates of desire for future births and for the intention to use contraception in the future. These desires or intentions are further related to actual use of FP or unmet need of contraception.

### 3.2.4 Contraceptive Continuation

Research Questions Related to Contraceptive Continuation
<ul style="list-style-type: none"> <li>• Continuation rates for contraceptive methods.</li> <li>• Characteristics of discontinuers.</li> <li>• Factors contributing to discontinuation.</li> <li>• Means to improve continuation rates.</li> </ul>

The *Jordan Population and Family Health Survey 1997* data show that almost half of all women using contraception, during the five years prior to the survey, had discontinued their method within 12 months of starting use (49 percent). Of these women, 14 percent became pregnant while using the method and 11 percent of women who stopped using their contraceptive method reported side effects as the reason for discontinuation.

The *Contraception Adoption Process* study conducted by CMS in 2000 reported that approximately 64 percent (of a sample of 155 women) discontinued their method within 12 months. The majority of pill discontinuers (66 percent) cited side effects as the reason for stopping. Among IUD users 39 percent stopped because of side effects and 41 percent wanted another pregnancy. This study mentioned the importance of husbands' influences on continuation of FP methods. In summary, factors contributing to the discontinuation of contraceptives include side effects, pregnancy (method failure or misuse), fears of harmful effects, desire for additional children and others.

A *CPP Discontinuation of Family Planning Methods Report* is limited in scope as it reports only the rates of discontinuation for CPP clients and does not report reasons for discontinuation. The data showed that 60 percent of the discontinuers abandoned their method within one year. The rate of abandonment for condoms was 58 percent; injectables, 62 percent; IUD, 8 percent; and Norplant, 65 percent.

The CPP report did present some characteristics of the clients who discontinued. Discontinuers were mostly younger women under the age of 30 years who might be expected to have more children. Surprisingly, the discontinuer group had a slightly higher proportion of employed women (19 percent) than those using FP did (14 percent). Approximately, 58 percent of discontinuers attended MOH clinics, 30 percent used Royal Medical Services (RMS) and 12 percent used NGO clinics.

In addition, the *Family Planning Knowledge, Attitudes and Practices in Jordan* study completed by JHU/PPP (with a sample of 1000 married women and 1000 married men, aged 15-49) reported that providers were cited as reason for discontinuation by only 7 women. From these findings, one would assume that provider influences do not play a large role in method discontinuation. However, the CMS report *Treatment Practices of Female General Practitioners in Amman* made a conflicting statement on provider influences regarding continuation (although the results are much more limited, the sample included only 30 physicians). The report concluded that discontinuation is increased by the following provider practices: 1) not asking for client preferences, 2) not disclosing side effects of FP methods, 3) advising discontinuation of select methods (mainly DMPA and injectables), and 4) not scheduling follow-up visits.

Findings were limited regarding approaches to reduce discontinuation. The CPP report found that clients' discomfort with specific methods could be strongly countered with adequate FP counseling, although concerns often resurfaced when influenced by family and friends. Moreover, the CMS report, while not reporting on interventions to improve continuation, does highlight possible areas for intervention including counseling and follow-up.

(It is important to note that clients who discontinue one FP method sometimes merely switch to a different method. It is therefore necessary to capture method switching to avoid overestimating discontinuation rates.)

### 3.2.5 Method Mix

#### Research Questions Related to Contraceptive Method Mix

- Reasons for IUD preference.
- Factors contributing to the apparent lack of acceptance of new contraceptives (such as Norplant and injectables) versus more established methods in Jordan.
- Effectiveness of introducing new, unfamiliar methods in Jordan (Norplant, injectables).
- Effectiveness of “pushing” methods which are not highly utilized, such as condoms.
- Effectiveness/viability of careful client-sensitive controlled introduction of injectables.
- Factors making traditional methods attractive to clients and ways in which programs can take advantage of these preferences.
- Probability that users of traditional methods can be converted to modern methods and ways to best serve traditional users interests.
- Possibility that mothers could be influenced to change from breastfeeding to LAM.
- Costs of condoms and the effect of cost on usage.
- Condom use rate among married men.
- Feasibility of introducing vasectomy as part of the method mix.

It is evident that misconceptions regarding family planning methods are widespread. There is a great deal of data that show that clients’ and providers’ perceptions about specific methods have immense impact on method adoption and use. Furthermore, fears of side effects and health implications, and the rumors that are related to these issues seem to play a role in method choice.

The IUD is well documented as a preferred FP method. JHU/CCP and JNPC (*Family Planning Knowledge, Attitudes and Practices in Jordan, 1997*) found that effectiveness, comfort, safety and obstruction of conjugal relations were important factors for women in contraceptive choice. According to the *CPP Rumors and Misinformation Study: Qualitative Research*, providers prefer the IUD due to the fact that it is a “fixed method” (thus, low effort for the client) and has the least side effects.

In general, Norplant implants and injectables are not well known methods in Jordan. The Government of Jordan, however, prompted a study *Introducing More Contraceptive Methods in Jordan* (conducted in 1998 by AVSC and Family Health International) to assess the feasibility of introducing Norplant and Depo-Provera injections in Jordan. The author reported that clients chose these methods due to the length of protection and ease of use, as well as a perception of fewer side effects than other methods and discontent with other methods. Following six-months of use, the satisfaction rates for Norplant and Depo-Provera were 80 percent and 33 percent respectively. Most clients reported side effects as the reason for being dissatisfied, although many other reasons were cited as well including pressures from providers, family members, husbands and others influenced by misinformation. The results were presented along with findings from other countries, and several recommendations were made to improve the feasibility of introducing the methods. These included improved training of providers, enhanced counseling skills, and care delivery protocols. AVSC was to work with the MOH to implement these suggestions, although more current findings were not found by PHCI.

The *Family Planning Knowledge, Attitudes and Public Advocacy: Findings from the 1997 Survey of Muslim Religious Leaders in Jordan* study reported that religious leaders view traditional methods more favorable than modern methods. This could be due to the fact that traditional methods are not tangible interventions in the limitation of childbearing, which is prohibited in Islam.

Breastfeeding is common in Jordan, although the length of time that mothers breastfeed seems to be decreasing. The “*Impact of the Healthcom Mass Media Campaign on Timely Initiation of Breastfeeding in Jordan*” (*Studies in Family Planning*) article stated that parity, residence, and where the child was born were all independent predictors of timely initiation of breastfeeding. The article also suggested that hospital policies support timely breastfeeding and that mothers should be provided with information about timely initiation and the benefits of colostrum.

Information on condom use is not very extensive. While data is available from the CPP project (and likely other projects) on the distribution rates of condoms from CPP centers, this should not be considered as a proxy to actual utilization rates. There is no easy method of determining the actual use of condoms utilizing supply side data. As reported in “*Men’s Knowledge of and Attitudes toward Birthspacing and Contraceptive Use in Jordan*,” 28 percent of men surveyed reported they were willing to use a male contraceptive and a third of the respondents said they would use male contraceptives if their wives could not use contraceptives for medical reasons. However, approximately 60 percent of men in such circumstances said they would not use a method and 15 percent did not know if they would be willing to do so. These findings are significant, although the sample was small (241 men). In contrast, the survey of Muslim religious leaders mentioned above showed that among modern methods, condoms had the most positive image. This finding is interesting, given that the majority of religious leaders in Jordan are male.

Moreover, in *Fertility and Family Planning in Jordan: Results from the 1985 Jordan Husbands’ Fertility Survey*, nearly 40 percent of husbands responded that they “do not believe in practicing contraception.” This finding, however, was deduced from the results of the 1983 JFFHS and should be reassessed with more current data.

Vasectomy is largely overlooked by the population and is not even recognized by many as a form of FP. Even female sterilization is considered a last resort intervention, and it is rarely if ever used as a contraceptive measure (when used, it is typically performed for medical necessity). This is probably due to the fact that it is against the tenets of Islam to consciously limit the number of children. The CMS Project, in a small projective study of women, found that female sterilization is severely stigmatized and viewed negatively. It can be assumed that the same attitudes would correspond to male sterilization. Moreover, in the study *In their Own Words: A Qualitative Study of Family Planning in Jordan* (JHU), sterilization was viewed by almost all participants as forbidden under Islam. It is not likely that the population would openly accept sterilization as a FP method.

### 3.2.6 Client Attitudes and Behaviors

Research Questions Related to Client Attitudes and Behaviors Regarding RH/FP
<ul style="list-style-type: none"> <li>• Level of social acceptance of FP.</li> <li>• Effect of religion on client behavior in FP.</li> <li>• Indicators of quality according to the patient.</li> <li>• Presence of changes in demand for contraceptives in the months prior to Ramadan and reasons why.</li> <li>• Attitudes and opinions regarding the use of oral contraceptives among patients.</li> <li>• User barriers to increased use of oral contraceptives.</li> </ul>

The level of social acceptance of FP in Jordan is fairly well documented. The majority of the population acknowledges that FP is acceptable within Islamic tenets. Moreover, it is well documented that both political and religious leaders accept FP. While social acceptance is high, it does not always translate into high utilization of FP methods.

Nearly 40 percent of husbands in 1985 responded that they “do not believe in practicing contraception”, as stated in *Fertility and Family Planning in Jordan: Results from the 1985 Jordan Husbands’ Fertility Survey*. Hammouda (1987) suggested that one of the reasons for negative/fatalistic attitudes towards contraceptive use among men was that FP services in Jordan had largely been directed only towards women.

The impact of religious beliefs on contraceptive utilization was mentioned previously. While most men, women and even religious leaders approve of the use of FP (*Family Planning Knowledge, Attitudes and Practices in Jordan*), there seems to be a large degree of indecision regarding the acceptability of specific methods within Islamic teachings as well as a low level of personal approval (while 72 percent approved of FP under Islam, only 49 percent approved personally). The study also found that men were more critical than women were regarding the acceptability of certain methods. The article “*Respect for Religion and Tradition: Key to Family Planning in Jordan*” mentions that marketing approaches linking FP to traditional and religious tenets (protecting the health of mother and child in Islam and recommended periods of breastfeeding in the Koran) seem to be very effective. In summary, most people feel that FP is acceptable within their religion (except for sterilization), although FP should be used for birth spacing not to limit future births. Additional efforts are required to ensure that the public is educated as to the acceptability of specific methods within Islamic tenets.

The *Segmentation of Family Planning Services by Sector* report by the POLICY project found that quality of services influenced the choice of FP service provider families with higher incomes. Price and accessibility were reported to be the major determinants for the lower income groups, while the middle income groups appeared to be more sensitive to quality than price. Public sector clients are concerned with the price of services and to a lesser extent with accessibility and quality, whereas NGO clients sought good prices and high quality. In addition, over 30 percent of families in the lower economic status index rankings used private sources for health care, which could indicate a perception of low quality of care at public facilities.

Oral contraceptives (OC) are popular among Jordanian women; according to most data, it is the second most popular modern contraceptive in Jordan. No studies were found that discussed the barriers to increased use of OC directly, but one could predict that provider attitudes and behaviors play largely into the decision-making process. Moreover, it is known that side effects, fears of health consequences and desire for additional children play into contraceptive acceptance and continuation.

<b>Research Questions Related to Care-Seeking Behaviors for RH/FP</b>
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|---|
| <ul style="list-style-type: none"><li>• Factors influencing the decision regarding where clients seek RH/FP services.</li><li>• Factors causing changes in trends regarding source of RH/FP services.</li><li>• Primary location of where clients seek care and type of provider (doctors, midwives, pharmacists).</li><li>• Client perceptions of nurses and midwives.</li><li>• Relationship between male providers and contraceptive use.</li><li>• Client population’s preferred source of information about RH/FP.</li></ul> |
|---|

- Care-seeking behavior of females in Jordan for STI services.

Data is readily available that documents where patients receive RH/FP care. According to the *Jordan Population and Family Health Survey 1997*, nearly three-quarters (73 percent) of women using a modern method of FP obtain contraception from a private source. Most often the private sources are Jordan Family Planning and Protection Association (JFPPA) clinics; for example, 36 percent of all IUD insertions were done at JFPPA facilities. Among those using a public source, 40 percent obtain contraception from maternal and child health centers. It would be interesting to look at the differences in the facilities, quality of care, user fees and provider behaviors between JAFPP and MOH facilities. The type of provider within the various type of facility was not reported in any of the studies, but is likely available. Findings related to trends, or studies assessing the existence of trends, regarding the source of RH/FP were not found.

Information on why clients chose a specific type of facility was less available, although some reasons that effected choice of facility were discussed above with results from the *Segmentation of Family Planning Services by Sector* report. In addition, the *Contraception Adoption Process* study (CMS Project) stated that women ranked the following factors as important in selecting a provider: 1) service quality, 2) good treatment, 3) proximity, 4) privacy, 5) cost, and 6) recommendations from others.

It is known that nurses and midwives are not highly esteemed professionals in Jordan (not documented in studies presented here). Specific studies looking at client perceptions of these providers, however, were not located. It is largely assumed that female clients prefer female providers for RH/FP services. The direct relationship between male providers and contraceptive use was not found. This type of comparison could be feasible by comparing utilization rates among users of public (primarily male providers) and users of JAFPP (primarily female providers) facilities to assess any significant differences.

Regarding sources of information on RH/FP in Jordan, the article "*Fertility Levels Among Jordanian Women Have Fallen Sharply, But Unwanted Childbearing Remains High*" stated that fifty-five percent of women were exposed to FP messages on both television and radio, 35 percent by television only, and 9 percent had never heard a message. Another article, "*Men's Knowledge of and Attitudes toward Birthspacing and Contraceptive Use in Jordan*" reported that while 69 percent of men were aware of male contraceptives on the market, 60 percent of them opposed the marketing of male methods. Nearly 70 percent did not know of a source of information about male contraceptives; 35 percent stated that media and information programs should be available, including 26 percent who called for a special television program addressing issues related to male contraception. The populations' most common source of information is through friends and family (word of mouth), although the preferred source of information is less understood.

Information dealing with sexually transmitted infections in Jordan was not found in many of the collected studies, and thus relevant studies on care-seeking behaviors were not located.

### **3.2.7 Integration of RH/FP into Primary Health System**

#### **Research Questions Related to Integration of RH/FP into PHC**

- Factors encouraging usage at freestanding MCH centers. Qualitative research examining why FP services appear to be under-utilized in PHCs, as well as to determine barriers to FP/RH.
- Acceptability of integration for the clients.
- Effect of integration on utilization rates of RH/FP services.

Information on utilization of specific types of centers is reported under care-seeking behaviors and client attitudes and perceptions, although specific information on the choice of freestanding versus MCH or PHC centers was not discussed.

As the concept of integrating RH/FP into PHC services is new in Jordan with PHCI's interventions, this type of research has not been conducted. It is advised, however, to gather information about the experiences of other countries that have integrated RH/FP into their PHC systems.

### 3.2.8 Community Participation

#### Research Questions Related to Community Participation

- Community participation in planning, designing, implementing FP services.
- Community interests in participating in planning, implementing FP programs.
- Cost-effectiveness of CBS program and feasibility of nationalizing training, materials and incentives.
- Feasibility that condom use be campaigned through projects designed and implemented by male partners in a community-based activity.

Information on community participation was limited among the studies collected in this effort. Most discussions regarding participation in the process of developing FP programs referred to political and religious leaders. Similarly, analyses of community interests in participation were not found.

Community based services (CBS) activities have been successful in Jordan. The JNPC in its *Policy and Legal Barriers* report suggested that the government fund CBS activities in order to improve continuity of care. While the JNPC study recommended expansion of CBS, it is unknown whether the services are considered to be cost-effective.

### 3.2.9 Specific Target Populations

#### Research Questions Related to Target Populations for RH/FP Services

- Identification of underserved populations.
- Ways to target the population aged 15-25 to increase their demand for contraceptives.
- Ways to target newly married couples for FP.
- Contraceptive practices among mothers with children aged 0-3.
- Ways to improve family planning in polygamous marriages.
- Measures to make males more instrumental in sustaining FP services.

The *Jordan Annual Fertility Survey 1999* reported that only 1.5 percent of married women with no children currently practiced any type of FP. Women with larger numbers of children are more

likely to be currently using FP than those women with fewer children are, indicating serious external pressures to have children soon after marriage.

Information on polygamous marriages was not located in the review.

There is general consensus that male participation in FP decisions is important. Improving outreach to the male population, improved FP education targeted to males and enhanced involvement of husbands in FP decisions are means to build upon this knowledge. Further research is warranted, however, to assess feasible interventions to improve males' roles in FP.

#### **Research Questions Related to Adolescent Reproductive Health**

- Reproductive health needs of adolescents (needs assessment).
- Extent of adolescents' knowledge regarding STIs.
- Psychological effects of adolescence that affect health.

The *Qualitative Research on Reproductive Health Knowledge and Needs among Jordanian Youth* report stated that the respondents recognized the ramifications of rapid population growth in Jordan. Most of the surveyed youth responded that they supported birth spacing and postponing marriage, but noted that FP education in schools was inadequate. The study found through focus group discussions that the following FP barriers were encountered by youth (defined as 15-24 years old). One of the major obstacles for youth acceptance of FP is the social pressures and traditional family norms that prevail and prevent the young people from limiting the number of children they have. The second obstacle that could prevent young people from achieving their goal is that they do not have reliable method of contraception that they trust, highlighting the need for more effective FP education to younger populations. These findings are based on the responses of only ten focus groups, however, and should not be considered as representative of the entire youth population.

In addition, one interesting finding noted that there was a strong dissatisfaction with the experience of growing up in large family and it seemed that youth did not want their own children to experience the same issues. The significance of the findings of this study is limited however, due to the small sample size.

The general effects of adolescence, psychological or physical, that affect health were not addressed in any studies. Findings regarding youth knowledge of STIs were not found.

### **3.2.10 Reproductive Health Status**

#### **Research Questions Related to Reproductive Health Status**

- Prevalence of gynecological and related morbidities among women.
- Women's perceptions about their reproductive health status.
- Care-seeking behaviors of women with RH-related symptoms.

The studies collected did not report on morbidities specifically, although service level data will likely show prevalence of specific conditions. Findings on care-seeking behaviors of women with symptoms of RH-related morbidities were not gathered.

#### **Research Questions Related to Antenatal and Postnatal Care**

- Number of antenatal care visits
- Prevalence of hypertension disorders of pregnancy, gestational diabetes mellitus, anemia.
- Extent of utilization of postnatal care services (at the national level).
- Quality of postnatal care received.
- Causes of non-utilization of antenatal and postnatal care.

The Comprehensive Postpartum Project focused its intervention on the provision of antenatal and postnatal care. The number of total antenatal care visits in Jordan can probably be tabulated by service statistics at various facilities (MCH, PHC, CPP, etc.). Additional information regarding the extent of utilization, quality of care and reasons for non-use should be available from CPP, although the findings could be limited.

#### **Research Questions Related to Sexually Transmitted Infections (STI)**

- Prevalence of STIs among women.
- Extent of utilization of health services by women with STI symptoms.
- State of knowledge of women about STIs (symptoms, transmission, complications and prevention).

The literature review, while it focused on reproductive health and family planning, did not come across many reports dealing with STIs in Jordan. The topic of sexually transmitted infections was scarce in most RH/FP reports. *The Situation Analysis of the Reproductive Health Program in Jordan* (Population Council) did, however, state that there were serious deficiencies in information exchange between providers and clients particularly for STIs and HIV/AIDS.

#### **Research Questions Related to Osteoporosis**

- Prevalence of osteoporosis among menopausal women.
- Women's awareness of the seriousness of the condition and ways to prevent it.

The review included only one report discussed osteoporosis. In the *Reproductive Health Needs of Menopausal Women in Jordan* report, nearly half of the sample (84 women) did not have any knowledge of osteoporosis, and of those who did know something about the condition, most had only a general understanding of condition and its causes. Some causes cited by women included old age, malnutrition, menopause, pregnancy/childbirth, overweight and decreased calcium in the bones. Only 2 women responded that they were at higher risk of osteoporosis after menopause

#### **Research Questions Related to Children with Special Needs**

- Prevalence of deafness among children and common causes.

The literature review focused on reproductive health and family planning and did not gather information on deafness among children in Jordan.

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### 3.3 Supply Related Research

#### 3.3.1 Integration of RH/FP into Primary Health System

<b>Research Questions Related to Integration of RH/FP in PHC</b>
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- |  |
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| <ul style="list-style-type: none"><li>• Effect of integration of RH/FP into PHCs versus vertical programs.</li><li>• Acceptability of integration for the PHC staff.</li><li>• Barriers at integrated centers for RH/FP utilization.</li></ul> |
|--|

As stated, the integration RH/FP into PHC services is new in Jordan with PHCI's interventions, and thus this type of research has not been conducted. It is advised, however, to gather information about the experiences of other countries that have integrated RH/FP into their PHC systems.

#### 3.3.2 Access

<b>Research Questions Related to Accessibility and Availability of RH/FP Services</b>
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- |  |
|--|
| <ul style="list-style-type: none"><li>• Adequacy and maintenance of volume at PHCs.</li><li>• Clinics' role in attracting clients for services.</li><li>• Consequences of premature cost recovery.</li><li>• Methods for cost containment with individual providers.</li><li>• Availability of condoms in STI clinics.</li></ul> |
|--|

Utilization statistics show that there is wide discrepancy in patient volume among PHCs in Jordan. The differences and the reasons for them deserve further research.

While there has been a great deal of IEC research in Jordan, few studies have focused on health facilities' responsibilities for marketing their own services to attract clients. The CPP project found that television ads were a fairly successful means to advertise the services offered at CPP centers, but family and friends continued to be the main source of information about available services.

Cost recovery and cost containment issues were not discovered in much of the preliminary research. A note was made in the market segmentation study suggesting that JFPPA clinics consider raising user-fees. This is important to note since charges at PHCs are typically lower than JFPPA clinics. It is necessary, however, to further analyze cost recovery issues as well as client willingness to pay.

#### 3.3.3 Quality of Care

<b>Research Questions Related to Quality of RH/FP Services</b>
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- Effect of quality at health centers on utilization.

It is well documented globally in the field of public health that quality is a major factor in the utilization of health services. The article “*Avoiding Unintended Pregnancy in Peru: Does the Quality of Family Planning Services Matter?*” published in *International Family Planning Perspectives*, stated that quality of care is also significantly associated with women’s ability to avoid unwanted pregnancies in Peru.

As stated previously, the *Segmentation of Family Planning Services by Sector* report by the POLICY project found that quality of services influenced the choice of FP service provider in families with higher incomes. Price and accessibility were reported to be the major determinants for the lower income groups. The middle income groups appeared to be more sensitive to quality than price. Public sector clients are concerned with the price of services and to a lesser extent with accessibility and quality, while NGO clients sought good prices and high quality. In addition, over 30 percent of families in the lower economic status index rankings used private sources for health care, which could indicate a perception of low quality of care at public facilities.

### 3.3.4 Role of NGOs in the Provision of RH/FP

#### Research Questions Related to the Role of NGOs in RH/FP Services Delivery

- Role of NGOs in the provision of RH/FP services.
- Need for expansion of NGOs’ role.

As mentioned previously, it is well known that JAFPP facilities are highly utilized for RH/FP services in Jordan. The POLICY Project reported that NGO clients sought fair prices and high quality, as mentioned. A comparison between public, private and nonprofit facilities, in terms of quality of care, is not available and should be completed prior to advocating a need to expanding the role of nonprofits.

### 3.3.5 RH/FP Specific Information, Education and Communication

#### Research Questions Related to RH/FP Information, Education and Communication Efforts

- Effectiveness/adequacy of IEC efforts for RH/FP.

The *Jordan Family Planning Communication Strategy 1997-2002* report (JNPC) assessed the overall situation and needs of IEC efforts for FP in Jordan. The strategy sought to create an integrated IEC strategy for family planning to increase the contraception prevalence rate. The report mentioned the following strengths and weaknesses of IEC for FP in Jordan:

*Strengths:* Widespread access to television and radio programs; high literacy levels; political commitment at high levels; and highly developed health infrastructure.

*Weaknesses:* Lack of coordination of IEC activities; lack of technical expertise in social communication research; rumors and misconceptions about family planning; uncertainties among religious leaders; and desires for large families.

Another report by the JNPC noted that there was a lack of cohesive policy for IEC, and lack of coordination at the national level leading to duplication and/or repetition of activities and a general lack of IEC materials. The Population Council's *Situation Analysis* reported that there was an inadequate use of IEC materials by providers.

The *CPP Study of Using the All-Contraceptive Methods Flip Chart* showed that both clients and providers enjoyed the use of IEC materials, such as the flipchart, during FP counseling (although the sample was small). The majority (90 percent) of mothers reported that the flip chart helped them understand what the counselors described and 75 percent said it helped them choose the most convenient method. However, both counselors and clients mentioned discomfort with graphics/pictures and some materials on the flip chart, suggesting a need for culturally appropriate material.

In addition, a report is available on the pretesting activities of other IEC materials produced by the CPP project. The population in general liked the materials (wall chart, poster and flyer) although some of the content and graphics were not easily understood.

### 3.3.6 Target Populations

Research Questions Related to Adolescent Reproductive Health
<ul style="list-style-type: none"><li>• Adequacy of school health programs for adolescents' needs for reproductive health information.</li><li>• Factors contributing to the success of UNRWA services for youth.</li></ul>



As noted previously in the *Qualitative Research on Reproductive Health Knowledge and Needs among Jordanian Youth* study conducted by the POLICY Project, Jordanian youth reported that FP education efforts in schools was not adequate. These findings are limited due to small sample size, and can not be used to assess whether or not a school health system has the capacity to supply adequate RH/FP information.

Successes of UNRWA in providing services to youth were not described in any collected studies.

### 3.3.7 Access

Research Questions Related to Insurance
<ul style="list-style-type: none"><li>• Extent that private insurance schemes include FP methods and services in their packages.</li><li>• Ways to motivate insurers to include FP.</li></ul>



A modest amount of information mentioning insurance schemes and their inclusion of FP services was discovered. In 2000, the POLICY Project completed the *Cost Benefit Analysis Study of Family Planning in the Context of Health Insurance in Jordan*. The report stated while most maternal and child services were included in basic health insurance packages, that no insurers (with the exception of one self-insured company) covered contraceptives. The analysis concluded that the inclusion of FP in basic packages would be cost effective.

### 3.3.8 Provider Issues

<b>Research Questions Related to Provider Attitudes Regarding RH/FP</b>
<ul style="list-style-type: none"><li>• Factors causing health providers to have misconceptions about contraceptive use and preferences for certain methods over the others.</li><li>• Attitudes and opinions regarding the use of oral contraceptives among health care providers.</li><li>• Provider barriers to increased use of oral contraceptives.</li><li>• Effects of provider misinformation/ misconception on contraceptive choices made by clients receiving services from MDs and midwives at PHCs.</li><li>• Effectiveness of counseling practices of physicians. Practicality that physicians be counselors.</li><li>• Adequacy/sufficiency of FP counseling given to couples by health providers and ways to improve quality.</li><li>• Characteristics of providers who fail to provide appropriate FP counseling (conservative, undertrained).</li><li>• Factors causing a drop in contraceptive use in the months prior to Ramadan, and ways providers can play a role in eliminating the decrease.</li><li>• Perceptions and attitudes of physicians towards nurses and midwives, especially with regard to the integration of FP into PHCs and the possibility of expanded roles (e.g., IUD insertion).</li></ul>

Provider misconceptions were noted in *Treatment Practices of Female General Practitioners in Amman (CMS)*, *Rumors and Misinformation Study: Qualitative Research (CPP)* and other reports. Also related and described in several studies was a lack of knowledge by providers of accurate FP information.

Providers seem to favor IUD and the pill as FP methods. A small sample of providers surveyed in the *CPP Rumors and Misinformation Study: Qualitative Research* seemed to have varying degrees of understanding of FP methods, views on suitability and comprehension of side effects. The IUD seems to be most preferred modern method since it viewed as having the least side effects and is a “fixed” method. In this study, providers appear to prefer methods based on convenience, among other things.

Specific information regarding effectiveness of counseling or characteristics of providers who exhibit good counseling skills versus those that fail to provide adequate counseling was not found. Although there were general statements alluding to the quality of counseling skills of providers, such as in the *CPP Rumors and Misinformation* study. The report stated that there was a lack of communication between provider and client and suggested that providers must be able to communicate effectively and clearly all information to the client about contraceptives. It noted a need for training in communication skills and the need for providers to use IEC materials.

The differentiation in contraceptive use in the months prior to Ramadan is not yet explained, thus provider roles have not been defined to alleviate the decline.

<b>Research Questions Related to Provider Preferences Regarding RH/FP</b>
<ul style="list-style-type: none"><li>• Impact of providers pushing products.</li></ul>

Research shows that providers do inevitably have preferences about FP methods, often based on misinformation and lack of full knowledge about methods as discussed above. Such preferences unquestionably impact client preferences, although specific research regarding the impact of “product pushing” was not found.

#### **Research Questions Related to Provider Motivations Regarding RH/FP**

- Motivating factors for providers to provide quality RH/FP services.
- Training and type of provider
- Extent of RH/FP in medical and nursing curricula.
- Effects of Academic Health institutions’ curricula on perceptions of contraceptives.
- Need for review and/or update of curricula.
- Effective utilization of nurses and midwives in FP programs and definition of their roles.
- Feasibility of the MOH training a certain number of midwives in IUD insertion.
- Feasibility of other professionals who could, after receiving proper training, provide effective counseling.

The *Analysis of Policy and Legal Barriers to Improved Reproductive Health Services in Jordan* report by the JNPC noted the barriers created due to the limited ability of nurses and midwives to provide FP services. It recommended the full utilization of midwives and nurses to provide RH/FP care for female clients, and to improve clinical and counseling services. In addition, practical nurses were identified as a means to improve sustainability of community based services, by providing health education and FP counseling at the community level (*CPP Brainstorming Results*).

#### **Research Questions Related to Community Based Care**

- Feasibility of nationalizing Community Based Services (CBS).

As mentioned previously, aspects of CBS were considered successful although no study assessed the feasibility of nationalizing this type of services. The *Analysis of Policy and Legal Barriers to Improved Reproductive Health Services in Jordan* report, however, recommended that CBS be utilized to improve continuity of care. The report also suggested that the government fund CBS activities, possibly indicating that the JNPC and POLICY Project viewed this as a feasible undertaking.



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## 4. Next Steps

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### 4.1 Prioritize Research Questions

The next step in the process of developing a research agenda is to prioritize the RH/FP research topics among those identified in the previous sections. The approach to setting priorities can sometimes vary for each stakeholder, but should follow the factors shown below. Figure 4.1 defines the tentative set of prioritization criteria established by the PHCI/MOH Research team.

**Figure 4.1: PHCI/MOH Prioritization Criteria**

**Criteria for Prioritizing Research Questions**

In general, the categories of research questions to investigate should deal with:

- Improving **quality or effectiveness** of health services;
- Improving **equity or accessibility** of health services;
- Improving **efficiency** (more output for the same/less input);
- Enhancing financial **sustainability** of the health system.

Specific criteria include the following:

- Does the question (or problem) affect a **large population** or number of people?
- Is the question (or problem) a **serious** one?
- Is the question (or problem) an **urgent** one?
- Is the question (or problem) **feasible** – politically feasible and culturally feasible – to investigate?
- Is it **ethical**?

#### 4.1.1 RH/FP Research Working Group

The PHCI/MOH Research Team has determined that the most appropriate mechanism for applying the above criteria to prioritize research items is a working group or task force. The MOH has established a RH/FP Research Task Force and has selected its members from a wide range of stakeholder groups. This group will meet in a more intimate environment to contend with priority setting and subsequent RH/FP-related research issues.

Priorities may vary for each stakeholder, especially when considering issues related to feasibility. It will be important for the Task Force to focus mainly on the criteria set forth in the previous section, as well as the expected impact of any findings. When a ranked list of research topics is made available, stakeholders can then assess the comparative feasibility of undertaking specific endeavors.

The MOH has scheduled the first RH/FP Research Task Force meeting for late June to prioritize the agenda.

#### 4.1.2 Dissemination of Prioritized List

PHCI will assist the MOH to disseminate the prioritized list of RH/FP research questions. This list will be distributed to all stakeholders and should be used to inform decision-making. Various groups, depending on their capacity, resources and objectives, can use the list from which to select research activities.

In addition to the prioritized list of questions, PHCI/MOH will make available the research documents that were collected during preliminary phases of this process and the resulting summary reports.

- **Volume III: Matrix of Existing Research on RH/FP in Jordan.** The matrix includes the title, objectives and condensed findings of the collected research studies on RH/FP in Jordan.
- **Volume IV: Summaries of Existing Research in Reproductive Health and Family Planning in Jordan.** Summaries exist for all studies contained in the matrix and contain information from the matrix as well as methodology, a more descriptive synopsis of findings and recommendations.
- Copies of the **original studies** that were summarized in the above documents.

In order to enhance dissemination of such documents, PHCI intends to make available the documents in the following formats:

- **Hard copy.** The matrix and summary documents will be available from PHCI in hard copy. In addition, bound copies of the original reports will be made available on a loan basis through the PHCI office.
- **Internet.** The matrix, summaries and original documents will be available on a planned PHCI website in the near future.
- **CD-ROM.** The documents will be produced and distributed in CD-ROM format.

#### 4.1.3 Continuing Dialogue Among Stakeholders

Critical to this process is ongoing and constructive dialogue among stakeholders. If possible, working groups should continue to meet to discuss the status of RH/FP research in Jordan. Some possibilities to allow for such discussions include:

- Monthly/Quarterly “brown bag” sessions to allow one or two research projects to report on methodology, implementation, preliminary/final results, implications, etc.
- Continuation of frequent roundtable events that engage a varied group of stakeholders. Agendas and topics of discussion could be predetermined (specific health issue, types of research methodologies, etc.) and any relevant materials distributed.

- Monthly/Quarterly newsletter that is distributed among stakeholders to which research projects provide frequent input to report findings, challenges, issues, future activities, etc.

A continued effort to share information among stakeholders, not only in terms of recent findings, but also to report planned activities, challenges, issues, etc. will contribute to the following:

- A decline in duplicated research efforts;
- An increase in the dissemination of findings and results and sharing of lessons learned;
- An increase in potential collaborations among various groups in research activities;
- An improved, enhanced and dedicated “RH/FP research community” committed to ensuring that the best interests of Jordan’s population are served.

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## 5. PHCI Role in Conducting Research

PHCI will continue to provide assistance in the next steps of prioritizing the national research agenda for RH/FP. The project will, in the next several weeks, discuss with the MOH the role it will play in the coming months regarding the finalization of the agenda and promoting continued dialogue among stakeholders.

Meanwhile, PHCI will establish its own research plan for the next three years. PHCI, however, will only be able to undertake research endeavors that correspond with the project mandate and mission. Accordingly, PHCI must consider the following factors when determining which research topics it will undertake:

- *PHCI Scope of Work:* The project is required to respect its contract with USAID and the overall objectives of the project.
- *Feasibility of Completion within Project Lifetime:* PHCI will only be able to undertake research activities that will be completed before the end of the project.
- *Compatibility of PHCI Resources:* The project can only assume responsibility for research activities for which it has available resources (financial, staffing, time, expertise, etc.).
- *Contribution to Sustainability, Policy Issues and USAID Strategic Objectives:* The project will attempt to select research activities that will promote sustainability in Jordan, will support effective policy making and that are consistent with USAID's strategic objectives in Jordan.

PHCI will develop its RH/FP research plan, with regard to the priorities expressed by the MOH, and present the proposed agenda to USAID for comments and approval. The project will then finalize the plan and develop detailed scopes of work – including staffing, budgets and timelines – for each activity.

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## Annex A: List of Participants

The following is a list of the participants from the Reproductive Health and Family Planning Roundtable, held on April 10, 2001. (Note: This list is not complete, additional MOH counterparts attended)

Dr. Sa'ed Kharabseh	MOH
Dr. Taher Abu Samen	MOH
Dr. Osama Samawi	MOH
Dr. Clara Syam (Res)	MOH
Dr. Ruwaida Rashid (Res)	MOH
Dr. Hiyam Al Yousef (Res)	MOH
Dr. Mai Saob (Res)	MOH
Dr. Nisreen Bitar	AVSC International
Dr. Nuha Khdeir (QA)	MOH
Dr. Safa' Qsous (QA)	MOH
Dr. Najwa Huweidi (QA)	MOH
Dr. Basima Steitieh (HCM)	MOH
Mr. Donald Eldridge	USAID
Dr. Salwa Bitar	USAID
Ms. Sana' Naffa'	USAID
Dr. Adnan Abbas	Jordan Public Health Association
Dr. Salah Mawajdeh	JUST
Dr. Alfred Yassa	Johns Hopkins University
Ms. Lina Qardan	Johns Hopkins University
Dr. Hind Dawany	Linkages
Dr. Mohammad Batayneh	MOH
Dr. Abdull Rahim Ma'ayteh	JNPC
Dr. Ra'eda Al Qutub	Office of Queen Rania
Dr. Amal Daghestani	The Futures Group International
Dr. Bill Goldman	USAID
Dr. Richard Yoder	PHCI
Dr. Ali Arbaji	PHCI
Dr. Mary Segall	PHCI
Dr. Calvin Wilson	PHCI
Dr. Carlos Cuellar	PHCI
Dr. Nayef Awwad	PHCI
Dr. Joe Smith	PHCI
Mr. Bob Karam	PHCI
Ms. Dana Shuqum	PHCI
Ms. Rita Habash	PHCI
Dr. In'aam Khalaf	University of Jordan
Dr. Takiko Sato	JICA
Dr. Haifa' Madi	UNRWA
Dr. Akef Al Azab (MCH)	MOH
Donna Bierregaard	PHCI
Dr. Ja'far Abu Taleb	PHCI
Eng. Hussein Al Heed	MOH



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# Annex B: Agenda for RH/FP Roundtable

## Research Roundtable II: Building A Research Agenda for RH/FP

10 April 2001: 9:00 – 2:00  
Amra Hotel (Jericho Room)

**Issue to be considered:** Contraceptive use appears to be leveling off. What are possible reasons for this and what should be done about it?

**Background:** Through the National Population Strategy, the Government of Jordan has adopted a policy of reducing the rate of nature increase through reducing fertility rates. Contraceptive use is felt to be important because it generally leads to increased spacing of births. Increased birth spacing generally leads to improved health of the mother and child. A consequence of increased birth spacing is reduced fertility and thus reduced rates of natural increase.

1. **Purpose of seminar:** To build a research agenda for Reproductive Health/Family Planning for the next 3-4 years. With this agenda, the MOH, donors and others can select questions that are consistent with their mandate, as worked out with the MOH, and implement these.
2. **Seminar Objectives:** To (a) reflect on and explore possible reasons for the leveling off of the CPR, and (b) develop a set of research questions to investigate.
3. **Method:** Seven people will prepare and present background papers that (a) respond to the issue of why the CPR is leveling off, and (b) identify specific research questions. Discuss. From this background, a list of key questions to investigate will be developed.
4. **Presentations:** (15 minutes each)
  - Dr. Mohammad Batayneh, Director, Maternal and Child Health, MOH
  - Mr. Bill Goldman, Director, Population and Family Health Office, USAID
  - Dr. Adnaan Abbas, Chair, Jordan Public Health Association
  - Dr. Ra'eda Al Qutob, Advisor, Childhood and Public Health, Office of Her Majesty Queen Rania Al-AbdullahCoffee and Tea break
  - Mr. Abdur Rahim Al Ma'aytah, National Population Commission
  - Dr. Amal Dagestani, Coordinator, Futures Group Int'l
  - Dr. Richard Yoder, Research Advisor, PHCI project
5. Further **Discussion** arising from presentations (30 minutes)
6. **Plenary: Identify additional questions** needing investigation from roundtable participants (30 minutes)
7. **Closing**

8. Lunch

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## **Annex C: RH/FP Roundtable Handout**

**Reproductive Health and Family Planning Research Agenda**  
**Possible Categories for Research Topics**

<b>Supply</b>	<b>Demand</b>	<b>Systems</b>
<i>Service delivery, provider practices, health education, effect of quality, user fees, availability, etc.</i>	<i>Client/patient attitudes, practices, preferences, knowledge, care seeking behaviors, etc.</i>	<i>Referral systems, logistics, insurance, management, etc.</i>

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## **Annex D: RH/FP Roundtable Presentations**

The following pages include copies of the presentations given at the RH/FP Roundtable consultation, held on April 19, 2001. Only those presentations available in PowerPoint format were included in this report.

## Presentation 1: Dr. Mohammed Batayneh, Director – Maternal and Child Health, MOH

**REPRODUCTIVE HEALTH - FP  
RESEARCH QUESTIONS.**



Dr. Mohammed Batayneh  
Director, Maternal and Child Health, Ministry of  
Health

**DEMOGRAPHIC STABILIZATION**

Why Jordan Can't Reach  
Demographic Stabilization

- Migration
- Population momentum due to previous high fertility
- Desire for Big family
- High life expectancy rate
- Unmet needs for F/P
- Leveling of contraceptive prevalence rate

**Desire for big family**

DHS showed that Jordanians desire a big family size (>4 children).  
What are the reasons behind such attitude:

- a) Cultural
- b) Social
- c) Religious

Is there any possible intervention to change such attitude and practice?

**Unmet needs**

75% of Jordanian fertile women doesn't want more children or want to postpone their pregnancies.  
though the prevalence of modern contraceptive use is about 40%.  
There is Unmet needs.  
What are the causes of this unmet need and what are the possible interventions and in which level "policy, system or services" were is the defect.

- Are the IEC program sufficient and effective?
- Is it worthy to direct program efforts toward unestablished methods "Norplant, Condoms"
- Are the counseling practices effective or can the physician be a good counselor.
- Are the nurses and midwives effectively included in F/P programs and what is their role?

Taking in consideration that there is a lack in female doctors especially in remote areas and the pelvic examination is not desired to be done by male doctors

- Can MOH train a certain number of midwives in IUD insertion and allow them to provide the service and to measure and compare the quality with that of the physicians.

- What is the role of the community in F/P programs?

CBS program was very successful in Zarqa and East Amman.

They increased the modern contraceptive prevalence rate up to 69% in some areas.

- Is such program cost-effective to be nationalized regarding training , materials and incentives .

## REPRODUCTIVE HEALTH ISSUES OTHER THAN FAMILY PLANNING

### Reproductive morbidities among women

- What are the prevalence of gynecological and related morbidities among women, as RTI, UTI, Genital prolapse, Incontinence, menstrual problems?
- What is the women perception about their reproductive health status?
- What are the care seeking behaviors of women with symptoms?

### Postnatal Care

- What is the extent of utilization of postnatal care services (at the national level)?
- What is the quality of postnatal care received?
- What are the causes of non-utilization?

### STD's

- What is the prevalence of STD's among women?
- What is the extent of utilization of health services by women with symptoms?
- What is the state of knowledge of women about STD's (symptoms, transmission, complications and prevention)?

### Osteoporosis

- What is the prevalence of osteoporosis among menopausal women?
- Are women aware of the seriousness of the condition and how to prevent?

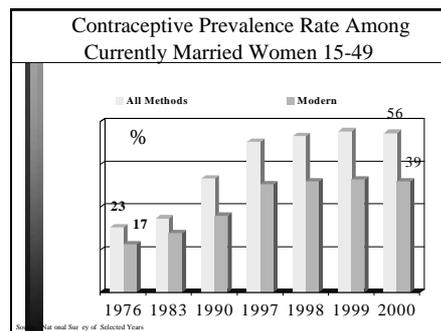
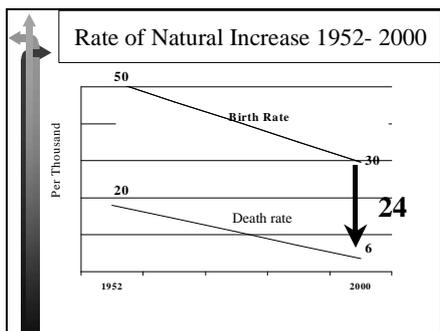
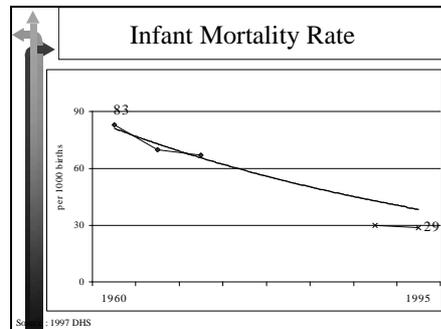
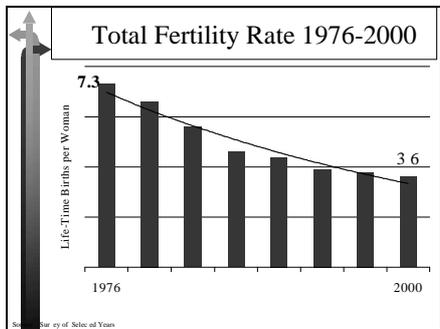
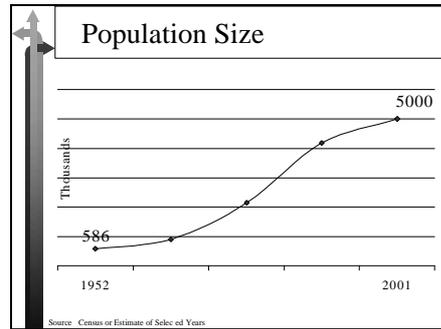
### Children with special needs

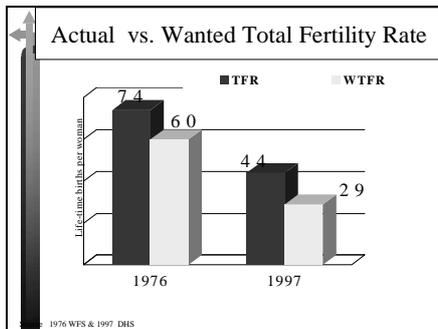
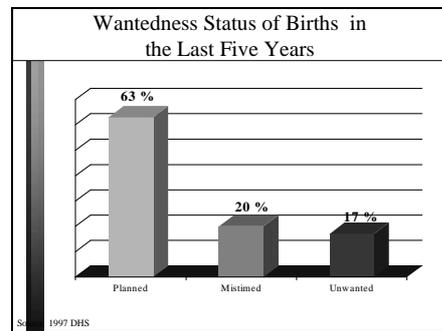
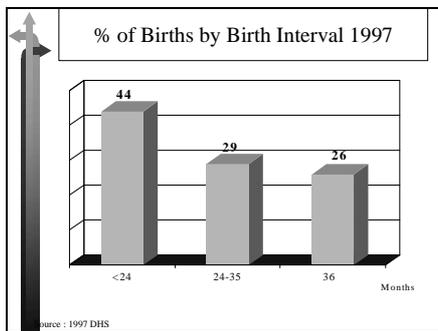
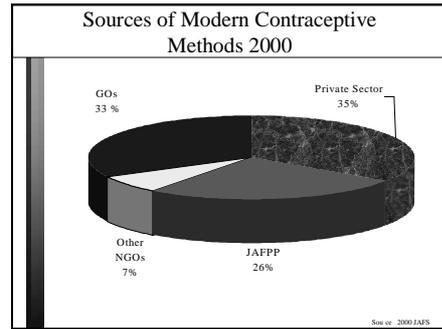
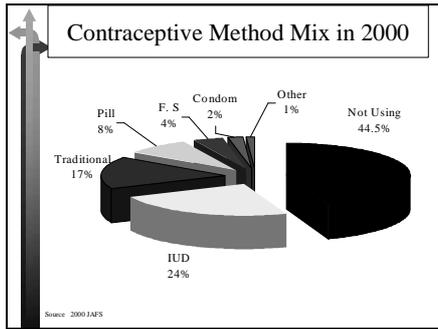
Till now we don't have a national registry for handicaps in Jordan.

We feel that some base line surveys should be done.

- What is the prevalence of deafness among children.
- What are the most common causes , (are they primary or secondary)?

**Presentation2: Mr. William Goldman, Director – Population and Family Health, USAID/Jordan**



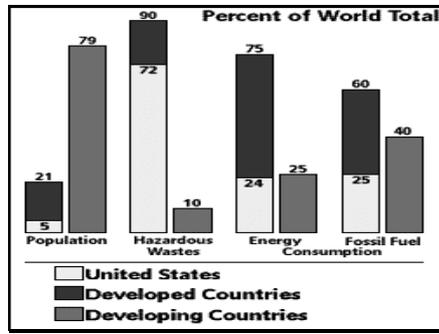
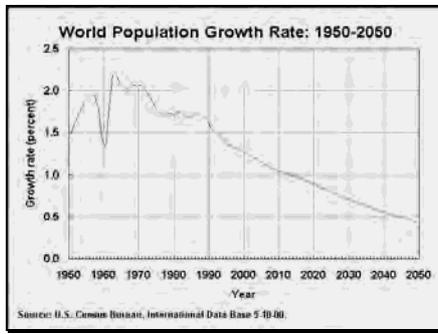
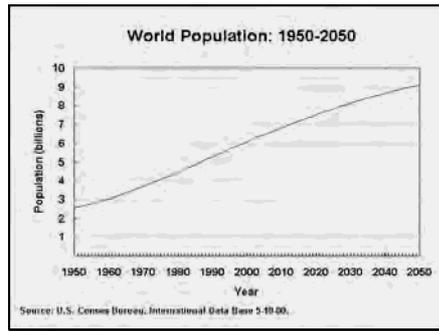


**Presentation 3: Dr. Adnan Abbas, Chair, Jordan Public Health Association**

**Research Issues In Reproductive Health**

Dr. Adnan Abbas

10.5.11.2008



The world's population grows by 90 million each year.

More than 1 in 5 people in the world do not get enough to eat.

Africa now produces 27% less food per capita than in 1964.

Jump to first page

Throughout the developing world, 95% of urban sewage is discharged untreated into surface waters

Jump to first page

**Today, an estimated 1.7 billion people lack access to clean drinking water and by the year 2000, the number of urban dwellers without access to safe water and sanitation services is expected to grow by 80%.**

Jump to first page 

**Each year, an estimated 27,000 species of animals, plants, fungi, and microorganisms become extinct, taking their ecological services and genetic secrets with them.**

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**The ozone-layer hole over Antarctica was 13 times wider in 1991 than in 1981**

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**Each person in the industrialized world uses as much commercial energy as 10 people in the developing world**

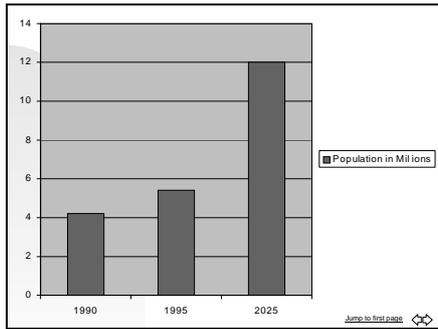
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**It is Quite Evident That There Is a problem A multi Dimensional One accordingly Interventions need be International & multidisciplinary**

Jump to first page 

**Jordan**

Jump to first page 



Jordan	World	De eloped	Less De eloped	
Pop. mid 2000	5,083	6.1	1.2	88
Birth Rate	33.3	22	11	25
Death Rate	.6	9	10	9
Natural Increase	2.9	1.	0.1	1.7
Doubling time	2	51	809	2
Projected pop 2025	8.8	7.8	1.2	6.6
Projected pop 2050	11.9	9	1.2	7.8
TFR	.	2.9	1.5	3.2
Less than 15	2	31	19	3
Over 65	3	7	1	5
% women Using birth control	53	60	7	56
% women using modern contraceptive	38	52	60	51
Government sew high birth rate				
Percent Urban	78	5	75	38
Pop. density per sq. mile	1	8	117	60
GNP per capita US\$	1	150	890	19
			8	1
				50

**JORDAN..... Recent**

**TFR 3.8**

**APGR 2.8.....1999/2000**

**APGR 1.94.....projected for 2020**

The Greatest contribution to these Achievements Came From Outside MEDICAL INTERVENTIONS!!!!!!!!!!

**THIS Raises Two Important ISSUES**

- \*Externalities Play A Major role exceeding what could be expected from Medical Based Interventions
- \*Population Policy Consequences Surpass Women's Health

**What could be a realistic expectation from Health based ?interventions**

**These mainly address :**  
Elements of informed choice.  
Unmet DEMAND .  
Demand Social and Geographical differentials  
Availing services ..... Access  
    Awareness  
    Physical  
    Financial

Jump to first page 

**Research Questions**  
1-Monitoring Unmet Demand?...  
Differentials, characterization of  
obstacles and groups  
2-Characterization of non user  
groups.  
3-Causes of Discontinuity

Jump to first page 

4-Integration within MCH versus vertical  
programs?  
5-Quality & Access

Jump to first page 

**QUALITY**  
QA....standards & protocols  
Training needs  
Facilities & Equipment

Jump to first page 

**ACCESS**  
Adequacy and maintenance of volume?  
 Evaluating consequences of premature cost  
recovery tendency?,  
Exploring ways cost containment within  
individual provider ?

Jump to first page 

**Maintaining role of NGO's?**  
Overlap over among Donors  
pushing products?  
Unwarranted Expectations

Jump to first page 

**Presentation 4: Dr. Ra'eda Al Qutob, Advisor – Childhood and Public Health, Office of Her Majesty Queen Rania Al-Abdullah**

**Is it Family Planning/  
Reproductive health / Women  
health**

- Family planning policy exists in the form of Birth Spacing concept in the 1996 approved National Population Policy ?
- Is Family Planning considered a component of reproductive health/ women s health?
- Is there a policy for reproductive health/ women health in Jordan
- Should there be one?

1

According to WHO, one of the key values for the realization of the Health for All in the 21<sup>st</sup> century is:

“Attaining the highest standard of health as a fundamental human right”

Reproductive / sexual health is a right for every couple (within the acceptable cultural norms).

2

But who is committed to fulfilling this right?

Political commitment for population policy exists at the highest level

Is this commitment expanded to include family planning?

Is family planning used as a mean to improve women's health status in general or is it an end to achieve a demographic goal?

3

Are policy makers aware of reproductive health rights? To what extent is their awareness translated into action?

Do policies that ensure equitable FP services and information to different geographical regions and by gender ...etc exist?

What is the impact of the frequently changing governments on population policy/family planning? How sustainable is the policy commitment?

Who sets the RH/FP policies? To what extent does it incorporate gender perspective?

5

What are the laws and regulations that effect RH/FP/Women's health like?

Are they timely? Activated? Amended?

Are couples informed of their rights?

Are providers informed of couples rights to quality service and information?

6

Who finances FP services?  
To what extent is the private sector involved in setting policies/strategies related to FP?  
How can FP become better sustainable? Do communities participate in planning, designing, implementing FP services?  
Shouldn't private insurance schemes include FP methods and services in its packages? What can motivate them to do that?  
Should the public sector regulate and monitor FP service provision in the private sector? Ensure Access? Equity? Quality?

7

Who plans FP programs?

Why is there high unmet needs for contraception? (~14%)  
What are the characteristics of the couples with unmet needs?  
Whom do they mostly see for service provision? Doctors? Midwives? Pharmacists?

8

What do they know about contraceptives? What is their preferred source of information?  
How often do they discontinue a method? What makes them do that?  
Why is there rural, southern and northern concentration of such cases?  
Why are the uneducated, younger age groups more likely to have unmet needs for contraceptives?

9

How can we target the 15-19, 20-25 age groups to increase their demand for contraceptives (8% and 38% of these two groups were married, and their met needs were 19%, 36% only i.e. currently using a method).

10

What are the best ways to improve family planning in polygamous marriages? Do we improve women status? Do we target males better?

How does women economic participation impact fertility and contraceptive use? Does this interact with education and women status indicators?

11

How can males be more instrumental in sustaining FP services?

Could condom use be campaigned through projects designed and implemented by male partners in a community based activity?

12

Why do health providers have misconceptions about contraceptive use? Why do they have preference for certain methods over the others?

Do Academic Health institutions curricula create such myths and misconceptions about contraceptives?

Why do health providers fail to provide couples with the much needed counseling for the contraception?

How can this be improved?

Do we need to review and update the Academic Health institutions curricula?

13

**Presentation 5: Dr. Amal Dagestani, Coordinator, The Futures Group International**

**Gender, Human Rights and Reproductive Health in Jordan**

- ⌘ Ability to Choose
- ⌘ Choice
- ⌘ Support System
- ⌘ Self Efficacy
- ⌘ Skills
- ⌘ Knowledge
- ⌘ Freedom of Choice
- ⌘ Number of choices available
- ⌘ Culture
- ⌘ Legal System
- ⌘ Networks

**Reproductive Rights**

**Gender Issues Related to Reproductive Rights**

- ⌘ To be informed
- ⌘ Freedom of choice
- ⌘ Quality of care from qualified personnel
- ⌘ Gender equality and protection from gender based cultural biases
- ⌘ Protection from violence and other harmful practices
- ⌘ Respect & dignity
- ⌘ Privacy and confidentiality

- ⌘ Gender based cultural biases
- ⌘ Gender inequality: power & control of resources
- ⌘ Lack of choice
- ⌘ Lack of men's involvement in FP
- ⌘ Poor representation of women in policy process
- ⌘ Lack of communication between couples in relation to RH issues
- ⌘ Gender based violence
- ⌘ Lack of information and research

- ⌘ Lack of counseling services
- ⌘ Providers' biases
- ⌘ More specific issues related:
  - Male child preference
  - Unwanted pregnancies
  - Short spacing between pregnancies
  - Domestic violence
- ⌘ - High morbidity
- ⌘

**Holistic Approach to RH**

- ⌘ Promote equity, self awareness and empowerment of women
- ⌘ Promote women participation in policy process
- ⌘ Involve men
- ⌘ Promote quality gender sensitive services
- ⌘ Promote the development of information and research
- ⌘ Promote the development of policies and programs

**The Big Question is:**

⌘What is The Link between Gender Norms and RH out comes?

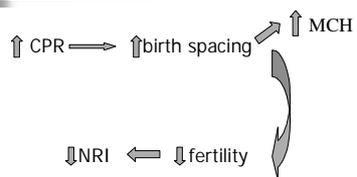
## Presentation 6: Dr. Richard Yoder, Research Advisor, PHCI

### New directions for RH/FP Research in Jordan?

### Question:

- Why has contraceptive use appear to have leveled off, and, what should be done about it?

### Rationale for increasing contraceptive use



### Question:

- Why has contraceptive use appear to have leveled off, and, what should be done about it?

### Hypothesis:

- That the effective demand for Family Planning services has largely been met and....

### Hypothesis:

- That the effective demand for Family Planning services has largely been met and....  
In order to increase contraceptive use, complimentary measures (non-direct FP interventions) are required

## Two broad perspectives on increasing contraceptive use

- Supply side: Improving the supply
- Demand side: Increasing the demand

## Assumptions of each perspective

- Supply side assumptions

## Supply side assumptions:

- There exists a substantial unmet demand for modern contraceptives
- Primary constraint to widespread use of contraceptives is:
  - Lack of knowledge
  - Lack of proper attitudes
  - Insufficient supply of quality FP services

## Supply side assumptions:

3. Where effective demand has been largely met, **new** couples can be "motivated" to use contraceptives -the primary purpose of "IEM" units world wide)

## Supply side assumptions:

3. Where effective demand has been largely met, **new** couples can be "motivated" to use contraceptives (the primary purpose of "IEM" units world wide)
4. That additional demand can be generated outside of significant social, structural or institutional changes

## Supply side problem redefined:

- How to develop a high quality Family Planning service delivery system

### Supply side programmatic implications

- improve FP logistics system
- provide better training in FP
- manage FP system better
- improve supervision and referral
- Do large communication campaigns

### Demand side assumptions

- Where there is a "KA-P gap" there is no significant unmet demand for FP supplies and services

### The "KA-P Gap"

- Knowledge of FP: 100%
- Positive Attitude towards FP:
  - wives: 95%
  - husbands: 81%
- Practicing FP:
  - 40% modern methods
  - 56% all methods

### Demand side assumptions

- Where there is a "KA-P gap" there is no significant unmet demand for FP supplies and services
- Having large families is a rational decision that serves parents' self interest:
  - increases chances of survival and security of parents
  - a source of personal satisfaction and income

### Demand side assumptions

3. Large families will continue until there are substitutes for many children
  - Change incentive system

### What do we know – Supply side?

- are gaps that need closing but basic infrastructure, supplies and services seem present:
  - basic and refresher training (60%-90%)
  - Staff providing FP services (90%-99%)
  - Adequate medical exam area; privacy a problem
  - Essential equipment and supplies (30%-56%)

### What do we know – Supply side?

- are gaps that need closing but basic infrastructure, supplies and services seem present:
  - Contraceptive supplies (pills & condoms: >90%)
  - IEC materials (90%-95%)
  - Record keeping and reporting “unusually well organized and efficient”

### What do we know – demand side?

- Evidence is mixed:
  - 14% = unmet need
  - 17% of births “not wanted”

Yet...

### What do we know – demand side?

- Evidence is mixed:
  - 14% = unmet need
  - 17% of births “not wanted”
  - Yet...
    - Ideal number of children = 4.2
    - No. of “children ever born” = 4.3

Which set of data is correct?

### Issues in obtaining and interpreting information

- “construct validity”
- Understanding, recall and bias
- Conditions under which people are asked about their fertility and FP preferences
- standard error

### Research questions

- Examine the validity of the assumptions on both supply and demand side
- What is the utility of children – an “economic” model of the demand for children
- What are the determinants of fertility?
- Compare socio-economic characteristics of high fertility and low fertility couples
- Examine relationship between male providers and contraceptive use

### Research questions – cont’d

6. Examine impact of complimentary measures (non-direct FP) on contraceptive use:
  - Status of women (education, financial independence, access to credit, decision making roles, employment, etc.)
  - Size and distribution of income and wealth
  - Improvements in quality of PHC system
  - Impact of an integrated Family Health model of PHC

## Conclusion

- We have an obligation to provide high quality RH/FP services
- However, further advances in contraceptive use will need to go beyond the direct provision of FP services and include complimentary measures

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## **Annex E: Matrix of Relevant RH/FP Research Studies**

The following matrix contains the list of identified RH/FP research topics and links each topic and question to relevant research studies collected by PHCI. The numbering of each research study corresponds to the report numbering in both the matrix and summaries reports.

Please attach hard copy (RHFP 2 Column as Annex.doc). Page numbers and footers have been matched to this report.

