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EVALUATION

USAID/Jordan: Health Services Strengthening II Midterm Evaluation

DECEMBER 2012

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ACRONYMS

AIA	American Institute of Architects
BCC	Behavior change and communication
CAC	Community action cycle
CBO	Community-based organization
CHC	Community health committee
CPAP	Continuous positive airway pressure
CPR	Contraceptive prevalence rate
CYP	Couple years of protection
DHS	Demographic and health survey
EOP	End-of-project
ESP	Essential service package
FP	Family planning
FPLMIS	Family planning logistics management information system
GH Tech	Global Health Technical Assistance Bridge II Project
GIS	Geographic information system
HCAC	Health Care Accreditation Council
HC	Health center
HD	Health directorate
HIS	Health information system
HMIS	Health management information system
HP	Health promotion/promoter
HPC	Higher Population Council
HSS II	Health Systems Strengthening II Project
IEC	Information education and communications
IT	Information technology
IUD	Intrauterine device
JHAP	Jordan Healthcare Accreditation Project
JHCP	Jordan Health Communication Partnership
JPFHS 2009	Jordan Population and Family Health Survey, 2009
JUH	Jordan University Hospital
KM	Knowledge management
MCH	Maternal and child health
MCHIS	Maternal and child health information system

MOH	Ministry of Health
NCD	Non-communicable diseases
NICU	Neonatal intensive care unit
NGO	Non-governmental organization
OB/GYN	Obstetrician/Gynecologist
OC	Oral contraceptive
PD	Position description
PHC	Primary health care
PIS	Perinatal Information System
PRA	Participatory rapid assessment
QIS	Quality information system
RH	Reproductive health
RMS	Royal Medical Service
SHOPS	Strengthening Health Outcomes through the Private Sector
SOW	Statement of work
TFR	Total fertility rate
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNRWA	United Nations Relief and Works Agency
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

This report presents the findings, conclusions, and recommendations of a team commissioned by USAID/Jordan to conduct a midterm evaluation of Health Systems Strengthening (HSS) II, a five-year (2009–2014), \$73 million USAID-funded project. The conclusions and recommendations of this evaluation are expected to be used not only to improve implementation of the ongoing project by Abt Associates (the HSS II implementing organization) but also to guide the design of future projects. The overall strategy of HSS II is to institutionalize strengthened health systems in support of reduced fertility rates and improved women’s health. Expected outcomes are public health initiatives in safe motherhood, family planning (FP), reproductive health (RH), and improved quality of and access to health care services.

FINDINGS

As of this evaluation, the HSS II project has met 13 of its 23 targets for year 3 and is on track to meet all its objectives by the end of the project. The team believes the project’s achievements go beyond what its indicators capture. The team also notes some of the project’s shortcomings. Overall, The HSS II project is well managed and has excellent relations with both the Ministry of Health (MOH) and U.S. Agency for International Development (USAID).

In result area 1, knowledge management (KM), the HSS II project has helped lay the foundation for a functional health management information system. Capacity-building and institutionalization of data systems has resulted in MOH ownership of the health management information system (HMIS). There are signs that data is now being used for decision-making. The MOH website will provide access to a wealth of data to MOH staff at all levels. More progress is needed, particularly in instituting better outcome indicators for both the project and the MOH.

In result area 2, primary health care (PHC), HSS II support for accreditation of primary health care centers is one of its most successful components. The MOH places extremely high value on accreditation and sees it as a critical component of HSS. Anecdotal evidence suggests that accreditation has introduced a culture of quality. However, project indicators for accreditation—as well as for other PHC systems improvements, such as supervision—do not adequately capture progress made. Although accreditation is technically sustainable, financial sustainability is unclear. Prioritization criteria for accrediting future PHC clinics are needed. Continued support for accreditation is likely to result in better health outcomes generally, while the inclusion of accreditation criteria for FP services would likely result in more FP users.

In result area 3, safe motherhood, the project’s comprehensive approach to maternal/neonatal care went well beyond what was required to meet its indicators. The introduction of evidence-based medicine, update of clinical guidelines, and creation of centers of excellence are highly valued by the MOH and benefit every family who delivers at a public hospital. The use of other maternal indicators, such as incidence/1000 births of eclampsia seizure and blood transfusions, would track outcomes better.

In result area 4, FP, the project has not reached its targets. Compared to the baseline at the beginning of the project, total numbers of couple years of protection (CYPs), service delivery points, and intrauterine devices (IUDs) inserted have all decreased. IUDs are the most popular FP method in Jordan; they have the lowest discontinuation rates and the greatest impact on

CYPs. The legal/administrative barriers placed on midwives performing IUD insertions are the major reasons for the failure to reach targets. CYPs would likely improve significantly if the requirement that physicians supervise IUD insertion by midwives was removed. Use would also expand significantly with appropriate incentives for provision of FP services (including IUDs). The likelihood of achieving end-of-project indicators for FP is directly dependent on resolving midwife IUD insertion issues. CYPs for condoms and pills have plateaued since the beginning of the project. However, CYPs are higher in accredited health centers than in non-accredited ones. While the reasons for this are not clear, the correlation suggests that a stronger link between accreditation and improved FP services would likely result in increased CYPs.

In result area 5, engaging communities, the HSS II project is on track to achieve its objectives, but it is too early to say if the community health committees (CHCs) are sustainable. There is anecdotal evidence of successful health promotion activities by CHCs and Health Directorates (HDs). However, project indicators measure activity level, quantifying numbers of active community committees and health promotion activities. Without outcome measures, it is impossible to know if these activities lead to increased knowledge, awareness, and use of services.

In result area 6, renovations, the project's activities are highly valued by all levels of the MOH. The renovations are seen as responding to health needs and as critical to HSS. The project's approach to institutionalize the use of American Institute of Architects (AIA) design standards has succeeded; the MOH Building Directorate has fully embraced the standards. While it is difficult to measure their direct impact on health outcomes, the renovations are of enormous value to the MOH and could provide a critical foundation for integrated MCH/FP from which to leverage improved FP outcomes.

OVERALL CONCLUSIONS

The HSS II project is highly regarded throughout the MOH for its responsiveness to health needs and for its integrated approach to health delivery. The project has strengthened critical health systems through its support to health management information systems (HMIS), renovations, accreditation, referrals, and capacity-building. Across all components, from beginning to end, the project has prioritized capacity-building and institutionalization. Consequently, the evaluation team believes that all of the initiatives begun are sustainable, at least technically if not financially.

These strengthened health systems not only help USAID and the project achieve their objectives and better monitor performance, they help the MOH do the same, which is one of the reasons the MOH considers USAID a critically important partner. A revised log frame with a better designed and more specific set of outcome indicators would capture more fully the impact of project activities and help to maintain focus on critical health outcomes.

RECOMMENDATIONS

In the final two years of the HSS II project, the evaluation team recommends that:

- USAID use its well-earned influence with the MOH to negotiate the removal of a requirement that midwives be supervised for IUD insertion.
- USAID and the HSS II project should similarly advocate for innovative incentive schemes and/or varying salary grades that reward midwives and doctors providing FP services.

- USAID and the HSS II project should revise project indicators to reflect health outcomes and impact. Revised indicators would not only enhance the project's ability to measure achievements and progress but would also improve project focus. Revisions to log frame indicators do not require new or expensive research studies; they should come from existing MOH service data. (See Annex C for an illustrative log frame.)

In the future, the team recommends that:

- The USAID strategy should focus on the health center level by implementing a package of HSS activities and integrated FP and maternal and child health (MCH) services. By focusing on the health center level, where the bulk of FP services take place, such a program will have maximum impact. The health system package should include support for HMIS, HC renovations, supervision, referrals, and accreditation, per below.
- USAID should continue to support PHC accreditation because it improves both MCH and FP outcomes, particularly if accreditation includes revised criteria explicitly linked to FP service provision (e.g., staff trained in FP norms and standards, availability of at least four modern FP methods, private counseling areas, and a gynecology table).
- USAID should continue to support an integrated MCH/FP program that builds on gains in maternal and neonatal health. An integrated program would sustain a USAID/MOH partnership and improve FP outcomes.
- USAID should continue to support a broad-scale mass media behavior change and communication (BCC) campaign that focuses on the health advantages of birth spacing and enables families to plan their desired family size. Such a program should target men as well.

I. INTRODUCTION

BACKGROUND

Jordan has a population of approximately 6.3 million and a population growth rate of 2.2%, one of the highest in the region. Jordan boasts a relatively modern health system that is accessible to virtually everyone. It comprises the Ministry of Health (MOH), the Royal Medical Services (RMS), public university hospitals, the United Nations Relief and Works Agency for Palestine Refugees (UNRWA), and an extensive network of private and non-government organizations (NGO) health care providers and facilities. The MOH is the largest provider of health services and, after households, is the second largest financing source of total health care spending. It is responsible for maintaining public health by offering prevention, treatment, and health control services, as well as organizing and supervising health services offered by the public and private sectors. Approximately 50% of Jordanians rely on MOH primary healthcare (PHC) centers for outpatient services. The MOH is the main—and sometimes sole—source of health services for populations in remote areas and for lower income groups, including vulnerable Iraqis living in Jordan and, more recently, Syrian refugees.

Given the worsening economic situation in Jordan, it is vital that the MOH PHC system sustains, if not advances, the health gains of the past two decades.

The U.S. Government remains the largest donor in Jordan's health sector. In order to ensure that programs complement one another and to minimize duplication, the U.S. Mission coordinates with the international donor organizations also are working in Jordan's health sector. For example, USAID and the United Nations Population Fund (UNFPA) work jointly with the Higher Population Council (HPC) to build its capacity to advocate for strong intersectoral population strategies to address rapid population growth.

The high rate of population growth means that the population of Jordan could double in the next 30 years, to 13 million. In the meantime, high population growth acts as a development constraint because of the country's limited natural resources: lack of water, dependence on energy imports, and the quantity and quality of public services that need to be provided. The 2009 Jordan Population and Family Health Survey (JPFHS) found a total fertility rate (TFR) of 3.8, with virtually no change from 3.7 in 2002 and 3.6 in 2007. The stagnation of fertility decline is a cause for concern. The usual association between an increase in women's education and a decline in fertility has not proved as strong in Jordan. Recent studies have concluded that limited economic opportunities for women and the relatively low opportunity cost of having many children are critical factors helping to explain the plateau in Jordan's fertility rate.¹ While the fertility rate is stagnant, the population is increasing in absolute terms as the growing base of young men and women enters the reproductive stage of life. The lack of change is largely due to a broadly held social value in favor of large families. The 2009 JPFHS reported an ideal family size of 4.2 children. The widespread desire for large families is reflected in stagnant national contraceptive prevalence rates (CPR). Contraceptive prevalence has leveled off for all methods at 59% (JPFHS, 2009), compared to 57% in 2002 (JPFHS, 2002).

¹ USAID, "Economic Impact of Fertility Decline in Jordan," 2012.

Several other factors also contribute to Jordan's high fertility rate and plateauing levels of contraceptive use. These include the use of traditional FP methods, government incentives for large families, shortages of female health care providers, health provider biases against some modern FP methods, missed opportunities for counseling, a gender bias in favor of sons, traditional values and lifestyles, and cultural and religious beliefs that favor large families. There may be a political dimension as well.

For all these reasons, FP programs in Jordan need to be carefully constructed. For example, information, education, and communication (IEC) messages promoting small families are likely to be resisted. FP counseling and IEC materials that encourage the use of permanent methods, such as voluntary sterilization, are inappropriate in the Jordanian context and will not find acceptance. However, FP counseling emphasizing methods that assure a quick return to fertility, such as IUDs, is likely to increase demand. An integrated approach to FP that promotes the health of the mother and child through birth spacing is well accepted in Jordan. Such a program that addresses unmet need and reduces missed opportunities for FP counseling offers the best chance of achieving the country's FP goals.

HEALTH SYSTEMS STRENGTHENING II: PROJECT OVERVIEW

Health Systems Strengthening II is a five-year (2009–2014), \$73 million USAID-funded project that works with the public health sector, namely the MOH, the RMS, the HPC, and the Jordan University Hospital (JUH). The purpose of HSS II is to institutionalize improved health systems, processes, and performance in support of reduced fertility and improved women's health. Expected results are public sector initiatives in safe motherhood, FP, and reproductive health (RH), as well as improved quality of and access to health care services and information at three levels of the health system: central MOH, health directorate (hospitals and primary health facilities), and the community.

II. PURPOSE AND METHODOLOGY OF THE MIDTERM EVALUATION

This external evaluation comes at the chronological midpoint of the project. It is a midterm formative evaluation with the following objectives:

- A. Review, analyze, and evaluate the effectiveness of the HSS II project in achieving program objectives and contributing to USAID/Jordan's efforts to increase contraceptive prevalence, reduce total fertility, and reduce maternal and infant morbidity and mortality through strengthening the health systems.
- B. Evaluate major constraints in achieving expected project results.
- C. Provide specific recommendations and lessons learned on strategies and approaches the program should pursue over the next years of implementation and for future program planning.

This report covers the project period from September 2009–September 2012. However, as this project is a follow-on program to the five-year USAID Jordan Health Systems Strengthening Project (2005–2010), it also examines the overall country context of HSS and FP/MCH.

The evaluation team worked closely with USAID/Jordan and Abt Associates. The team began with a review of project documents, reports, health sector studies, MOH country strategies and policies, and other relevant documents.

Key informant interviews were conducted in-country over a span of more than two weeks. The evaluation team prepared a semi-structured questionnaire to guide its interviews. Persons interviewed included representatives from USAID; the central, directorate, hospital, and health center (HC) levels of the MOH; the RMS; and community health committee (CHC) members. The team spoke with the main projects: Strengthening Health Outcomes through the Private Sector (SHOPS), the Jordan Health Communication Partnership (JHPC), and the Jordan Healthcare Accreditation Project (JHAP). The team also met with the principal international donor on FP, the UNFPA. (See Annex C for a complete list of persons interviewed, and Annex D for the questionnaire.)

The evaluation team visited hospitals, health centers, health directorates (HDs), and communities in 4 of the 12 HDs in Jordan. For control purposes, evaluators also visited a health center not associated with the HSS II project.

With respect to the time allocated to carry out the evaluation, the team felt it was appropriate. The balance among interviews, site visits, and report writing—both in-country and at home—was also considered adequate. The team would have benefited from an initial briefing by senior USAID/Jordan management about its expectations of the evaluation.

III. FINDINGS

RESULT AREA I: PROMOTE THE PRINCIPLES AND PRACTICE OF KNOWLEDGE MANAGEMENT TO STRENGTHEN MINISTRY OF HEALTH DECISION-MAKING ORGANIZATIONAL PERFORMANCE

R 1.1: Health information systems collect reliable and valid data and generate simple and understandable information for providers and decision-makers at all levels.

The target for this sub-result is a maturity score for using a KM model. The baseline for this indicator is 1.74. The year 2 result was 1.74. The year 3 target is 2.0. The year 5 target is 2.3. The year 3 target was not achieved.

The evaluation team has struggled to understand the project's complicated scoring system. We understand that the KM model has five levels of maturity. The scoring is based on the Likert scale; scores range from 0 to a maximum of 4. This scoring system is based on an understanding of norms and concepts in the use of data as part of management decision-making.

The problem result area I seeks to address is a weak data culture in Jordan, a country where KM and health information systems are new concepts. They need to be promoted as part of a new and more effective management approach. In order for a new management approach based on quantified decision-making to be integrated into the MOH, strategic planning and needs assessments were conducted in a participatory and fully collaborative manner with MOH staff. Capacity-building was built in from the start. The approach was deliberately top-down, in order to identify capacity gaps or areas where cross collaboration between MOH departments and HDs was deficient. When the first HSS project began, data was not being collected systematically, nor was it sufficient in quantity or quality. Decision-making was only partly based on data. In addition, to the extent health information systems were used, each of the 12 HDs tended to have their own systems. Thus, there were issues of incompatibility, lack of data sharing, gaps between systems, as well as lack of maintenance of hardware and software. Information technology (IT) infrastructure was limited, as were trained IT staff.

The project's activities began with a KM assessment study in July 2010, followed by the development of a KM strategic plan based on the findings. The strategic plan was completed in September 2010. An IT staff training assessment was conducted in August 2010. A quality information system (QIS) improvement plan was completed at the same time. A comprehensive MOH data website plan was done in September 2010. In year 2 of the project, the family planning logistics management information system (FPLMIS) was upgraded. Also, the QIS was installed at the central level, and the performance assessment report was finalized. In year 3 of the project, the QIS—along with the IT equipment—was installed in 90 health centers. The perinatal information system (PIS) was also updated. The MOH website was developed and installed in July 2012.

There were delays in the completion of some of these activities, notably to the development and installation of the MOH website. In effect, the delay was deliberate. Instead of hiring an IT subcontractor to install an adapted, off-the-shelf website, the project decided to train MOH IT staff to develop and install their own website in order to build capacity and institutionalize

website management. This decision is consistent with the project's mandate to strengthen systems, and the evaluation team believes this decision will pay off.

Year 4 and 5 activity targets include launching the MOH website, installing an upgraded geographic information system (GIS) on the website, and conducting the final KM maturity survey.

R 1.2: *MOH staff at the central, HD, hospital, and HC levels have documented use of information generated by various health information systems for decision-making and quality improvement of services.*

The evaluation team noted examples at the HD level of data on referrals and IUD insertions being used to identify gaps in coverage and to request an additional midwife. There were other examples of data being used in planning and setting targets.

While the team has considerable anecdotal evidence that MOH staff at all levels are using data, it is difficult to find outcome data. This difficulty probably has more to do with project indicators, an issue discussed in detail in sections to follow. With the launching of the MOH website at the end of 2012, there is potential for an enormous expansion in data use. The team considers this result partially achieved.

R 5.3: *MOH has the capacity to regularly update the community resource GIS and use the information for planning and implementation of interventions at the HD level.*

While the delays previously noted affected the achievement of this objective, the team believes that the launching of the GIS in the MOH website will enable health staff at the directorate level to track progress in non-communicable diseases (NCD) care, as well as identify health centers' FP services capacities—including staffing and supply statuses.

R 1.3: *Performance assessment system institutionalized at the MOH to improve MOH ability to use performance data in assessing its progress and advocating policy changes for further improvement.*

The performance assessment (PA) reported on 66 key performance indicators related to monitoring, financing, human resources, and data management functions of the MOH. This PA report was conducted and disseminated in year 3 of the project, delayed from year 2. One of the report's findings was that the MOH lacked clear job descriptions for all categories of employees. Key MOH officials recognized that this would prevent any sustained improvement in organizational performance. Accordingly, the MOH requested assistance from USAID. Although not specifically called for in the contract, the HSS II project was asked to develop job descriptions for all categories of MOH employees. The process continued for more than a year and followed an extensive consultation with the MOH at all levels. The HSS II project developed new position descriptions (PDs) for about 445 categories of personnel. These PDs include performance indicators for each job title.

The evaluation team considers this a significant achievement for USAID and the HSS II project. The use of these PDs is the first step in establishing a staffing system that is transparent, provides a career ladder, and is based on merit.

The evaluation team struggled to understand the number of information systems in use. The PIS, maternal and child health information system (MCHIS), GIS, and FPLMIS were developed by predecessor projects; all of them have been updated by HSS II. The FPLMIS update included

moving from an old centralized database to a web-based Oracle system. As for the MCHIS and PIS, a set of new indicators were added, and the interface was made more user friendly. The GIS can now provide, for example, disaggregated data by region, level in the health system, health staff, health staff training received, contraceptive logistics, and other categories through the MOH website. The MOH website—with separate tabs and dashboards for the national, directorate, and lower levels—will serve as a tool for accessing indicators and variables collected by various information systems. The QIS is the only new system developed by HSS II project. Its purpose is to monitor quality improvements at the 120 health centers undergoing preparedness for accreditation.

Altogether, these systems provide a wealth of information for planning and management purposes. The task of integrating these different information systems into one unified and coherent health management information system (HMIS), however, seems daunting. In addition, the team wonders about the use of data by decision-makers in the MOH. Will data from the website, available to all levels in the health system, be simple to access and user friendly? Will it enable improved tracking of MCH/FP data at the health center level? How will the data be merged or integrated with the anticipated electronic records project? These are all questions to be addressed in the final two years of the project and beyond. The challenge for the project now is to measure outcomes and to assist the MOH in improving its monitoring and data use at all levels.

Conclusions

In summary, the evaluation team believes that the HSS II project has helped lay the foundation for a functional and effective HMIS. This is a considerable achievement.

RESULT AREA 2: IMPROVE QUALITY OF CARE AT PRIMARY HEALTH CARE LEVEL

Approximately 50% of the Jordanian population relies on primary health care (PHC) centers and clinics for outpatient services. A number of systemic constraints exist at the primary health care level: 1) services are primarily focused on curative care at the expense of preventive care and health education; 2) FP services are inadequate; 3) some physicians and midwives do not consider FP services to be a priority; and 4) there are weak linkages between hospitals and PHC centers.

HSS II's overall objective under this result area is to support a culture of quality and performance excellence that is essential to the accreditation of PHC centers. The HSS II approach was to strengthen the following systems:

- Management and planning systems for health center directors.
- Administrative systems, including referral and appointment and medical records.
- Supportive supervision to reinforce clinical best practices.
- Quality improvement systems to assist managers in identifying, solving, and monitoring quality issues.

The focus of HSS II's activities has been twofold: 1) preparing eligible PHC centers for accreditation by improving quality services and 2) institutionalizing the Essential Service Package (ESP) to improve access to quality services.

R 2.1: *Among HCs, 120 facilities are fully prepared for formal accreditation, and at least 50 of those are formally accredited.*

This indicator measures the total number of health centers that successfully meet all criteria for and are awarded Health Care Accreditation Council (HCAC) accreditation. Originally, project indicators included 200 “prepared” primary health centers of which 50 would be accredited, but this indicator was revised downward to reflect the considerable time and human resources required to prepare and achieve accreditation.

The project assisted the MOH to achieve accreditation for 26 of 30 health centers in the first round of accreditation activities (against a year 3 target of 20; target surpassed by 30%). By the end of year 5, the project target is 50 accredited centers. This target will likely be achieved.

HSS II used the HCAC standards for PHC and FP accreditation standards. The standards are organized around the most important eight functions, referred to as “clusters”: community integration, organization and management, management of information, continuum of care, client and family education, quality improvement and client safety, client care support, and human resources.

The HSS II project has divided the accreditation process into three phases called collaboratives. In the first collaborative (2010–2012), 30 HCs were enrolled, of which 28 were successfully accredited by the end of year 3. A further 60 HCs are currently enrolled in the second collaborative (2012–2013), and 30 more will be enrolled in the final phase (by the end of 2014). Of the total 120 enrolled and prepared centers, the end-of-project target is 50 fully accredited health centers countrywide.

The HSS II project provided training in a number of key areas, including infection control, patient safety, communication skills, patient education, referrals, and knowledge management (KM).

At the beginning of year 3, HSS II established a special “A-Team” of accreditation experts to increase the intensity and focus of its technical support with the aim of reducing the timeframe to accreditation. A-Team members conducted special visits to HCs and HDs, and coordinated more closely with the central MOH to help enable compliance with standards.

No financial support for infrastructure renovations or equipment purchase was provided by HSS II. All necessary renovations to facilities and equipment, as well as purchases of supplies and educational materials, were paid for by the MOH.

Field visits and interviews recorded a number of perceived benefits derived from accreditation. These included: client satisfaction (exit interviews report over 80%) and improvements in privacy, comfort, and waiting times; improved infection control (due to new sterilization equipment and waste disposal systems); unified patient records and improved filing systems; improved laboratory functions and capabilities; and the establishment of at least one training center per HD.

QUOTES from MOH Stakeholders in Support of Accreditation:

“Accreditation has created a culture of quality.” –MOH HD staff

“The shortest and simplest way to improve ourselves.” –central level MOH staff

“It is wonderful, the process of accreditation itself. The staff is now performing at more than 100%. The system is working with them and not against them.”—a doctor in an accredited PHC center.

The evaluation team strongly believes that continued support of accreditation as an HSS component will result in improved PHC. It is possible that FP services will be more trusted and sought out at HCs due to the enhanced overall quality of services at accredited HCs. The team notes that the MOH is very committed to accreditation.

R 2.2: A functioning referral and appointment system in all HDs.

Without a functional referral system, MOH hospitals are faced with a high number of unnecessary referrals, overloaded specialists, reduced quality of health services (e.g., doctor-patient encounter time), a large proportion of patients bypassing the referral system, low numbers of referrals being tracked, limited feedback information from referrals, inadequate controls over prescription duplication, and inadequate communication between facilities.

This indicator measures the functionality of the referral and appointment system. The criteria for a functional referral system include:

- At least one hospital with an appointment unit in each HD.
- 20% return rate on referral forms from hospital specialists to GPs at the PHC center.
- Monthly reports on referrals produced by HDs.

The project has yet to meet any of its annual targets. In year 1, the project reported only 2 functional HD referral systems against a target of 6; in year 2, only 1 of the target 10 were deemed functional. In year 3, the project helped the MOH to significantly increase this to 6 HDs with functional referral systems. Unfortunately, this is still 40% below the year 3 target of 10.

However, given the increase between year 2 and year 3, the project could still achieve its year 5 end-of-project (EOP) target of 10. The primary constraint in reaching targets to date is the low rate of information flow from hospitals down to HCs and care providers.

The HSS II project worked with the MOH to update and revise their referral forms and registers, their referral and clinical guidelines, and their referral reporting systems at all levels. Administrative staff at all levels of the MOH, hospital specialists, and HC staff were all trained on the updated/revised processes. In year 1, the project assisted the MOH with implementing a revised referral system in two HDs (Aqaba and Tafeileh). Year 2 saw a decline in functional referrals to only one HD. By year 3, the referral and appointment system was expanded to all 12 HDs. Increased numbers of hospital staff—both technical and administrative—were trained on referral systems to improve the feedback loop to HCs.

The project has helped the MOH implement regular assessments of its referral system at central MOH, HD, hospital, and HC levels. The third-year assessments showed significant improvements as a result of technical assistance provided over the course of the year, which is encouraging.

The MOH is now implementing almost all referral functions independently, without support from the HSS II project. To some extent, the referral system is on its way to being institutionalized. The project is now expanding the referral system to include the country's largest hospital, Al-Bashir. HSS II will provide ongoing technical assistance and IT equipment in the coming year.

The evaluation team noted the following during field visits and interviews: health staff at all levels felt a functional referral system is important for continuity of care; more control of drug use and for gate-keeping purposes; numerous MOH staff indicated that the referral system was still not well established and achievements had been slow; and a few health centers indicated that a system existed for patients to carry their own information to the consulting physician and back to their primary care provider.

R 2.3: *Operational planning, supervision, and monitoring systems are functioning in all HDs with documented improvements in health care delivery.*

Indicators under this measure assess planning and management of two NCDs, and FP among HDs. The first indicator is the percent of controlled hypertension patients attending MOH PHC facilities. The baseline/year 1 measure for this indicator was 59.56%. For years 2–5, the project target is set at 60%. At the end of year 2, 61.7% of all hypertensive patients were properly managed. By end of year 3, 65% of hypertensive patients were properly managed (target exceeded by 8%).

The second is the percent of controlled diabetes patients attending MOH PHC facilities. At baseline/year 1, the project recorded 41.57% of diabetic patients being properly managed at HCs. In year 2, 44.9% were properly managed, against a target of 40%. For years 3–5, the project target is 42%. By end of year 3, 44.6% of patients were being properly managed (target exceeded by 6%).

The third indicator measures the number of HDs that include interventions addressing long-acting FP methods. At the beginning of the HSS II project, none of the HDs had interventions addressing such methods incorporated into their annual plans. The project successfully assisted all 12 HDs with incorporating this element into their plans by year 3. The target was achieved. The team believes that this component will be sustained and that all 12 HDs will have long-lasting FP methods in their plans by the EOP.

No activities addressing improved clinical management of hypertension or diabetes were reported or noted in year 1 or year 2 of this project. Similarly, the inclusion of long-term FP in HD annual plans was only introduced in year 3.

In year 3, the HSS II project undertook a number of activities aimed at strengthening the planning and supervision processes of the MOH: MOH staff were trained in strategic planning to support the development of the coming five-year strategic plan (2013–2017); four central MOH directorates were assisted in developing strategies and operational plans; workshops were conducted to improve use of data for decision-making; and indicator scores and quality control

charts for hypertension and diabetes were reviewed to identify challenges and improve clinical management.

At the HD level, all 12 HDs undertook a midterm review and updated their operational plans. HSS II also facilitated quarterly meetings and provided technical support to PHC, MCH, and HP supervisors during routine supervision meetings. The Employee Engagement Model was tested in one directorate and found to have a positive effect on staff motivation and performance. At hospital and HC levels, technical assistance and workshops were provided to improve planning and supervisory capacity.

Only in year 3 did the HSS II project update clinical guidelines for diabetes and hypertension which are, in December, finally being printed. NCD and MCH indicators were also updated in the third year of activities.

Conclusions

Of all the result areas, the indicators for this result appear the most problematic to the evaluation team. Two indicators only measure input and activity level: number of HCs accredited and number of operational plans mentioning FP. Of these, the mention of FP in a plan signifies little and does not guarantee implementation, impact, or relevance to project objectives. Second, while the use of health outcomes (e.g., management of hypertension and diabetes) as a proxy for supervision may be plausible, the team is not confident that clinical outcomes will improve in the short term. Moreover, the targets set for these indicators were essentially unchanged from baseline levels. The evaluation team believes project activities very likely had a substantial impact on effective supervision. However, because of the indicators selected, the important gains are not captured and lessons learned are lost.

The accredited centers themselves are proud to be accredited, and those not yet accredited are eager to become so. Ownership of the accreditation system lies firmly with the MOH and the process has been successfully institutionalized. While it is technically sustainable, it remains unclear if it is financially sustainable—certainly not for 100% of its centers. To remain accredited, the relatively costly process of re-accreditation is required every two years. Were additional HCs to be accredited, this would represent an added expense.

Referral systems appear to be on their way to institutionalization, though the high level of staff turnover within the MOH continues to be a constraint. The evaluation team was unable to determine with certainty whether planning and supervision have improved based on the current indicators.

RESULT AREA 3: MATERNAL AND NEONATAL HEALTH

R3.1: *Documented improvements in maternal and neonatal health care services at public sector hospitals (MOH/RMS).*

According to UNDP/WHO, the 2005 maternal mortality rate in Jordan was 62 per 100,000 live births (Ministry of Planning and International Cooperation/United Nations Development Program [MOPIC/UNDP] report it at 19.8 per 100,000 live births in 2009). In Jordan, 99% of all births occur in hospitals, and of those, about 60% occur in public (MOH/RMS/University of Jordan) hospitals. The four most common causes of maternal death are hemorrhage, thrombosis, sepsis, and pregnancy-induced hypertension. The most common cause of infant

mortality in Jordan is neonatal mortality. The vast majority of both maternal and neonatal deaths occur in-hospital, where the quality of care directly affects mortality rates.

HSS II is tasked with helping to improve the quality of safe motherhood (maternal/neonatal) services at the hospital level. An indicator of quality is the percent of women monitored during labor using the partograph. The baseline was 80%; the year 3 target was 90%, and the year 5 target is 95%. The year 3 achievement was 86%. Another indicator of quality is the percent of women with pregnancy-induced hypertension managed according to the clinical guidelines. The baseline was 80%; the year 3 target, 90%; the year 5 target, 95%. The year 3 achievement was 88%. These targets were achieved.

The HSS II approach to increase use of partogram and compliance with clinical guidelines for management of pregnancy-induced hypertension primarily involved assisting the MOH/RMS to:

- Strengthen appreciation of the importance of evidence-based medicine.
- Develop the Mother-Newborn Package of hospital services.
- Institutionalize best practices and strengthen providers' skills at hospitals to reduce maternal and neonatal mortalities by developing and printing the practices, training trainers, and conducting didactic and on-the-job training.
- Standardize hospital maternal and neonatal medical records.
- Increase use of the partograph per se.
- Strengthen hospital emergency obstetric care and neonatal care clinical guidelines.
- Strengthen the capacity of hospital safe motherhood committees to plan and to monitor and supervise care.
- Reinforce the adoption of active management of third stage of labor by didactic and on-the-job training (per request of the MOH).

HSS II helped develop and printed many materials, including: “Evidence-Based Medicine Manual for Health Care Providers,” “Best Practices for Implementing the Mother-Newborn Package of Services at Hospitals – Maternal, Best practices for Implementing the Mother-Newborn Package of Services at Hospitals – Neonatal, The Essential Obstetric Care Competency Based Training Modules for Physicians.

The maternal best practices publication addresses 23 topics relevant to care; the publication on neonatal best practices covers 25 topics. These materials are comprehensive and can be a valuable resource to providers. The providers interviewed by the evaluation team cite the guidelines as a big achievement and claim to be using them.

The partogram helps encourage regular attention to the laboring patient and appropriate intervention if labor is not progressing normally. Moreover, it is an important record of critical clinical information. Prior to introduction of the partogram and HSS II's introduction of a “check-the-box” style labor summary form, labor and delivery records were cumbersome and only cursorily completed. The staff at the hospitals visited by the evaluation team thoroughly grasped the value of the partogram—one nurse described it as “golden.”

The potential for impact on clinical obstetrical practices extends well beyond the hospitals where HSS II has worked; six of these hospitals serve as training hospitals for medical, nursing, and midwifery students—as well as pediatric and obstetrics and gynecology (OBGYN) residents. Therefore, where practices are improved, the students and residents will take what they learned with them wherever they practice in the future. This is sustainability. One challenge to sustainability that does exist is the very high rate of turnover of trainers. In the span of one year, turnover of MOH trainers can be between 50 and 60%.

The OBGYNs we spoke with were enthusiastic about the kinds of motherhood assistance the project was providing. They loved the help and were excited about the renovations and new equipment.

Another indicator of quality of maternal services is the percent of hospitals (currently 25 hospitals; to be 30 hospitals by end of year 4) using confidential inquiry into maternal deaths and near misses. The baseline was 0%; the year 3 target, 50%; the year 5 target, 85%. The year 3 achievement was 52%. The target was achieved.

The HSS II approach to introduce and support use of confidential inquiry includes:

1. Developing guidelines for confidential inquiries into maternal mortality and near misses.
2. Developing necessary reporting forms and training providers in their use.
3. Assisting the forming of safe motherhood committees at the hospital level and the central MOH levels (the latter which is chaired by the secretary general).
4. Training hospital safe motherhood committees to conduct confidential inquiries and develop plans to do so.
5. Assisting the committees with analyzing data and implementing quality improvement interventions.

Institutionalizing confidential inquiry is a challenging task. The idea is new to many. Distrust about confidentiality is common among providers, and the true value of the process is not always immediately obvious. Therefore, achieving the year-3 target is laudable. A significant challenge to sustainability is the high rate of turnover among safe motherhood committee members. The committee is chaired by the hospital director—and the hospital director is the committee's most important member. In one hospital, for example, there were three different hospital directors in the span of a year. Therefore, the process of confidential inquiry will likely need continued support beyond the years of the HSS II project, until its value is clear to physicians and administrators.

An indicator of the quality of newborn services is the percent of inborn neonates admitted to the neonatal intensive care units (NICUs) at selected MOH/RMS hospitals (renovated hospitals, currently 12 hospitals reporting) who are discharged home alive. The baseline Y2Q2 was 86.3%; the year 3 target, 88%; the year 5 target, 90%. The year 3 achievement was 88%. The target was achieved.

The HSS II approach to increasing the survival rate of neonates admitted to the NICUs involved assisting the MOH/RMS with the following:

- Institutionalizing the package of services, best practices, medical records, and clinical guidelines as described above.

- Conducting didactic and on-the-job training on continuous positive airway pressure (CPAP, helps obviate the need for intubation) at all of Jordan's 30 hospitals with labor and delivery units.
- Developing an effective neonatal referral process.
- Developing aseptic IV fluids preparation management guidelines, training materials, and monitoring tools.
- Developing the safe motherhood committees (described above) that also oversee the NICU.

The neonatology staff with whom the evaluation team met enthusiastically embraced the introduction of CPAP. One of CPAP's virtues is that it can be managed by the neonatology nurses. This is an appropriate and needed technology. The pediatricians also embraced the best neonatal practices. Although the neonatal referral process and training on aseptic IV fluids preparation were not part of the original strategy for HSS II, the project stepped in to meet these needs when problems were identified in those areas.

The clinical materials HSS II has helped develop, though of a high quality, are not easy to update because they are hardbound. They can become obsolete almost as soon as they are published. A ring-bound set of clinical materials with a table of contents containing dates for each section would make it far easier for the MOH to update these materials.

Conclusions

HSS II adopted a much more comprehensive/holistic approach to maternal/neonatal care than would necessarily be required to merely meet the indicators (for example, the use of partograph and management of pregnancy-induced hypertension). HSS II helped introduce evidence-based medicine and best practices, develop or update clinical practice guidelines, and so on. Moreover, HSS II identified and tackled unrecognized problems—such as neonatal transfer and IV fluid preparation. The obstetrics and NICU physicians/nurses with whom the evaluation team met could not speak more highly of the assistance. HSS II should be commended. The evaluation team also believes the use of good practices and clinical guidelines is being institutionalized and is sustainable.

The evaluation team notes that the use of partograph, correct management of pregnancy-induced hypertension, and use of confidential inquiry are all process indicators for maternal care—not outcome indicators. Moreover, the use of partograph and management of hypertension were introduced before the onset of HSS II, and both were already quite well established, as evidenced by the high baselines of the respective indicators. While the neonatal outcome measure of NICU survival is appropriate, the team believes other measurable maternal outcome indicators exist and could be used.

RESULT AREA 4: IMPROVE QUALITY OF AND INCREASE ACCESS TO FAMILY PLANNING/REPRODUCTIVE HEALTH SERVICES

The problem to be addressed is a stagnating TFR, which was 3.7 in 2002 and 3.8 in 2009, after having dropped from 7.4 in 1976. The high fertility rates drive a population growth rate of 2.2% per year. At that rate, Jordan's population will double to nearly 13 million by 2040.

R 4.1: (Contribute to) increased use of modern FP methods, a shift from traditional to modern method usage, and decreased total fertility and FP discontinuation rates.

HSS II is tasked with helping to increase use of FP services. One indicator for measuring this is the percent of the 444 MOH HCs providing at least four modern FP methods (i.e., condoms, oral contraceptives, IUDs, injectables, implants). If four methods are provided, a long-term method (IUD or implant) is included by definition. The baseline for this measure was 29.7%; the year 3 target, 40%; the year 5 target, 50%. The year 3 achievement was 28.7%. Not only did the project fail to reach its year 3 target, but the percent reached is actually lower than the baseline. The CYP data mirrors the results on this indicator. Total CYPs from HCs in the first quarter of 2010 was 31,895, while total CYPs in the second quarter of 2012 was 28,140. In the next section, this evaluation examines why this occurred and makes recommendations accordingly.

The HSS II approach to increasing access to FP services includes:

- Training in IUD insertion for midwives and physicians; refresher training for midwives; refresher training for providers on contraceptive technology, including IUD insertion; and introducing IUD services to 20 additional HCs and hospitals.
- Developing a training module for long-acting hormonal contraceptives, conducting a training of trainers, training providers, and introducing Implanon to 40 HCs/hospitals.
- Training midwives on forecasting and management of FP commodities.
- Training MCH supervisors.
- Integrating FP into the curricula of Jordan University medical and nursing schools, RMS Princess Muna Nursing College, and the family medicine residency program (in progress), with staff from these institutions attending orientation workshops.

The single most important reason the project failed to meet its target was a problem that developed regarding midwives and their role of providing IUDs. Although midwives in Jordan have been inserting IUDs since 2004, various groups inside and outside the MOH raised the issues of client safety and legal protection for midwives performing this procedure. Many MOH midwives decided not to continue providing IUDs—presumably because of liability concerns but also, in some cases, because of the additional workload.

Access to IUD services is of critical importance in Jordan for several reasons:

- According to the 2009 DHS, 50% of women using a modern FP method use IUDs.
- The DHS reported that among women not currently using FP but intending to do so in the future, the four most preferred methods were IUDs, 44.6%; pills, 22.5%; withdrawal, 11%; and condoms, 5.8%.
- The 2009 DHS reported that the discontinuation rate for IUDs (15%) is 3–4 times lower than for any other method.
- According to the USAID-sponsored report, “The Cost of Family Planning in Jordan” (2009), the cost of IUDs in the public sector (\$1.65/CYP) is much less than that of any other method: condoms (\$2.48/CYP), injectables (\$3.49/CYP), implants (\$7.23/CYP), and pills (\$13.29/CYP).

The 2009 DHS found that the public sector provides about 40% of all IUDs inserted in Jordan. In late 2009, about 47% of those were provided by midwives. Midwives are important because of the Jordanian women's preference for a female physician or midwife to perform the insertion. Midwives are also important because their turnover at the HCs is much less than that of physicians. One head of MCH at the health directorate estimated that midwives typically stay two or three years; physicians typically turn over every six months.

As a result of the controversy over midwives inserting IUDs, the percent of IUDs provided by midwives had dropped to 24% in 2011 from 47% in 2009. Correspondingly, the CYPs generated by IUDs plummeted from 17,590 (Q1, 2010) to 7,730 (Q2, 2011). Overall CYPs (all methods) dropped from 31,895 in 2010 to 23,023 in 2011. The MOH conducted a situational analysis on the safety of midwives inserting IUDs. No safety issues emerged from the analysis. A compromise policy emerged (captured in the midwives' newly drafted job description) whereby the MOH decided that a midwife could insert an IUD if a "trained" physician, who would assume medical/legal responsibility, was present at the same facility. In order to meet this requirement, physicians with no prior expertise in IUD insertion received a two-day course in supervision of IUD services.

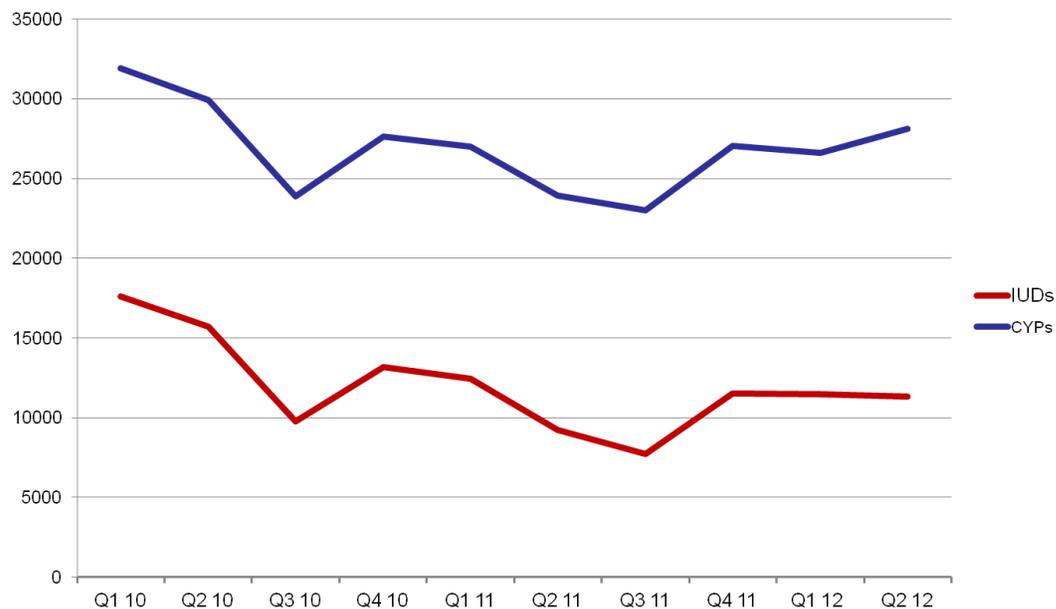
Although the MOH's "compromise policy" of allowing midwives to insert IUDs under the supervision of physicians has helped remedy the problem—CYPs provided by IUDs have risen to 11,320—CYPs still fall far short of the 17,590 CYPs in 2010.

Additional challenges to access to IUD services include:

- Inadequate number of supervising physicians located in the same HCs as IUD-trained midwives.
- Some providers' possible belief that not providing IUDs is somewhat condoned by the MOH. Therefore, they have been allowed to decline training, refuse to supervise, or find other ways to avoid providing services.
- Lack of space, sufficient privacy, and furniture (proper table) in some HCs to provide IUD insertion.
- Inadequate number of IUD-trained physicians/midwives—situation aggravated by turnover.
- Lack of incentives for providers to provide IUDs (e.g., existence of an official certification to provide IUDs, or other long-term methods, that would add to the qualifications considered with determining a provider's salary grade).

Although the IUD midwife issue has been the biggest problem in terms of CYPs, CYPs for condom and pills at HCs are also stagnant. CYPs for condom Q1 2010 was 5,042; in Q2 2012, they were 5,012. CYPs for pills in Q1 2010 were 7,602; in Q2 2012, they were 8,739—but the overall trend over the 2 ½ years was almost flat (see figure 1). When the evaluation team pointed out to a senior MCH official at the central MOH that CYPs are now lower than at the beginning of the project and asked whether HSS II had been effective in helping the MOH's FP program, the official responded, "Imagine how low the CYPs would be without HSS II."

Figure I: IUD Insertion & CYPs Over the Life of the Project



HSS II has succeeded in helping to introduce Implanon in 40 HCs and hospitals. The MOH has been the supplier of Implanon and injectables to Jordan. We understand that MOH line-item budgets will assure the continued supply of these methods in the future.

R 4.2: *A more comprehensive client-centered ESP that enables service providers to expand their services and provides clients and communities with better quality FP information and services.*

The indicator for this measure is the percent of missed opportunities for FP education at PHC centers. The baseline is 82.5% (measured by exit interviews at a sample of HCs); the year 3 target, 70%; and the year 5 target, 50%. The year 3 achievement was 65%. The HSS II project exceeded the target.

The overall approach for decreasing missed opportunities at health centers has been to help:

- Conduct FP orientation for non-MCH health providers.
- Task the HC clerks with distributing referral cards for FP services to women of reproductive age.
- Task non-FP service providers with referring clients for FP (with name of provider written on referral card and a log book in the FP clinic that records the providers' names who referred clients).
- Focus project's efforts on HCs involved in the accreditation process.

The project abandoned the idea of the clerks distributing the referrals when this turned out to be ineffective. The approach of generating referrals from other service providers has been piloted, found to be working, and is now being expanded.

The percent of CYPs from long-term methods in the 90 HCs selected for accreditation rose by 6.4% compared to a rise of 0.7% in the other HCs. In the 90 participating HCs, CYPs increased by 18% (from 2011 to the first half of 2012); in the other health centers, the increase was only

3.5%. Although these findings are difficult to interpret because accredited health centers received more attention than non-accredited centers (e.g., more on-the-job [OTJ] counseling training), there appears to be a relationship between accreditation and use of FP services. This relationship could be made much stronger were the criteria for accreditation to include specific and comprehensive FP-related requirements.

R 4.3: *Health care providers are counseling and motivating women to use long-term contraceptive methods and to minimize discontinuation.*

Lastly, HSS II has been charged with improving the quality of FP services. The indicator that corresponds to quality of services is the percent of IUD and oral contraceptive (OC) clients discontinuing their method within one year. The baseline is 14% for IUDs and 42% for OCs. The year 3 target was 13% for IUDs and 40% for OCs. The year 5 target for IUDs is 12% and for OCs, 38%. The year 3 achievement has not been determined because the sentinel surveillance study (responsibility of the MOH) has not yet been completed; results are expected by January 2013, if not earlier.

The overall approach of HSS II for improving the quality of services has been to:

- Update FP and reproductive care clinical guidelines.
- Conduct provider training (previously mentioned).
- Establish counseling trainers.
- Train midwives in the use of FP educational materials.
- Develop counseling and clinical management job aids—a counseling flip chart and, How to Manage Side Effects, Complications, and Other Problems for Modern Family Planning Methods.

The training on counseling and clinical management of side effects will likely improve the quality of services, as will use of job aids. However, a particularly high-quality set of handouts for new users, developed by the JHCP, are available at some of the MOH FP service sites. The evaluation team did not see them in all sites it visited. Failure to use these in all sites is itself a missed opportunity.

Failure rates of IUDs and pills, although not indicators for this project, can signal the quality of services. According to a 14-country study², the mean failure rate for IUDs was 2.5%, while that of Jordan was 2.8% (though the rates are not disaggregated by public and private sector). That Jordan's failure rate was close to the mean indicates that, in terms of technical skills, midwives and physicians in Jordan are performing well. Failure rate of pills in Jordan is reported in the DHS at 8.1%. This compares to a very similar rate, about 8%, in the United States. Jordanian pills users (again, data not disaggregated by public and private sectors) are achieving very acceptable efficacy rates. The low failure rate for pills suggests good quality of services.

The evaluation team could not tell whether the project had met its discontinuation targets. There are some reasons to believe it will not achieve the target for IUDs. The baseline IUD discontinuation rate is 14%. The 2009 DHS reported a desired family size of 4.2 children. The

² Long Term Contraceptive Protection, Discontinuation, and Switching Behavior—IUD use dynamics in 14 countries.

previously cited 14-country study reported a 12-month discontinuation rate of 13.2% (mean for 14 countries)—only slightly lower than Jordan’s baseline. Moreover, of women in all countries who discontinued IUDs, 5.9 % did so because they wanted to get pregnant; in Jordan, 17.3% did so for that reason.

In contrast to the IUD discontinuation rate, Jordan’s 12-month discontinuation rate for pills (42%) is relatively high compared to the rate reported from a six-country study³ where the rate for the pill was 35.5% (mean for six countries). Moreover, the DHS reported that, compared to IUD users, pill users are more likely to discontinue due to method failure, side effects, and wanting a more effective method. Therefore, improved counseling should lower the discontinuation rate for pills more than for IUDs.

The only other assessment of quality of services was the Missed Opportunities Client Exit Interview 2011 Report. Among women intending to use an FP method on the day of the interview, the percent of those who received thorough counseling (six of six key topics addressed and ability to choose method) decreased from 74% (in 2010) to 57%.

Although the HCs chosen for this survey were selected from all MOH HCs, not just those health centers where providers participated in counseling training (organized with the help of HSS II), it is still a disturbing finding. Providing adequate counseling is important to discontinuation rates—especially for pills—and is a factor that is almost wholly under the control of the health system.

R 4.4: *FP services are offered to postpartum and post-miscarriage women at MOH RMS hospitals and JUH.*

Another opportunity to improve use of FP is after miscarriage. The indicator for this is the percent of post-miscarriage clients receiving a modern method after discharge at 26 selected hospitals (the total number of deliveries from these hospitals will represent 80–85% of annual public sector deliveries). The baseline was 0%; the year 3 target, 20%; the year 5 target, 40%. The year 3 achievement was 20.4%. The target was met.

HSS II’s overall approach to increasing acceptance of post-miscarriage methods included:

- Developing service standards.
- Establishing family counseling standards for head nurses of obstetric wards.
- Training PHC and hospital staff to serve as trainers, conducting a refresher course on FP/RH training for trainers at the hospital and PHC levels, and training trainers on updated FP counseling curriculum.
- Orienting hospital safe motherhood committee members on postpartum/post-abortion FP services.
- Training health providers (hospital and PHC levels) on FP counseling.
- Orienting hospital staff about FP for post-miscarriage and postpartum clients.
- Testing an appointment system to the hospital’s postpartum clinic.

³ *Contraceptive Discontinuation in Six Developing Countries: A Cause Specific Analysis*—Guttmacher web site.

- Encouraging informal supervision by the head nurses.

The few hospitals that have assigned a full-time staff member to conduct post-abortion and postpartum FP education/counseling report good performance on the degree to which these patients receive education/counseling. In the remaining hospitals, the job is shared among various nurses and is one of many responsibilities. In these hospitals, the job is sometimes viewed as extra work, an attitude that is a possible threat to sustainability.

The expectation of achieving the year 5 target of 40% of post-miscarriage clients accepting a method may not be realistic. By mid-2011, 25.5 % of post-abortion clients were receiving a method. However, a year later, the percent had dropped to 23.0%. There is seldom a medical contraindication to a woman's getting pregnant (without delay) after a miscarriage. Although the exact percent is not known, a large portion of miscarriages were desired pregnancies; in these cases, the majority likely hopes to become pregnant again with minimal delay. Another challenge to meeting subsequent targets is the lack of hospital budgets for IEC materials, which has already led to stock-outs in some hospitals.

In addition to improving access, the HSS II project is responsible for helping increase demand for FP services. Two indicators relate to increasing demand. One indicator is the percent of postpartum clients receiving FP counseling/information before discharge from selected hospitals. The baseline is 0; the year 3 target is 20%; the year 5 target is 40%. The year 3 achievement was 35%. Thus, the target was met. Moreover, the percent of postpartum clients actually receiving a method (though not an official indicator) rose from 0 to 25.5%.

The overall approach for providing postpartum education/counseling is the same as that for increasing the percent of post-abortion acceptors. In contrast to the post-miscarriage target, it seems likely that the year 5 postpartum counseling target will be met. The threats to sustainability of the postpartum program are the same as those to the post-miscarriage program: lack of staff, resistance to doing extra work, and lack of budget for IEC materials.

R 4.5: *Number of PHC and MCH centers providing a FP service is increased, with emphasis on poor and underserved areas.*

To date, HSS II reports having included a small percent of the physicians/midwives from poor and underserved areas in their IUD and counseling trainings. HSS II plans to focus more on these areas in years 4 and 5.

The GIS data that HSS II is helping develop will have the potential to show FP service capacity (e.g., availability of four methods, space, privacy, equipment for FP, exam couch, and staffing for IUD insertion) with an overlay (e.g., population density or income level). This tool could be used to ensure adequate services in poor areas and to identify underserved areas.

R 4.6: *A functional FP supervision and monitoring system at central and HD levels (health centers and hospitals) that will help ensure proper counseling, the provision of contraceptive information and methods, and effective follow-up with clients.*

HSS II is tasked with helping to improve the effectiveness of supervision of FP/RH services. The indicator is the number of HDs with a functioning FP and MCH supervision system. The baseline was 0; the year 3 target was 12 of 12, with 60% of scheduled visits completed. For year 5, the target is 12 of 12, with 70% of scheduled visits completed. The year 3 achievement was 9 of 12. The target was not met.

The HSS II approach to improving the effectiveness of MCH supervision consisted of:

- Revising and updating MCH supervision tools—focusing on FP services.
- Assisting MCH at directorates to define, document, and disseminate roles and responsibilities.
- Helping develop/revise the indicators.
- FP - % HCs with four modern methods.
- Percent postpartum clients using modern FP method (not an HSS II project indicator)
- Women health - percent of antenatal clients tested for anemia, percent of antenatal clients assessed for risk (Coopland Score) during first trimester, percent of antenatal clients returning for postpartum care.
- Child health - percent children < 1 tested for anemia.
- Training on MCH indicators and on MCH supervision.

Although the MCH supervisory system is still immature, there is evidence of progress in its ability to monitor and interpret data and take actions based on that data. For example, in one of the directorates visited by this evaluation team, an MCH supervisor reported that there were many HC to HC referrals for IUD insertion originating from a particular geographic area. In response, the supervisor reassigned an IUD-trained midwife to that location. The sustainability of improvements in the MCH supervisor system is jeopardized by high staff turnover. When a central MCH official was asked to identify her biggest needs (in terms of FP), she cited the fragility of the supervisory system and the need for ongoing support of that system.

Conclusions

1. At the HC level, measurement of missed opportunities is determined by using an exit survey. Conducting the survey is labor intensive, vulnerable to methodology problems, and does not provide information on all service sites.
2. Efforts to increase postpartum education and counseling have not only met indicator targets but have increased users. Efforts to increase post-miscarriage users have achieved their target, but there is likely little more room for growth in user rates in this population.
3. The central MOH MCH unit itself recognizes that the supervision system is still fragile.

RESULT AREA 5: ENGAGE AND EMPOWER COMMUNITIES TO ADOPT HEALTHIER LIFESTYLES

The objective of result area 5 is to improve the health status of communities, with particular emphasis on the “poverty pockets” and underserved areas. To do so, the project has two primary approaches:

- Strengthen capacity within the MOH to institutionalize its health promotion (HP) program.
- Empower communities to identify and address their own health needs through community-led initiatives and mobilization.

R 5.1: *Community health committees (CHCs) are established and functioning in all HDs with special emphasis on poor and underserved populations, both in rural and urban areas.*

The indicator for this measure is the percent of active CHCs in HDs (out of eligible CHCs). The indicator for this result was changed from the total number of CHCs established and active in years 1 and 2 to the percentage of active CHCs in years 3 through 5. The target is 80%.

An active CHC must fulfill three criteria:

- A demonstrated SOW, roles and responsibilities, and operational instructions.
- Updated annual workplans addressing health needs in the community.
- 60% of the activities in the annual workplan must be implemented within the allocated timeframe.

Of the 75 CHCs covering 88 HC catchment areas established at the end of year 3, 90% were active. Target achieved.

In year 1, the HSS II project and MOH updated the community needs assessment tool to include more process and results criteria to better evaluate the effectiveness of its HP activities. The project also trained CHCs to use the Community Action Cycle (CAC) methodology, which assists in prioritizing problems, generating local solutions, and improving ownership of health outcomes. The project initiated the establishment of new CHCs in defined poverty pockets, with the successful “activation” of two (in Mafraq and Amman).

In year 2, the project increased the number of active CHCs to 29 across all 12 HDs. CHC workplans developed for the year included raising awareness among men and women about birth spacing and the use of modern FP to improve the health and lives of mothers and children, as well as the family’s overall quality of life. FP awareness sessions were held at HCs, women’s and charity associations, and specially organized health awareness events.

In year 3, the project helped to establish 39 new CHCs, bringing the total to 75 CHCs covering 88 HCs (43 active CHCs were reported out of 47 that were eligible). All CHCs developed and updated their annual action plans using participatory rapid assessment (PRA) and the CAC. Plans addressed the community’s health priorities, including RH/safe motherhood, adolescence, and healthy lifestyles. Planned activities varied from conducting health surveys to holding free medical days; introducing healthy eating habits at school cafeterias; and holding FP and birth spacing sessions at mosques, voluntary societies, and women’s charity associations.

HSS II handed over full responsibility for supervising and following up on 15 CHCs to the Health Communications and Awareness Directorate. As part of this process, HSS II provided capacity-building and on-the-job-training to directorate staff. Joint visits to selected CHCs were also conducted. The project helped create an annual assessment tool for established CHCs with criteria based on the committee’s documentation process, networking skills, and action plan implementation. To make the annual assessment more meaningful, and to motivate and help sustain CHCs, the project and MOH are jointly developing a recognition and award system.

R 5.2: *Information on ESP; FP; RH; and maternal, neonatal, and child health are promoted at the community level.*

The indicator for this sub-result is the number of HDs with an active health promotion program. The HDs provide health promotion information on ESP; FP; RH; and maternal, neonatal, and child health. The information is in turn promoted through women's groups, youth groups, and community groups. An HD with an active health promotion program must have:

- A certified health promoter (HP) trainer.
- At least 60% of its health centers trained on HP concepts and practices.
- At least 60% of its planned HP activities implemented at its health centers.
- At least 60% of those health centers who receive training reporting on a monthly basis.

While the HSS II project surpassed its targets in year 1 (6 HDs with an active HP program) and year 2 (10 HDs with an active HP program), it recorded only 8 active HP programs in year 3, failing to reach its target of 10. Staff turnover at HDs was the primary reason the project did not meet this target.

In year 1, HSS II conducted a number of workshops at the central level to assist the MOH Health Communications and Awareness Directorate to develop its five-year strategic plan. HSS II also conducted training of trainers for new and existing HP supervisors to build and reinforce managerial capacity and assist with the proper implementation of community-based health promotion activities. The project also held a two-day workshop for community-based organization (CBO) board members to develop capacity in fundraising and proposal development. Other HSS II trainings included a three-day "Arab Women Speak Out" workshop for women leaders from the Jerash governorate and a three-day workshop for adolescent males and females from various youth centers in Jerash.

In year 2, a training module entitled "Designing of Community-based Interventions," which included social change theories and practices for HP supervisors, was developed. The HP training curriculum was updated for all 12 HDs. A further 14 workshops were incorporated in annual action plans of various health centers, and 336 staff from 89 health centers were trained on HP. Training of trainers at the supervisor level was conducted to support ongoing training of HC and community staff. A total of 12 women's groups and 12 youth groups were formed to promote life planning and healthy lifestyle skills. Three community mobilization campaigns were conducted, and more than 100 community events reached 9,400 women with FP messages.

In year 3, the project developed and updated tools to support implementation of the MOH health promotion program in collaboration with the health promotion supervisors. These were tested and revised to ensure ease of use and efficiency for MOH staff. The MOH and HSS II project launched a one-year "Family Planning and Healthy Lifestyle" campaign in the Amman governorate with a series of health fairs held in different locations. As part of this initiative, 12 groups of peer educators, 13 women's advocacy groups, and the Doctors and More community group conducted education and outreach activities.

The evaluation team noted several anecdotal examples of success stories from both the CHCs and the HD health promotion initiatives. While CHCs are intended to address issues and problems identified from within the community, the project does ensure that all CHCs include activities related to FP in their monthly workplans. All of the midwives interviewed in HCs gave numerous examples of specific changes in the knowledge of, acceptance of, and felt need and demand for FP in the last 3-5 years (among women and, importantly, their partners). However,

they could not say whether or not these changes were in part attributable to either the work of the CHCs or of HD health promotion departments. Nor was it clear whether FP will remain a priority focus of community outreach work in later years as CHCs graduate from project assistance to direct supervision from the HDs.

Conclusions

Although the HSS II project is on track to achieve its objectives, it is too early to say if the CHCs are sustainable (which is a requirement of the HC accreditation process). The project is on course to institutionalize health promotion activities within HDs, but sustained outreach activities by the various groups formed (women, youth, etc.) are less likely. The project is measuring its targets at the activity level, quantifying the number of community structures or programs in place rather than the effect of these activities over the short and long term. Without any impact measures, it will be impossible to know if these activities increase knowledge and awareness or lead to increased use of services.

RESULT AREA 6: RENOVATE, EQUIP, FURNISH, AND MAINTAIN HEALTH FACILITIES

R 6.1: Obstetric and neonatal departments and emergency rooms in selected hospitals renovated and upgraded to comply with international standards.

Originally the project design called for 18 hospitals to be renovated and upgraded. That number was reduced to 14 according to a contract modification in September 2012. The cumulative targets up to and including year 3 of the project were 7 hospitals, 4 of which were completed. The project therefore did not achieve its target. The targets for year 4 of the project are to complete construction on an additional 6 hospitals, for a total of 13 of the 14 planned. The renovation of the final hospital is expected to be completed by the end of year 4.

The problems addressed by this component included overcrowding and lack of space for proper monitoring of the laboring patient, delivery rooms, immediate postpartum observation, operating theater for emergency cesarean section, postpartum ward, and number and proximity of NICU beds. Maternity admissions account for 40% of all hospital admissions at Al Basheer Hospital. Upgrading OB wards affects the lives of almost every family in Jordan.

Instead of subcontracting for engineering and related design services, the project's approach to renovation and upgrading, consistent with its mandate, was to work on health systems and institutional strengthening in the Directorate of Buildings. Project technical assistance focused on upgrading hospital standards in building design and institutionalizing them into the Directorate's plans and construction operations. The standards used are derived from the AIA. The design and engineering for hospital renovations was done through a subcontractor with participation from the Directorate of Buildings, the MOH engineering department, relevant hospital staff, and HSS II and USAID engineers.

As for maintenance of the hospital renovations, a one- to two-year guarantee or warranty exists for the contractor of each hospital renovation. The responsibility for managing these warranties is with the Directorate of Buildings of the MOH. A maintenance manual has been prepared, with project assistance, and the directorate staff has been trained in its use. The evaluation team has been assured an adequate MOH budget for spare parts exists.

This component of the project was an impressive success, even though there were delays and some cost overruns. The MOH is very proud of their upgraded hospitals. The team heard comments that renovation created a physical environment that enhanced quality of care, facilitated better organization of services, resulted in a capacity to handle more patients, and permitted more in-house staff training. One OB department chairman identified improved patient flow, more ability to observe patients, better privacy, and improved infection prevention. Another told the team about the design of areas by function, such that triage and both visual and electronic patient monitoring were improved. Other design features described were delivery rooms located next to laboring patients; operating rooms located next to delivery rooms; and the proximity of the NICU, facilitating transport of babies from delivery rooms to NICU when needed—a critical issue. At Al Basheer Hospital, the medical director appreciated the location of a special elevator between the delivery rooms and the NICU, another feature that facilitates critical transport. The Al Basheer director also mentioned the increased NICU capacity, enabling it to meet a growing need from referring hospitals. A related effect of NICU renovations and increased bed capacity has been to increase referrals to upgraded hospitals from non-upgraded hospitals. This has the potential to create centers of excellence in quality of care, as well as more strategic allocation of scarce health resources.

Senior MOH engineers said that they considered the HSS II renovations to be a model for the rest of the hospitals. Other hospital directors have reportedly said, “We want our hospital to be like theirs.” New hospital construction will adopt the AIA standards used by the project. It was requested that the four hospitals dropped from the list be added back. All of this strongly indicates that the hospital renovation and upgrading standards and processes have been integrated and institutionalized into the MOH operations.

R 6.2: *A standard list of essential medical equipment and furniture is provided to all MOH and RMS hospitals according to priority needs.*

Medical equipment, such as neonatal monitors and ventilators, was procured from the United States, while furniture was procured locally. These lists were to be developed in cooperation with MOH engineers and technicians. This result was achieved in year 3 of the project. Hospital directors expressed pride in the state of the art equipment in the NICUs.

Equipment maintenance is addressed through regular field visits by project staff in concert with directorate officials.

R 6.3: *Selected primary health training centers renovated, equipped, and furnished.*

By year 3, 10 of the 10 targeted training centers had been renovated, equipped, and furnished. Sub-result achieved. These renovations included rooms for MCH/FP counseling and training.

The evaluation team visited some of these renovated training centers at health facilities and can report a high level of satisfaction from the center staff. Staff assured the team that the quantity, if not the quality, of counseling and training had improved as a result.

R 6.4: *IT equipment to strengthen/expand/develop health information system (HIS) is procured installed and utilized.*

This result measures MOH approval of the HIS plan and procurement and installation of software and hardware. Technical assistance from the project helped develop the plan, which

was approved by the MOH IT department. IT software and hardware, including networking, were installed in 90 HCs. This sub-result was achieved.

The evaluation team notes that this is a process or input indicator. It does not measure the extent to which data is collected, used, and analyzed, or if a functioning health information system exists. Such outcome indicators belong in result 1.

R 6.5: *A standardized and efficient facility and IT maintenance system at central and hospital levels established, functioning, and sustainable.*

This indicator measures the development of maintenance guidelines and their approval by the MOH. It also measures training in their use and procurement of maintenance tools. This was accomplished and the sub-result was achieved in year 3 of the project.

The project provided technical assistance in the development of a building maintenance manual that includes standards, supervision guidelines, record-keeping, and inventory procedures for maintenance monitoring. Project staff also helped the MOH set up a maintenance taskforce; this effort included developing terms of reference, formulating a maintenance improvement plan, procuring tools, creating a maintenance record-keeping system, and training staff. The evaluation team believes that as a result of these capacity-building measures, proper facility maintenance has been institutionalized in the MOH.

Conclusions

The evaluation team noted that the renovations and PHC accreditations are well known and highly valued within the MOH as being responsive to health needs and critical to HSS. As a result, the MOH sees USAID as an important and credible partner.

IV. CONCLUSIONS

Objective	YR3 Target	YR3 Actual	Achieved?
Result Area 1: Knowledge Management			
1.1 Maturity score for KM	2 (YR2: 1.74)	TBD ongoing (YR2: 1.74)	TBD
1.3 MOH-wide performance assessment report done	1	1	Yes
Result Area 2: Primary Health Care			
2.1 # of accredited health centers	20	26	Yes
2.2 Functional referral system	10	6	No
2.3 Operational planning, supervision, and monitoring systems	2.3a 60% controlled hypertensive patients	65%	Yes
	2.3b 42% controlled diabetic patients	44.6%	Yes
	2.3c Long-acting FP in 12 HD operational plans	12	Yes
Result Area 3: Safe Motherhood			
3.1 Improved maternal-neonatal services at hospital level	3.1a 90% monitored by partograph	86%	?
	3.1b 88% neonates discharged alive	88%	Yes
	3.1c 90% PIH managed by clinical guidelines	88%	?
	3.1d 50% use of confidential inquiries	52%	Yes
Result Area 4: Family Planning			
4.1 Increased use of modern FP methods	4.1 40% PHC with 4 modern methods	28.7%	No
	4.2 70% missed FP counseling opportunities	65	Yes
	4.3 Discontinuation: IUD–13%, OCs–40%	TBD/ongoing	TBD
	4.4a 20% of post-miscarriage clients receiving modern method	20.4%	Yes
	4.4b 20% of postpartum clients receiving FP counseling	35%	Yes

Objective	YR3 Target	YR3 Actual	Achieved?
	4.6 12 HDs with FP/MCH supervision system	9	No
Result Area 5: Community Health			
5.1 #/% active CHCs	5.1 80%	90%	Yes
5.2 Information provision on ESP, FP, MCH	5.2 10 HDs with active HP	8	No
Result Area 6: Renovations			
6.1 OB/NICU departments renovated	6.1 EOC/NICU: 5, ER: 2	2 and 2	No
6.3 # training centers renovated	6.3 10	10	Yes
6.4 IT equipment procured	6.4 100%	100%	Yes
6.5 Maintenance guidelines	6.5 100%	100%	Yes

The table above summarizes the findings from the previous section. It shows year 3 targets for 23 indicators compared to what was achieved—in other words, a summary of progress achieved to date. The results are 13 targets achieved; 2 targets TBD; and 2 uninterpretable targets, because the margin for error in data collection is too large.

In the previous section, we analyzed why some targets were not achieved. Judging from this table alone, one can conclude that the HSS II project is on track. In its remaining two years, the project is very likely to achieve its objectives.

The evaluation team believes that this table does not sufficiently reflect what has occurred to date. The project's achievements go beyond what this table captures. Some of the project's shortcomings are noted as well.

The HSS II project is well managed and has excellent relations with all levels of the MOH. The team heard many comments from the MOH about their great satisfaction with the project. The MOH considers the project one of its most important partners, and it regularly contacts project staff to obtain technical advice. Communications and relations with USAID have also been excellent.

RESULT I: KNOWLEDGE MANAGEMENT

The HSS II project has helped lay the foundation for a functional and effective HMIS. The project is in the process of transforming a weak data culture. Its approach to building capacity and institutionalizing norms and standards of data management has created internal MOH advocacy and commitment to HMIS. There are signs that more data is available throughout the health system and that it is beginning to be used in decision-making. The MOH website, scheduled to launch in December 2012, houses the various HMIS. It promises to make accessible to all levels in the MOH a wealth of disaggregated health data. To help the MOH measure, track, and manage all its programs, more progress needs to be made, particularly by using more and better outcome indicators, both for the project and for the MOH.

RESULT 2: PRIMARY HEALTH CARE

The accreditation component of the project is one of its most successful. The MOH places extremely high value on the accreditation of its PHC centers. The MOH sees accreditation as being responsive to health needs in the country and critical to strengthening its health system. There is anecdotal evidence that accreditation has created a culture of quality and that accredited HCs perform better in terms of quality and quantity of services offered. However, the existing indicators do not adequately capture such improvement. Other health system improvements, such as supervision and referrals, are also not well captured by the existing indicators.

Accreditation has been institutionalized in the MOH. While it is technically sustainable, financial sustainability is unclear. The evaluation team believes strongly that continued support for accreditation as an HSS component will result in better PHC, MCH/FP, and NCD care. If future criteria for accreditation specifies in detail the required level of FP services, more FP users would likely result. One challenge will be to determine the criteria for the selection and prioritization of HCs to be accredited in the future.

RESULT 3: SAFE MOTHERHOOD

The MOH highly values what the project has achieved under this result. HSS II adopted a much more comprehensive/holistic approach to maternal/neonatal care than would necessarily be required to merely meet the indicators. It helped introduce evidence-based medicine and best practices, and develop and/or update clinical practice guidelines. Moreover, HSS II identified unrecognized problems—such as neonatal transfer, IV fluid preparation, and active management of the third stage of labor—and tackled them. HSS II should be commended for the quality of assistance provided.

Another example of the project's more comprehensive approach was the de facto creation of centers of excellence by virtue of clinical training and renovations. These centers provide extensive pre-service clinical training (to medical, nursing, OBGYN, and pediatric residents, as well as midwife students) on maternal and neonatal services. They also serve as referral centers for complicated cases. These centers of excellence benefit every family who delivers at a public sector hospital.

The evaluation team also believes the use of good practices and clinical guidelines are being institutionalized and are sustainable. Confidential inquiry is an important concept, but recognition of its potential value by staff at MOH hospitals will take time.

The evaluation team notes that the use of partograph, and correct management of pregnancy-induced hypertension are both process indicators for maternal care rather than outcome indicators. Moreover, use of the partograph and management of hypertension were introduced and quite well established before the onset of HSS II—as evidenced by the high baselines of the indicators. While the neonatal outcome measure of NICU survival is appropriate, other measurable maternal outcome indicators exist and could be used.

RESULT 4: FAMILY PLANNING

The number of health centers offering four methods is the single most important indicator for FP. Of these, IUDs have the greatest impact on CYPs. They are also the most popular and have

the lowest discontinuation rates. Nurse-midwives are the most important health providers of IUDs. To the extent the project achieves its FP objectives, it will be through increasing the numbers of IUDs inserted by midwives.

The project's results are well below baseline. In fact, compared to the beginning of the project, CYPs have decreased, service delivery points have decreased, and the number of IUDs inserted has decreased. The barriers placed by the MOH to the insertion of IUDs by midwives is the major reason for these results. Use would likely improve significantly if the requirement that a physician supervise midwives for IUD insertion were removed. Use would also expand significantly with appropriately designed incentives for physicians/midwives to provide FP services (including IUD insertions).

Along with the decline in CYPs for IUDs, the CYPs for condoms and pills have plateaued since the beginning of the project.

The evaluation team notes that overall CYPs, as well as long-term CYPs, are higher in the accredited health centers than in the non-accredited ones. While the reasons for this are not clear, we believe this positive relationship has significance. Linking accreditation more explicitly with the adoption of FP norms and standards would very likely result in better FP services and increased CYPs.

At the HC level, measurement of missed opportunities is determined through an exit survey. Conducting the survey is labor intensive and likely not sustainable.

While data is not yet available for IUD discontinuation rates, this indicator is not well chosen and is unlikely to be achieved. The discontinuation rate for oral contraceptives would be a better project indicator because the rate in Jordan is relatively high and therefore more likely to be influenced by quality of counseling.

Efforts to increase postpartum education and counseling have not only met indicator targets but have increased users. Efforts to increase post-miscarriage users have achieved their target, but there is likely little more room for growth in user rates in this population.

The project's success in adding FP to pre-service curricula is commendable.

RESULT 5: ENGAGING COMMUNITIES

While the HSS II project is on track to achieve its objectives, it is too early to say if the CHCs are sustainable. There is anecdotal evidence of successful health promotion activities managed by CHCs.

The project is measuring its targets at the activity level, quantifying the number of community organizations reached and health promotion activities undertaken. Without outcome measures, it is not possible for the project or the organizations themselves to know if these activities lead to increased knowledge, awareness, and use of services.

It is not clear if the project is focused on reaching "poor and underserved" areas where there is higher unmet need, lower CPR, high population density, and so on. The focus of project activities to date has primarily been in support of HC accreditation.

RESULT 6: RENOVATIONS

The evaluate team notes that the project’s renovation activities are well known and highly valued by the MOH, at all levels. They are seen as responding to health needs and as critical to HSS. (This applies to accreditation as well.) For example, the MOH sees the project’s hospital renovations as helping to create centers of excellence for maternal and neonatal care, benefiting all families who seek care from MOH hospitals.

The project’s efforts to institutionalize the use of AIA design standards have succeeded. These standards have been fully embraced and internalized by the MOH Building Directorate. Other hospital directors say, “We want our hospitals to look like that.”

OVERALL CONCLUSIONS

The HSS II project is highly regarded throughout the MOH for its responsiveness to health needs and for its integrated approach to health delivery. For example, when asked how he would respond to a request from the Minister to improve the project, one HD director said, “The first thing I would say is to thank the Minister for this project.”

The project has strengthened critical health systems through its support to HMIS, renovations, accreditation, referrals, and capacity-building. This support is highly valued by the MOH as well. These strengthened health systems not only help USAID and the project achieve its objectives and better monitor performance, they help the MOH do the same.

Such support has enabled the project to contribute to results beyond what was called for, such as the creation of centers of excellence in MOH hospitals and improvements in the quality of maternal and neonatal care.

In all its activities, the project has made capacity-building and institutionalization its priorities. Consequently, the evaluation team believes that all the activities begun are sustainable—technically, if not financially.

The evaluation team has noted in almost all the result areas the presence of input indicators where better outcome indicators could be used. A better designed log frame and a revised set of indicators would capture more fully the impact of the project. This is particularly true for FP indicators. An example of such a log frame is in the annex to this report.

V. RECOMMENDATIONS

The evaluation team’s recommendations are divided into two parts: one for the remaining two years of the HSS II project (the near term) and one for the follow-on project (the long term). These recommendations are based on the findings and conclusions described in the preceding section. They are not necessarily in order of priority.

NEAR TERM

USAID should use its well-earned influence with the MOH to negotiate the removal of the supervision requirement for midwives inserting IUDs. USAID should consult closely with HSS II project leadership in planning and organizing how to best approach the MOH on this issue.

USAID should use its influence in a similar manner to discuss with the MOH ways to introduce incentives for midwives. One possibility is to recognize FP training/service provision in the determination of salary. As per the above, USAID should consult closely with HSS II project leadership on approaching the MOH on this issue.

The indicators in the current log frame should be revised to reflect outcomes or impact. The evaluation team has noted throughout this report that the current set of indicators tends to be process or input oriented. As a result, there is a corresponding tendency to lose sight of the prize (i.e., outcomes and impact). We believe the project is having a significant impact that is not being fully captured. Such a revision would not change activities. Nor would it require costly and time-consuming surveys or studies. The information would come from existing service data. See Annex C for an illustrative log frame. The following are specific subrecommendations on this subject:

- Revised indicators that measure FP outcomes across various systems strengthening components would assist USAID and the project in evaluating how and which of these activities are most likely to increase FP use and CYPs over time. Similarly, outcome indicators for FP will keep the project better focused and able to rapidly recognize and respond to new challenges (such as IUD insertions by midwives) and to adjust strategies and activities as needed.
- To assess missed opportunities, the team recommends measuring the number of FP acceptors compared to the total number of HC patient visits (all diseases, all visits).
- The indicator of discontinuation rate for IUDs should be eliminated. It should be replaced with indicators for quality of care (e.g., six out of six counseling points achieved among women intending to use an FP method [based on exit interviews], and a handout card [for new users, developed by JHU] given to all new users).
- The FP literature suggests that there is a low likelihood of significant increase in post-miscarriage acceptors and that FP counseling directed at such patients is not likely to make a substantial contribution to CYPs. Therefore, the level of HSS II program efforts should be adjusted accordingly. The year 5 target for post-miscarriage acceptors should also be adjusted downward. In its place, postpartum patients—far more likely to use FP—should be targeted and the “percent postpartum users” should be added as an indicator.

- The evaluation team believes the community involvement result area could play a larger role in the next two years in health promotion in general and in FP awareness in particular. We recommend introducing simple methodologies for measuring impact of CHC activities, such as small-scale community surveys, reporting on numbers of new patients for FP, and community screening events. All of these can be sustained by CHCs and HDs in the future.

LONG TERM

The USAID strategy should focus on the HC level by implementing a package of HSS activities and integrated FP/MCH services. By focusing on the HC level, where the bulk of FP services take place, such a program will have maximum impact.

We recommend continued support for accreditation, because such health system support will improve both MCH and FP outcomes. The HSS package should also include support for HMIS, HC renovations, supervision, and referrals.

We recommend inclusion of revised accreditation criteria at the HC level that is more explicitly linked to FP service provision. Such criteria should include staff trained in FP norms and standards, the availability of four+ modern methods, private counseling areas, and a gynecology table.

USAID should continue supporting an integrated MCH/FP program. Such a program will maintain MOH commitment while increasing FP outcomes.

USAID should continue to support a broad-scale mass media/BCC campaign that focuses on the health advantages of birth spacing and that enables couples to plan their desired family. Such a program should target men as well. A long gap in BCC and demand promotion activities will have an adverse effect on USAID's efforts to increase access.

ANNEX A. SCOPE OF WORK

GLOBAL HEALTH TECHNICAL ASSISTANCE BRIDGE II PROJECT

GH Tech

Contract No. AID-OAA-C-12-00027

SCOPE OF WORK

Nov 1, 2012

I. TITLE:

USAID/Jordan: Mid-Term Evaluation of the Health Systems Strengthening II Project

II. CONTRACT:

Global Health Technical Assistance Bridge II Project (GH Tech)

III. PERFORMANCE PERIOD

Work is to begin depending on the availability of the selected consultants, with work beginning early November 2012, with field work completed during mid-November 2012 and final report and close out concluding by January 24, 2012.

IV. FUNDING SOURCE

USAID/Jordan Mission field support funds

V. PURPOSE OF ASSIGNMENT

This external evaluation comes at the chronological mid-point of the project. It is a mid-term formative evaluation whose objectives are to determine:

1. Review, analyze, and evaluate the effectiveness of the Health Systems Strengthening II (HSS II) Project in achieving program objectives and contributing to USAID/Jordan's efforts to increase contraceptive prevalence, reduce total fertility and reduce maternal and infant morbidity and mortality through strengthening the health systems.
2. Evaluate major constraints in achieving expected project results.
3. Provide specific recommendations and lessons learned on strategies and approaches the program should pursue over the next years of implementation and for future program panning.

The evaluation should cover the project period from September 2009 to September 2012. However, this project is a follow-on program to 5 years of USAID investments in this area; particularly the USAID Jordan Health Systems Strengthening Project (2005-2010), and therefore should be examined in the overall country context of health systems strengthening and FP/MCH.

The findings and recommendations of the evaluation will be used to improve implementation of the ongoing project and will also be used in the design of future follow-on project or in the design of other relevant health projects/programs. With the exclusion of procurement sensitive

sections USAID intends to disseminate the report widely with the public health stakeholders such as government and NGO program managers, USAID implementing partners, donors and health professional associations. Upon clearance on procurement sensitivity, USAID will actively share the document with government agencies, donors, implementing partners and other NGOs through mail correspondences and seminar/workshops. USAID expects the evaluation report will benefit the implementing partners, host government, and other donors in improving their understanding on the program and in designing interventions for future programs.

VI. BACKGROUND

Jordan Health Situation

Jordan has a population of approximately 6.3 million and a relatively advanced health care system compared to other countries in the region. The population growth rate of 2.2% is one of the highest in the region, and continues to be a major development constraint, especially in light of the quantity and quality of services that need to be provided to accommodate this rapidly increasing population and the fact that Jordan has a limited natural resource and economic base.

Jordan boasts a relatively modern health system that is accessible to virtually everyone. It is comprised of the Ministry of Health (MOH), the Royal Medical Services (RMS), Public University Hospitals, The United Nations Relief and Works Agency for Palestine Refugees (UNRWA) and an extensive network of private and NGO healthcare providers and facilities. The MOH is the largest provider of health services and, after households, is the second largest financing source of total healthcare spending. It is responsible for maintaining public health by offering prevention, treatment and health control services, as well as organizing and supervising health services offered by the public and private sectors. Approximately 50% of Jordanians rely on MOH Primary Healthcare Centers for outpatient services. The MOH remains the main and sometimes sole source of health services for populations living in remote areas and for lower income groups, including vulnerable Iraqis living in Jordan and recently to Syrian refugees. Given the worsening economic situation in Jordan, the role of the primary healthcare system is becoming more vital in sustaining, and even advancing, the health gains of the prior two decades.

The USG remains the largest donor in Jordan's health sector. In order to ensure that programs complement one another and to minimize the duplication of efforts, the US Mission coordinates with the international donor organizations that are working in Jordan's health sector. For example, USAID and the United Nations Population Fund (UNFPA) work jointly with the HPC to build its capacity to advocate for strong inter-sectoral population strategies to address rapid population growth, build gender sensitivity, develop the capacity to conduct high-level population-related advocacy activities, and build capacity for monitoring and evaluation.

The 2009 Jordan Population and Family Health Survey (JPFHS) found a total fertility rate (TFR) of 3.8, with virtually no change from 3.7 in 2007. The stagnation of fertility decline is a cause for concern, as declines in fertility rates are typically associated with increases in a population's rate of education, increased social and economic opportunities for women, and awareness of the individual and social cost of having many children. Also of concern is that, while fertility rates are stagnant, the absolute number being added to the population increases as the growing population base of young men and women enter the reproductive stage of life. The lack of change is due in large part to a broadly held social value in favor of large families. The 2009 JPFHS reported an ideal family size of 4.2 children. The widespread desire for large families is

reflected in stagnant national contraceptive prevalence rates (CPR). Contraceptive prevalence has leveled off for all methods at 59% (JPFHS, 2009), as compared to 57% in 2002 (JPFHS, 2002).

Many other factors contribute to Jordan's high fertility and plateauing levels of contraceptive use, including high discontinuation rates, use of traditional FP methods, government incentives for large families, shortages of female health care providers, health provider biases against some modern methods and desire for large families, and missed opportunities for counseling, a gender bias in favor of sons, traditional values and lifestyles, and cultural and religious beliefs that favor large families

Health Systems Strengthening II: Project Overview

Health Systems Strengthening II is a five-year (2009-2014) \$73 million USAID-funded project that works with the public health sector namely; Jordanian Ministry of Health (MOH), Royal Medical Services (RMS) the Higher Population Council (HPC) and Jordan University Hospital (JUH) to institutionalize improved health systems, processes and performance to the benefit of the Jordanian people who use the public health services. Expected outcomes, in direct support of reduced fertility and improved women's health, are primarily public sector initiatives in safe motherhood, family planning and reproductive health, and improved quality of and access to health care services and information at three levels of the health system—central MOH, Health Directorate (hospitals and primary health facilities), and the community.

Health Systems Strengthening II: Main Objectives and End of Project Results

I. Improve quality of and increase access to FP/RH services

- (Contribute to) increased use of modern family planning methods, a shift from traditional to modern method usage, and decreased total fertility and discontinuation rates.
- A more comprehensive client-centered Essential Services Package that enables services providers to expand their services and provides clients and communities with better quality family planning information and services.
- Health care providers are counseling and motivating women to use long-term contraceptive methods and to minimize discontinuation.
- Family planning services are offered to post-partum and post-miscarriage women at MOH hospitals.
- Number of PHC and MCH centers providing a FP service is increased with emphasis on poor and underserved areas.
- A functional FP supervision and monitoring system at central and health directorate (health centers and hospitals) levels that will help ensure proper counseling, the provision of contraceptive information and methods, and the effective follow up of clients.
- Strengthened management and planning capacity of HDs, so that operational plans take into account factors related to population growth and family planning issues

- Community level health promotion plans and interventions developed and implemented for clients and surrounding communities that include family planning and be synergized with community mobilization activities whenever Community Health Committees exist in the health centers' catchment area.

2. Improve quality of safe motherhood at hospital level

- Documented improvements in maternal and neonatal mortality and morbidity at public sector hospitals (MOH/RMS).
- Postpartum/post-miscarriage care including counseling and provision of family planning methods is institutionalized in MOH hospitals.

3. Improve quality of care at primary health care level

- 200 health centers are fully prepared for formal accreditation and receiving five stars through the current Reward and Recognition system and at least 25% of the 200 health centers are formally accredited by the end of this task order.
- A functioning referral and appointment system in all 12 HDs with major improvements in the reduction of crowding (patient flow), increased provider-client encounter time, and increased patient-provider satisfaction at specialty clinics in comprehensive health care centers and hospitals.
- Operational planning, supervision and monitoring systems are functioning in all health directorates with documented improvements in health care delivery. Increased prevalence of modern contraceptive use, decreased prevalence of method specific discontinuation rates, increased proportion of patients with controlled chronic illnesses such as diabetes and hypertension with clear validation methodology and documentation are illustrative examples of improvement in provision of service delivery.

4. Promote the principles and practice of knowledge management at the MOH

- Health information systems collect reliable and valid data and generate simple and understandable information for providers and decision makers at all levels.
- MOH staff at the central, Health Directorate, hospital and health center levels have documented use of information generated by various health information systems for decision making and quality improvement of services.
- The Performance Assessment system is institutionalized at the MOH so that the use of PA will improve the ability of the MOH to use performance data in assessing and improving its progress and advocate policy changes for making progress.

5. Improve Community Health

- Community health committees are established and functioning in all 12 HDs with special emphasis on poor and underserved populations both in rural and urban areas.
- Information on the ESP, family planning, reproductive health, maternal, neonatal and child health are promoted at the community level.

- MOH has the capacity to regularly update the community resource GIS and use the information for planning and implementation of interventions at the HD level.

6. Renovate, equip, furnish and maintain health facilities

- Obstetric and neonatal departments in 13 selected hospitals renovated and upgraded to comply with international standards.
Emergency departments in five selected hospitals renovated and upgraded to comply with international standards.
- A standard list of essential medical equipment and furniture is provided to all renovated MOH and RMS hospitals according to priority needs.
- Ten selected primary health training centers renovated, equipped and furnished.
- IT equipment to strengthen / expand / develop health information systems is procured installed and utilized.
- A standardized and efficient facility maintenance system at central level established, functioning and sustainable.
- An efficient decentralized maintenance system for hospital facility and equipment established, functioning and sustainable.

VII. SCOPE OF WORK

The evaluation should address the following questions:

1. To what extent has the project achieved its objectives against established project results and indicators?
2. How has the project contributed to strengthening the national health system processes and services, especially for FP and MCH? Service delivery, health workforce and health information system are the main building blocks to be evaluated.
3. What components of the project have been most/least effective and what can be done to improve the project performance?
4. How effectively has the project coordinated with the Government of Jordan (GOJ) and other donors to achieve its objectives?
5. What recommendations or actions should USAID take to support future scale up of the project activities?
6. Has the rehabilitation and infrastructure component of the project helped it to achieve desired outcomes? If so, how has it helped?
7. What are the project management issues that adversely impact performance of the project?

VIII. METHODOLOGY

The evaluation team will work in close consultation with USAID/Jordan and Abt Associates. The key issues to be addressed by the evaluation team should be developed in consultation with the Jordan Population and Development Office during the evaluation team's first meeting with the

Mission. The evaluation team should start its work with a paper review of all the documents cited in the “Document Review” section.

It is recommended that the evaluation team consider a mixed-method evaluation approach with a focus on current clients and potential clients. The methodology should combine a review of quantitative data and application of qualitative evaluation techniques to obtain information, opinions, and data from counterparts, contractors, partners, clients, beneficiaries, GOJ entities, and other donors. The approach should be participatory and should involve the use of questionnaires as appropriate.

By using a mixed approach, the evaluation team will gain insight on the impact of the HSS II project activities (mostly from quantitative data collected by the project and others) and the processes (mostly qualitative information provided by the project staff and key informants) that lead to those impacts. Sequential and iterative approaches should be used to integrate the mixture of methods at various stages of the evaluation.

In consultation with USAID/Jordan Population and Development Office staff, the evaluation team will draft an assessment methodology/design for USAID approval. The team will conduct a two-day in-country team planning meeting upon arrival in Jordan and before starting the in-country portion of the assessment. Members of the USAID Jordan Population and Development team will participate in sections of the planning meeting. The planning meeting outcomes will be shared with USAID/Jordan for review and feedback before the assessment begins.

The following essential elements should be included in the methodology as well as the additional methods proposed by the team:

Review of background documentation: USAID Jordan Population and Development Office will provide the Team Leader with a core list and/or copies of the Agreement, reports of recent relevant assessments and other key documentation before the assessment begins. The Evaluation Team Leader will be responsible for expanding this background documentation as appropriate, review, prioritize and distribute it to other team members for their review. All team members will review relevant documentation before their initial team meetings, including:

The evaluation team should consult a broad range of background documents apart from project documents provided by USAID/Jordan. These include documents such as the national strategies, donor and multilateral partner strategies and evaluations of related health projects. USAID and the HSS II Project will provide the assessment team with a package of briefing materials, including:

- HSS II Project Description
- HSS II Project Monitoring Plan
- Project quarterly and annual reports, work plans and management reviews developed as part of routine monitoring
- The Jordan Global Health Initiative Strategy
- USAID/Jordan Country Development Cooperation Strategy 2012-17 (as cleared by the front office).

- 2009 Jordan Demographic and Health Survey
- Jordan Health Systems Profile, 2011
- Jordan's National Population Strategy
- HSS II project website: www.hss.jo

Planning meetings: The full evaluation team will meet upon arrival in Jordan and will finalize planning during their two day planning meeting in-country. The team planning meetings are essential in organizing the team's efforts. During the team planning meetings, the team should:

- clarify all team members' roles and responsibilities, including drafting of report;
- develop and review final assessment questions;
- review and finalize the timeline and share this with Population and Development Office;
- develop and finalize data collection methods (disaggregated – by sex, age, geographical region, education level, etc.) and instruments (USAID data standards apply);
- review and clarify any logistical and administrative procedures for the assignment;
- establish a team atmosphere, share individual working styles, and agree on procedures resolving differences of opinion;
- develop a preliminary draft outline of the team's report; and
- assign drafting responsibilities for the final report.

Initial Team briefing meetings with the Jordan Population and Development Office:

The full team will have an initial meeting with Population and Development Office staff in Jordan. During this meeting they will share an outline and explanation of the design of the assessment, and receive feedback from the Population and Development Office. The evaluation team will have follow-up meetings with specific Population and Development Office staff at the outset of the process, and will remain available for consultation throughout the length of the evaluation.

Key informant interviews: The full evaluation team or designated team members will have interviews with the following (not inclusive):

- Relevant USAID offices in Jordan
- HSS II implementing partners at both HQ and field level
- Key GOJ representatives across multiple sectors (MOH, RMS and Jordan University) including field level staff engaged in family planning and maternal-neonatal health programs
- Stakeholders: beneficiaries, Higher Population Council, universities, community members etc.
- Major donors involved in health systems strengthening and FP and MCH

- Staff from other relevant USAID implementing organizations, especially USAID Jordan health projects.

Data from key informant interviews may be organized to quantifiable information on certain indicators or be used to validate data obtained from other reports.

Implementation Site visits: Team members, as appropriate, will visit selected project implementation sites in at least three out of the 12 health directorates in Jordan. Potential sites include but not limited to health directorates (both central and governorate level), hospitals, primary healthcare centers and community health committees.

Limitation: The evaluation will not be engaged in primary data collection from any statistically designed sample of beneficiaries or providers to measure the effect of the project on defined indicators. It will rather depend on the secondary data available from the routine management information system records and the reports of other surveys and assessments conducted by this project or other programs. Since key informant interview will be a major source for validation of information available from the project, chances of bias are likely. The evaluation should carefully decide on the methodology and select interviewees in a way that the possibility of bias is avoided or reduced to a minimum.

IX. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Team Composition

We would like to engage the services of a four person evaluation team. The team should include three international consultants and one local consultant. The former should include specialists with the following areas of expertise: health systems strengthening, family planning and maternal health, sustainability and experience in conducting evaluations. The local consultant should have an excellent understanding of the Jordan public health system and be fluent in Arabic. The team leader should be an evaluation and health systems expert.

The Team Leader should be an independent consultant, and one of the technical specialists could be from the USAID/Washington Global Health Systems Strengthening Division. If it turns to be feasible for a person from USAID/Washington to participate, the team should include two international consultants in addition to the Team Leader. The fourth team member will be a local technical consultant.

Team Leader (Health Systems and Evaluation Specialist):

The Team Leader should be an independent consultant with appropriate educational and professional qualifications, including a degree in public health and/or medicine/nursing and postgraduate training in public health program evaluation. S/he should have at least 10 years senior-level experience working in health systems programs or health program evaluation in developing countries. S/he should have extensive experience in conducting qualitative and quantitative evaluations. Excellent oral and written communication skills are required. The Team Leader should also have experience in leading evaluation teams and preparing high-quality documents. This specialist should have wide experience or familiarity of USAID-funded reproductive health programs and should have a good understanding of health systems in the Middle East, preferably in Jordan. S/he should also have a good understanding of project administration, financing, and management.

The Team Leader will take specific responsibility for assessing and analyzing the project's progress towards quantitative targets, performance, and benefits/impact of the strategies. The team leader will also look at the potential sustainability of HSS II project approaches and activities.

The Team Leader will be responsible for overall management of the evaluation, including coordinating and packaging the deliverables in consultation with the other members of the team. S/he will provide leadership for the team, finalize the evaluation design, coordinate activities, arrange meetings, consolidate individual input from team members, and coordinate the process of assembling the final findings and recommendations. S/he will also lead the preparation and presentation of the key evaluation findings and recommendations to the USAID/Jordan team and key partners. The Team Leader will submit the draft report, present the report and, after incorporating USAID Jordan staff comments, submit the final draft report to USAID/Jordan within the prescribed timeline.

Technical Specialist(s):

The FP/MCH specialist will have at least 7-10 years of experience in management of, or consulting on, FP and MCH programs. S/he should have a proven background and experience in FP/MCH and a strong understanding of the challenges facing the health system in Jordan. S/he should also have a good understanding of the relevant national programs in FP and MCH, particularly for the public sector.

The specialists will be responsible for assessing the ability of the project to achieve outcomes in FP/MCH and provide technical leadership in FP/MCH. The FP/MCH specialist will also assess the technical quality of HSS II project interventions. S/he will document key lessons learned and provide recommendations for modifications in approach, results, or activities. S/he will also look at the sustainability of HSS II project approaches and activities as well as the ability of the project to leverage and influence the MOH.

If the team is not able to procure a health systems expert from the USAID Global Health Bureau, at least one of the technical specialists will need to have expertise in health systems strengthening.

Host Country National Health Expert: The Host Country National Health Expert will serve under the Team Leader. S/he should have at least 10 years of experience working in the field of family planning and maternal health and have thorough knowledge of the national health system. Duties will be determined in consultation with the Team Leader. The host country national will participate in team meetings, key informant interviews, group meetings, site visits, and contribute in drafting the notes for the report relevant to his/her expertise and role in the team. S/he will also participate in presenting the report to USAID or other stakeholders and be responsible for addressing pertinent comments provided by USAID/Jordan or other stakeholders. S/he will communicate with the Team Leader and other consultants to produce written notes to incorporate in the report as required in addressing comments and feedbacks from USAID. S/he is required to make his/her contributions to the Team Leader within the timeline.

ESTIMATED LEVEL OF EFFORT (LOE):

A six-day work week will be approved when the consultants are working in country. This is a preliminary timetable and USAID/Jordan may choose to make changes to it during the course of the project based on technical and logistical considerations:

Task/Deliverable	Team Leader LOE (days)	International Technical Specialists	Local Technical Specialist	Logistics Coordinator	Translator	Estimated Timeline
Read Background Documents & Preparatory Work.	3	3	3	3		Nov 5-7
Travel to Jordan	2	2	0			Nov 11-12
Team Planning Meeting	2	2	2	2		Nov 13-14
Assessment work						
<ul style="list-style-type: none"> Stakeholders interviews and site visits (including in-country travel) 	11	11	11	11	10	Nov 15 - 26
<ul style="list-style-type: none"> Discussion, analysis and draft report preparation 	5	5	5			Nov 27- Dec 2
<ul style="list-style-type: none"> Presentation of findings to Mission and partners 	1	1	1			o/a Dec 4
<ul style="list-style-type: none"> Evaluation team completes draft report – revise report & incorporate debriefing comments into draft report 	2	2	2			Dec 5-6
Return travel	2	2	0			Dec 7-8
USAID/Jordan sends technical feedback/comments on draft report to GH Tech (within 5 working days of submission)	0	0	0			Dec 13
Evaluation team leaders finalizes the report	4	2	2			Dec 14-19
USAID/Jordan reviews/signs off on final report (within 2 days of receipt)	0	0	0			Dec 23
Total LOE	32	30	26	16	10	

A six day work week in country is authorized.

X. LOGISTICS

GH Tech will provide:

- Economy tickets (except with medical justification approved by USAID) for international travel to and from the consultants' point of origin to Jordan.
- GH Tech consultant per diem and lodging expenses as well as all local costs and travel expenses.
- Country cable clearance. Point of Contact is Ms. Farah Khalili: fkhilili@usaid.gov
- Reserve hotel accommodations in country.
- Arrange transportation for the team in Amman as well as in other governorates.

XI. LOGISTICS

GH Tech will be responsible for all international travel and consultant logistics.

XII. DELIVERABLES

Work plan: During the planning meeting in Jordan, the team will prepare a written methodology plan (evaluation design/operational work plan) and share it with USAID prior to assessment work. The work plan might need to be updated based on the experience in the field.

Key Informant Interview Questionnaire: Different set of questionnaires will be prepared for interview with key informants at different levels during the planning meeting and discussed with USAID prior to evaluation.

Debriefings: The full evaluation team will debrief Population and Development Office, USAID Mission Director's office, and other USAID/USG offices and on their findings, conclusions and recommendations, before leaving Jordan using a PowerPoint presentation and any briefing materials required. The Population and Development Office will provide feedback during the briefing meeting. The team will also debrief USAID Implementing Partners and/or Government of Jordan officials using PowerPoint presentation and other briefing materials as required.

Draft Evaluation Report: The evaluation team will provide the Population and Development Office with a full draft report that includes all the components of the final evaluation report prior to their departure from the country. The Population and Development Office will provide comments on the draft report to the evaluation team within 5 working days of receiving the draft report.

The draft evaluation report will include, at a minimum, the following: scope and methodology used; important findings (empirical facts collected by evaluators); conclusions (evaluators' interpretations and judgments based on the findings); recommendations (proposed actions for management based on the conclusions); and lessons learned (implications for future designs and for others to incorporate into similar programs).

Final Assessment Report: The team will submit a final report to GH Tech and USAID incorporating Mission comments and suggestions no later than five days after USAID/Jordan

provides written comments on the team's draft final evaluation report (see above). The final report should have the following criteria to ensure the quality of the report:

- The evaluation report should represent a thoughtful, well-researched and well organized effort to objectively evaluate what worked in the project, what did not and why.
- Evaluation reports shall address all evaluation questions included in the scope of work.
- The evaluation report should include the scope of work as an annex. All modifications to the scope of work, whether in technical requirements, evaluation questions, evaluation team composition, methodology or timeline need to be agreed upon in writing by the COR of HSS II.
- Evaluation methodology shall be explained in detail and all tools used in conducting the evaluation such as questionnaires, checklists and discussion guides will be included in an Annex in the final report.
- Evaluation findings will assess outcomes and impact on males and females.
- Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence and data and not based on anecdotes, hearsay or the compilation of people's opinions. Findings should be specific, concise and supported by strong quantitative or qualitative evidence.
- Sources of information need to be properly identified and listed in an annex.
- Recommendations need to be supported by a specific set of findings.
- Recommendations should be action-oriented, practical and specific, with defined responsibility for the action.

The format of the final evaluation report should strike a balance between depth and length. The report will include a table of contents, table of figures (as appropriate), acronyms, executive summary, introduction, purpose of the evaluation, research design and methodology, findings, conclusions, lessons learned and recommendations. The report should include, in the annex, any dissenting views by any team member or by USAID on any of the findings or recommendations. The report should not exceed 30 pages, excluding annexes. The report will be submitted in English, electronically. The report will be disseminated within USAID.

A second version of the report will be professionally formatted and edited by GH Tech Bridge if sign-off on the final draft is received by Dec 24, 2012 from the Mission. This second version of the report excluding any potentially procurement-sensitive information will be submitted (also electronically, in English) to Development Experience Clearinghouse (DEC) for dissemination among implementing partners and stakeholders.

All quantitative data, if gathered, should be (1) provided in an electronic file in easily readable format; (2) organized and fully documented for use by those not fully familiar with the project or

the evaluation; (3) owned by USAID and made available to the public barring rare exceptions. A thumb drive with all the data could be provided to the COR.

Reporting Requirements (to be finalized during the team meeting).

The total pages, excluding references and annexes, should not be more than 30 pages. The following content (and suggested length) should be included in the report:

1. **Table of Contents;**
2. **Executive Summary**—concisely state the project purpose and background, key evaluation questions, methods, most salient findings and recommendations (2-3 pp.);
3. **Introduction**—context in which intervention took place, including a summary of any relevant history, demography, socio-economic status etc. (1 pp.);
4. **The Development Problem and USAID’s Response**—brief overview of HSS II project, USAID program strategy and activities implemented in response to the problem, (1 pp.);
5. **Purpose of the Evaluation**—purpose, audience, and synopsis of task (1 pp.);
6. **Methodology**—describe evaluation methods, including strengths, constraints and gaps (2 pp.);
7. **Findings/Conclusions**—describe and analyze findings for each objective area using graphs and tables, as applicable, and also include data quality and reporting system that should present verification of spot checks, issues, and outcome (12-15 pp.);
8. **Recommendations**—prioritized for each objective area; should be separate from conclusions and be supported by clearly defined set of findings and conclusions (3-4 pp.);
9. **Lessons Learned**—provide a brief of key technical and/or administrative lessons that could be used for future project or relevant program designs (2-3 pp.);
10. **References** (including bibliographical documentation, meetings, interviews and focus group discussions);
11. **Annexes**— to include statement of work, documents reviewed, evaluation methods, data generated from the evaluation, tools used, interview lists and tables. Annexes should be succinct, pertinent and readable. Should also include if necessary, a statement of differences regarding significant unresolved difference of opinion by funders, implementers, or members of the evaluation team on any of the findings or recommendations.

The Mission should receive an electronic copy as well as 5 hard copies of the final report. The report format should be restricted to Microsoft products and 11-point type font should be used throughout the body of the report, with page margins one inch top/bottom and left/right.

XIII. RELATIONSHIPS AND RESPONSIBILITIES

GH Tech will coordinate and manage the evaluation team and will undertake the following specific responsibilities throughout the assignment:

- Recruit and hire the evaluation team.

- Make logistical arrangements for the consultants, including travel and transportation, country travel clearance, lodging, and communications.

USAID/COUNTRY will provide overall technical leadership and direction for the evaluation team throughout the assignment and will provide assistance with the following tasks:

Before In-country Work

- SOW. Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Tech, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation) and if necessary, identify a person to assist with logistics (i.e., visa letters of invitation etc.).

During In-country Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the evaluation team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After In-country Work

- Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

XIV. MISSION CONTACT PERSON

Mohammed A. Yassien
Deputy Director, Office of Program Management
USAID / Jordan
Direct Tel: 962-6-5906675
E Fax: 962-6-5907300
Mobile: 962-79-5491177
E-Mail: moyassien@usaid.gov

Dr. Ali Arbaji
Acting Health Team Leader
USAID/Jordan
Tel: 962795821691
Email: aarbaji@usaid.gov

XV. COST ESTIMATE

GH Tech will provide a cost estimate for this activity.

ANNEX B. PERSONS CONTACTED

HEALTH SYSTEMS STRENGTHENING PROJECT II

Dr. Sabrey Hamza, Chief of Party
Bruce Rasmussen, Deputy Chief of Party
Ms. Hala Al-Sharif, Community Team Leader
Dr. Haneen Al-Halawani, Hospital Quality Improvement Task Manager
Dr. Manal Jrasat, FP/RH STM
Mr. Mahdi Mansour, I Technology Task Manager
Dr. Osama Samawi, Accreditation STM
Johan de Koning, Quality Improvement
Eng. Hania Naber, Procurement Manager
Eng. Osama Obeid, Renovations Senior Task Manager
Raed Fessesi, HMIS Team Leader

ROYAL MEDICAL SERVICES

Dr. Aiman Al-Sumadi, MD, MRCOG
Consultant OB/GYN, Reproductive Medicine, Planning Dept., Royal Medical Services
Issa Hassa, MD, Brig. General, Consultant OB/GYN
Consultant Pediatric Nephrologist, Director of Planning, Royal Medical Services

HEALTH CARE ACCREDITATION COUNCIL, JORDAN HEALTH CARE ACCREDITATION PROJECT

Mr. Edward Chappy, Chief of Party

AL BASHEER HOSPITAL

Dr. Issam Al-Shraideh, Hospital's Director
Dr. Issa Jaber, Chief of OB/GYN Specialty
Dr. Sameer Faouri, Chief of Pediatrics Specialty

TOTANJI HOSPITALBHJ

Dr. Khaled Kokash, Assistant to Hospital Director
Dr. Hanan Al-Duri, Head of Outpatient Clinics
Dr. Haitham Abu Hmaidan, Physical Rehabilitation
Dr. Mousa Abu Mathana, OB/GYN Specialist

JERASH GOVERNORATE

Dr. Fatin Janim, Community Health Physician, Assistant to the Health Director

Ms. Reem Shibly, IT Coordination
Khadejah Shahada, Midwife at Jerash Health Center
Dr. Mayson Amareen, General Practitioner
Dr. Waleed Momani, Assistant to the Director of Jerash Hospital

MAFRAQ GOVERNORATE

Dr. Hani Olimat, Director of the Maternity Hospital
Mrs. Sharifa Al-Sarhan, Assistant to the Director for Nursing Affairs
Dr. Hisham Al-Najar, General Practitioner at Al Manshiah Health Centers

MARJ AL HAMMAM HEALTH CENTER (NOT WITH HSSI I)

Mr. Adnan Ishak

COMMUNITY HEALTH COMMITTEE AT THE SHISHAN SOCIETY IN SWEILEH

Mrs. Amal Shabsogh, Head of the CHC

Attendance: 14 members of the CHC were present. They represent schools for boys/girls, environment sectors, NGOs, Amman municipality, Director of the Health center, MOH, and the nurse-midwife.

MINISTRY OF HEALTH

HE Dr. Deifalla Al-Louzi, Secretary General
Dr. Bassam Hijawi, Director of Primary Healthcare Administration
Dr. Khalid Al-Edwan, Director of Planning Administration
Dr. Ahmad Qutaitat, Director of Hospital Administration
Dr. Ghassan Fakhoury, Director of Quality Improvement
Dr. Nidal Al-Azab, Director of Women and Child Department
Dr. Rajai Faris, Director of Health Directorates Administration
Dr. Dr. Malek Habashneh, Director of Health Awareness and Communication
Dr. Moh'd Tarawneh, Director of Non-communicable Diseases
Dr. Abeer Mwaswas, Women and Child Department
Dr. Rhagad Bgaeen, Health Awareness and Communication Department
Engineer Muna Hirzallah, Head Project and Planning
Ms. Samar Samoa, Head of IT Department
Dr. Abdulrahman Al-Ma'ani, Director of Administrative Affairs Administration
Eng. Rateb Maghnam, Director of Buildings and Maintenance Directorate
Dr. Eng. Firas Abu-Dalou, Biomedical Engineering Directorate
Eng. Nasser Ttaiti, Studies Department, Biomedical Engineering Directorate

AMMAN CAPITAL HEALTH DIRECTORATE

Dr. Lail Al-Fayez, Director

Dr. Mahmmoud Salameh, Director of Quality Assurance Department

Dr. Hanan Al-Jabiri, Quality Assurance Department

PRINCESS BASMA COMPREHENSIVE HEALTH CARE CENTER

Dr. Marwan Majdoub, Director of PB HC

Dr. Mervate Samour, Family Physician

Mr. Souad Al-Batma, Nursing Director

Mr. Roqaia Al-Qadi, Midwife

STRENGTHENING HEALTH OUTCOMES THROUGH THE PRIVATE SECTOR PROJECT (SHOPS)

Mr. Reed Ramlow, Chief of Party

Dr. Maha Shadid, Deputy Chief of Party

Ms. Houda Khayame, Social Marketing Manager

JOHNS HOPKINS COMMUNICATION PARTNERSHIP

Ms. Rula Dajani, Deputy Chief of Party

Ms. Lina Qardan, Senior Technical Advisor

Ms. Huda Murad, Senior Specialist, Service Delivery & Community Interventions

UNFPA

Ms. Muna Idris, Assistant Representative

USAID/JORDAN

American Embassy, Amman

Ms. Beth S. Paige, Mission Director

Mr. Douglas H Ball, Deputy Mission Director

Dr. Ali Arbaji, Project Management Specialist, Population & Family Health Section

Mr. Mohammed Yassien, Deputy Director, Office of Program Management

Mr. Ziad F. Muasher, Project Management Specialist, Population & Family Health Section

ANNEX C. ILLUSTRATIVE LOG FRAME WITH REVISED INDICATORS

LEVEL	INDICATOR	
GOAL	Improved health of all Jordanians USAID: 1) Decreased maternal and neonatal mortality and morbidity 2) Decreased TFR MOH: 1) Decreased mortality and morbidity from NCDs and other diseases contributing to major disease burden	
IMPACT	1) Total number of FP users (new, long-lasting, etc.) 2) CPR and CYPs 3) Increased neonates going home alive 4) HMIS impact data for the MOH (NCDs, MCH, etc.)	
	OUTPUT	INPUTS/ACTIVITIES
Objective 1: Knowledge Management	<ul style="list-style-type: none"> Evidence-based decision-making (EBDM) at all levels of MOH (use in planning, etc.) 	<ul style="list-style-type: none"> Comprehensive HMIS established and maintained Reliable data being generated regularly Training, supervision, etc.
Objective 2: Primary Health Care	<ul style="list-style-type: none"> % health centers with increased quality of care measured through Improve use/provision of ANC, PNC, etc. # accredited centers complying with clinical guidelines and standards % functioning referral systems % supervision plans leading to quality improvement 	<ul style="list-style-type: none"> # of accredited centers # of centers prepared for accreditation Preparation of referral and supervision systems

	OUTPUT	INPUTS/ACTIVITIES
Objective 3: Safe Motherhood	<ul style="list-style-type: none"> • Improved clinical outcomes, e.g., decreased # of women with hemorrhage/requiring blood transfusions, decreased rate of eclamptic seizures, etc. • % providers completed L&D records adequately • % of confidential inquiries conducted/results used adequately 	<ul style="list-style-type: none"> • Use of partograph and magnesium sulfate • Update and revision to clinical guidelines, best practices • Training, supervision, etc. • Standardized records, etc.
Objective 4: Family Planning	<ul style="list-style-type: none"> • #/% of service delivery points – 4+ methods, IUD, etc. • % postpartum/post-miscarriage who receive FP • Discontinuation rate of OCs • Quality of counseling – 6/6 on exit surveys 	<ul style="list-style-type: none"> • Creation of clinical guidelines for Implanon • Training, supervision – midwives and docs on IUDs, non-MCH staff, etc. • Counseling/missed opportunities
Objective 5: Community Health	<ul style="list-style-type: none"> • % women who know where they can receive long-lasting FP methods • % men who can list reasons why birth spacing is good for health of family • % women who know about/want breast screening • % adults who know risk factors for diabetes/hypertension 	<ul style="list-style-type: none"> • #/% established and active CHCs • #/% active HP programs in HDs • Baseline, midterm, end community mini-surveys
Objective 6: Renovations	<ul style="list-style-type: none"> • Output is hard to measure—may stand as is 	<ul style="list-style-type: none"> • Renovate hospitals, health centers, • Buy equipment • Train on guidelines, maintenance, etc. • Maintenance procedures established

ANNEX D. METHODOLOGY: QUESTIONS FOR HSS II EVALUATION

PRIMARY HEALTH CARE

Please provide specific examples of how the project helped you respond to major health needs in PHC. Are they sustainable?

Please also provide examples where project activities were not as helpful or effective.

Please provide examples of how the implementation of the referral and appointment system has helped your facility. Are they sustainable?

Does the newly installed data system help you? In what specific ways? Do you feel confident managing the data?

If not, please give some examples of how the data system could be made better.

Please provide specific examples of how the accreditation process helped this facility. What does it mean and in what ways does it make the facility work better, such as in quality of care, increased service delivery, etc.?

Please provide specific examples of how the community health committees (CHCs) were effective and helpful to the facilities. Are they sustainable?

For the communities, what are some specific examples of how the CHCs helped them get better health care, for chronic diseases and/or FP/MCH? Are they sustainable?

What are some examples of where the CHCs were not as effective?

For female/male clients, if possible: Has health center changed in last year? If so, how?

What new services are available for women? Were they seen as effective? What are ones not as appreciated?

When and where did these clients hear information about FP/MCH? Is it available at the health facility?

SAFE MOTHERHOOD AND FAMILY PLANNING

Please provide specific examples of how the quality of FP services has improved (at this facility during the past three years? Are they sustainable?

What has not worked as well to improve quality of FP care?

Please provide examples of how the utilization of FP services increased at this facility during the past three years. Are they sustainable?

What has not worked as well to improve utilization of FP services?

In what ways could the utilization of FP be improved?

Please provide examples of how the quality of obstetrics/neonatal care has improved at this facility? Are you seeing better obstetrics/neonatal clinical outcomes?

Please provide examples of what has not worked as well to improve quality of obstetrics/neonatal care?

In what ways could the quality of FP/OB/neonatal services be improved?

KNOWLEDGE MANAGEMENT

Please provide examples of specific knowledge management changes instituted by the project that worked and how they made a difference in service delivery. Are they sustainable?

Please also provide examples of specific knowledge management changes that did not work and why.

What are the most significant issues in KM that remain unaddressed or partially addressed?

In what ways could the KM component's technical approach be improved?

RENOVATION AND EQUIPMENT

Please provide examples of how this activity improved service delivery in your facility. Why did it work and how did it make a difference? Are they sustainable?

Please provide examples of this activity that did not work as well and why.

What are the most significant issues in renovation and equipment that remain unaddressed or partially addressed?

In what ways could this component's technical approach be improved?

ANNEX E. REFERENCES

PROJECT WORKPLANS, STRATEGIES, REPORTS

Health Systems Strengthening II Five Year Strategic Plan 2010–2015

Health Systems Strengthening II Monitoring and Evaluation Plan

Health Systems Strengthening II Annual Report Year One

Health Systems Strengthening II Annual Report Year Two

Health Systems Strengthening II Annual Report Year Three

Health Systems Strengthening II Year 1 Workplan

Health Systems Strengthening II Y1Q1 Report

Health Systems Strengthening II Y1Q2 Report

Health Systems Strengthening II Y1Q3 Report

Health Systems Strengthening II Y1Q4 Report

Health Systems Strengthening II Year 2 Workplan

Health Systems Strengthening II Y2Q1 Report

Health Systems Strengthening II Y2Q2 Report

Health Systems Strengthening II Y2Q3 Report

Health Systems Strengthening II Y2Q4 Report

Health Systems Strengthening II Year 3 Workplan

Health Systems Strengthening II Y3Q1 Report

Health Systems Strengthening II Y3Q3 Report

Health Systems Strengthening II Y3Q4 Report

Health Systems Strengthening II Year 4 Workplan

PROJECT TECHNICAL PAPERS, GUIDELINES, AND MANUALS

Clinical Guidelines in Obstetric and Neonatal Care

Safe Motherhood Committee Manual

“Primary Health Care Center Accreditation Guidelines”

Community Health Committee Community Needs Assessment Tool and Community Action Cycle

Various JHCP-produced BCC materials for family planning, including flip charts and leaflets

Hospital Renovations and Maintenance Manual

NATIONAL STRATEGIES, POLICIES, AND RESEARCH PAPERS

Almasarweh, Issa S. "Adolescent Reproductive Health in Jordan: Status, Policies, Programs, and Issues." *The Policy Project*. January 2003.

Communication for Family Health KAP Survey 2005.

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Ministry Of Health, Communications and Awareness Directorate Five Year Strategic Plan

Ministry of Health (Jordan). *Strategic Plan 2006–2012*.

National Population Commission. *Jordan National Population Strategy*. Amman, Jordan. September 2000.

United National Population Fund, Arab States Regional Office. "Women's Need for Family Planning in Arab Countries." July 2012.

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For more information, please visit
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