Enhancing Performance of Health Systems

End of Project Report

USAID-funded
Health Systems Strengthening II Bridge Project
October 2014 – October 2015

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Health Systems Strengthening II (HSS II) Bridge

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HSS II BRIDGE END OF PROJECT REPORT

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MESSAGE FROM THE CHIEF OF PARTY

After a decade of investments, dedicated work and commitment to strengthening Jordan’s health care delivery system and services, the United States Agency for International Development (USAID) launched the Abt-led HSS II Bridge project to capitalize on the gains and momentum of predecessor health system strengthening projects. These investments have increased service delivery performance while focusing on aspects of system strengthening that help accelerate the uptake of successful practices and establish a culture of continuous performance improvement.

During its one-year implementation, HSS II Bridge assisted public health sector entities to further strengthen the health system in Jordan and increase the uptake of quality high priority health care services focusing on maternal, newborn and family planning services. This report identifies the HSS II Bridge project’s key achievements including implementation of the innovative Family Planning Service Delivery Improvement Collaborative approach in health centers. Employment of this approach resulted in 49 percent increase in couple years of protection from the baseline in participating health centers. The project also developed two models: the Preconception Care model to ensure continuity of safe motherhood and family planning services and the Jordan Maternal Mortality Surveillance and Response System model, which when implemented, will help Jordan achieve its national goals by eliminating preventable maternal deaths. Another key achievement was the scale up of the use of Continuous Positive Airway Pressure in public sectors hospitals as a low cost technology to improve care to newborns suffering from respiratory problems. This scale up increased neonatal survival up to 89 percent. In addition, the project expanded the use of the Workload Indicator for Staffing Needs as a tool to help the Ministry of Health allocate and manage human resources for health.

Given its short implementation timeframe, HSS II Bridge managed to deliver measurable results that I believe will help guide future health care development programs for Jordan. This report also illustrates the major challenges and lessons learned to help decision makers further improve health systems and services in Jordan.

The strong partnership with government counterparts at all levels of the health care system was the cornerstone of our success. The unwavering support from our vital partners at the Ministry of Health, the Royal Medical Services, the Higher Population Council, and Jordanian communities during implementation of our joint programs, in addition to the great collaboration with fellow USAID implementing partners has all contributed to the realization of our mutual goal of improving health status for all.

None of these impressive achievements could have been accomplished without USAID's excellent guidance and commitment to support the resilience of Jordan’s health care system to respond to both existing needs of the Jordanian population, as well as emergent health needs of refugees and underprivileged groups.

Finally, I would like to thank the Jordanian people for entrusting the project to further improve the health outcomes of their families and communities.

Dr. Sabry Hamza
HSS II Bridge Chief of Party
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<th>Full Form</th>
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<tr>
<td>ACNM</td>
<td>American College of Nurse-Midwives</td>
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<td>AMTLS</td>
<td>Active Management of Third Stage of Labor</td>
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<td>ASFR</td>
<td>Age specific Fertility Rate</td>
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<td>BMI</td>
<td>Body Mass Index</td>
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<td>BP</td>
<td>Blood Pressure</td>
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<td>C/S</td>
<td>Cesarean Section</td>
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<td>CBC</td>
<td>Complete Blood Count</td>
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<td>CBO</td>
<td>Community Based Organization</td>
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<td>CHC</td>
<td>Community Health Committee</td>
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<td>CI</td>
<td>Confidential Inquiry</td>
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<td>CIS</td>
<td>Civic Initiative Support</td>
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<td>CME</td>
<td>Continuous Medical Education</td>
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<td>CNE</td>
<td>Continuous Nursing Education</td>
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<td>CPAP</td>
<td>Continuous Positive Airway Pressure</td>
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<td>CSPD</td>
<td>Civil Status and Passport Department</td>
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<td>CYP</td>
<td>Couple Years of Protection</td>
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<td>DAG</td>
<td>Directorate Advisory Group</td>
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<td>DHS</td>
<td>Demographic Health Survey</td>
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<td>DNF</td>
<td>Death Notification Form</td>
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<td>DOS</td>
<td>Department of Statistics</td>
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<td>DSS</td>
<td>Decision Support System</td>
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<tr>
<td>EMPHNET</td>
<td>Eastern Mediterranean Public Health Network</td>
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<td>EOC</td>
<td>Essential Obstetric Care</td>
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<td>FASD</td>
<td>Fetal Alcohol Spectrum Disorders</td>
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<td>FMD</td>
<td>Forensic Medicine Department</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>GOJ</td>
<td>Government of Jordan</td>
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<tr>
<td>HC</td>
<td>Health Center</td>
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<td>HCAC</td>
<td>Health Care Accreditation Council</td>
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<td>HD</td>
<td>Health Directorate</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>HPC</td>
<td>Higher Population Council</td>
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<td>HRH</td>
<td>Human Resources for Health</td>
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<td>HSS</td>
<td>Health Systems Strengthening</td>
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<td>IT</td>
<td>Information Technology</td>
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<td>IUD</td>
<td>Intrauterine Device</td>
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<td>JAFPP</td>
<td>Jordan Association for Family Planning and Protection</td>
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<td>J-CAP</td>
<td>Jordan Communication, Advocacy, and Policy</td>
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<tr>
<td>JMMSRS</td>
<td>Jordan Maternal Mortality Surveillance and Response System</td>
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<td>JNC</td>
<td>Jordanian Nursing Council</td>
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<tr>
<td>LAM</td>
<td>Lactational Amenorrhea Method</td>
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<td>LARC</td>
<td>Long Acting Reversible Method</td>
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<td>LMS</td>
<td>Logistics Management Information System</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MDR</td>
<td>Maternal Death Review</td>
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<td>MgSO4</td>
<td>Magnesium Sulfate</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<tr>
<td>MMSR</td>
<td>Maternal Mortality Surveillance and Response</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOI</td>
<td>Ministry of Interior</td>
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<td>MWRA</td>
<td>Married Women of Reproductive Age</td>
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<td>NAG</td>
<td>National Advisory Group</td>
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<tr>
<td>NB CPAP</td>
<td>Nasal Bubble Continuous Positive Airway Pressure</td>
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<tr>
<td>NCD</td>
<td>Non-Communicable Diseases</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>NICU</td>
<td>Neonatal Intensive Care Unit</td>
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<td>NTD</td>
<td>Neural Tube Defects</td>
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<td>OB/GYN</td>
<td>Obstetrics and Gynecology</td>
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<tr>
<td>PC</td>
<td>Preconception Care</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>PIH</td>
<td>Pregnancy Induced Hypertension</td>
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<tr>
<td>PIRS</td>
<td>Performance Indicator Reference Sheets</td>
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<tr>
<td>RMS</td>
<td>Royal Medical Services</td>
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<td>SDIC</td>
<td>Service Delivery Improvement Collaborative</td>
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<td>SHOPS</td>
<td>Strengthening Health Outcomes through the Private Sector</td>
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<td>SIDS</td>
<td>Sudden Infant Death Syndrome</td>
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<td>SMC</td>
<td>Safe Motherhood Committee</td>
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<tr>
<td>SWOT</td>
<td>Strengths, Weaknesses, Opportunities and Threats</td>
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<tr>
<td>TDY</td>
<td>Temporary Duty Yonder</td>
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<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
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<tr>
<td>TM</td>
<td>Traditional Method</td>
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<td>TOT</td>
<td>Training of Trainers</td>
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<tr>
<td>TWG</td>
<td>Technical working Group</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNRWA</td>
<td>United Nations Relief and Works Agency for Palestine Refugees in the Near East</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>WCHD</td>
<td>Woman and Child Health Directorate</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WISN</td>
<td>Workload Indicator for Staffing Needs</td>
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<tr>
<td>WRA</td>
<td>Women of Reproductive Age</td>
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I. INTRODUCTION

The Health Systems Strengthening II Bridge project (HSS II Bridge) built on previous United States Agency for International Development (USAID) investments to strengthen health systems and improve the quality of health care delivery in Jordan’s public sector. HSS II Bridge used continuous quality improvement principles to strengthen the delivery of family planning (FP), obstetric, and neonatal care services; support the information technology infrastructure at the Ministry of Health (MOH); engage community groups; and develop a pre-conception care model that exceeded the project’s goals and contributed to the improved health of the Jordanian population.

The HSS II Bridge team worked hand-in-hand with Jordan’s MOH; the Higher Population Council (HPC); USAID’s Strengthening Health Outcomes through the Private Sector (SHOPS) Activity in Jordan; the Jordan Communication, Advocacy, and Policy (J-CAP) Activity; the Royal Medical Services (RMS); and other counterparts across the Kingdom to advance work on maternal mortality surveillance, improve access to voluntary FP services, and introduce tools to increase the effectiveness of obstetric and neonatal care in hospitals. HSS II Bridge achieved measurable improvements in the delivery of essential healthcare services in Jordan while strengthening the capacity of the Government of Jordan (GOJ) and counterparts to sustain these gains following the Project’s closure. The project’s partnership with the MOH supported USAID and the GOJ’s goals of improving the health of the Jordanian population through the provision of essential services in the public sector.

This report begins by detailing the achievements made under all four of the HSS II Bridge project’s objectives and deliverables (Section II). In Sections III and IV, the report highlights achieved results beyond the project’s stated deliverables, challenges encountered, and lessons learned along the way. The report ends with a list of annexes, including financial reports; an overview of project indicators, guidelines, and checklists developed by HSS II Bridge; and other relevant project documentation.
II. ACHIEVEMENTS UNDER PROJECT OBJECTIVES

OBJECTIVE 1: EXPAND ACCESS TO EQUITABLE AND SUSTAINABLE FACILITY BASED FAMILY PLANNING (FP) SERVICES

Deliverable 1. Selected MOH hospitals and primary health care centers adopted the FP Service Delivery Improvement Collaborative (FP SDIC) approach to improve FP service delivery and use with special emphasis on urban poor areas

BACKGROUND

Thirty-five years ago, Jordan had one of the highest population growth rates in the world. Since 1980, stakeholders have achieved considerable progress in reducing fertility with sustained support from USAID. However, during the years 2002-2012, the modern contraceptive prevalence rate among married women in Jordan plateaued.

While USAID-funded projects achieved essential infrastructure and technical capacity improvements to increase the quality of and access to FP services, some challenges remained. Multiple factors contributed to the stalled progress, including high turnover of trained staff, lack of a client-centered approach, sub-optimal aggregation and use of data for decision making, and demotivated administrative and technical staff. Recognizing these gaps, the MOH worked with the HSS II Bridge team to develop a new collaborative approach engaging the health directorate (HD) and facility level in decision-making and quality improvement.

TECHNICAL APPROACH

The project team designed this new approach - the FP SDIC - as a dynamic, data-driven process to achieve change through a structured learning process, shared experiences, coaching, and performance-based monitoring. The FP SDIC, shown in Figure 1, brings together teams from different health facilities and their community health committees (CHCs) to make improvements in their FP performance. HSS II Bridge and the MOH focused on changing the behavior of service providers by involving them not only in delivering services, but also in developing and carrying out improvement plans within their own facilities and teams.

To improve the uptake of quality FP services and carefully monitor progress toward achieving results, HSS II Bridge designed the FP SDIC around four pillars that affect different aspects of the delivery and uptake of FP services: supply, systems, quality, and access. The design included operational indicators for each pillar to guide the FP SDIC interventions.
Twenty-four Health Centers (HC) from seven HDs and six hospitals participated in the first FP SDIC. Each HC team included maternal and child health (MCH) service providers (midwives and physicians) in addition to community members. Hospital teams included midwives and obstetric/gynecological (Ob/Gyn) physicians from in-patient and out-patient units. MOH teams and their community counterparts attended learning sessions to identify and analyze their challenges relative to the four pillars, design “change packages” to address those challenges, and then monitor and evaluate progress through data review.

The project team led the facility teams through three learning sessions followed by three action periods during which the teams implemented changes they identified during the sessions. During implementation of the change-packages, HSS II Bridge technical field coordinators provided technical support to the facility teams and the HD MCH supervisors.

In the first learning session, facility teams reviewed their baseline data and conducted root cause analysis to identify facility-level challenges in FP service delivery. Facility teams addressed their challenges by gaining an understanding of contributing factors and how to measure outcomes. Teams then developed change packages accordingly. CHCs also developed their own change packages to help the HC teams achieve their goals. In the second and third learning sessions, facility teams reviewed their progress, shared experiences, modified their approaches to address previously identified challenges, and defined new gaps to address.
To determine the best way to encourage improvements in hospital-based FP services, the six hospital teams participated in the FP SDIC in two different ways. Two of the hospitals, Al Bashir in Amman and Prince Faisal in Zarka, participated in the same learning sessions as the HC teams from their catchment areas to increase the mutual understanding between the different levels and create a stronger continuum of care. The other four hospitals - Jordan University Hospital, Princess Bade’a in Irbid, Mafraq Obstetric and Children’s Hospital, and Karak Hospital - participated in a separate set of learning sessions to evaluate whether collaboration among hospital teams with similar challenges would spur improved performance.

The MOH Women and Child Health Directorate (WCHD), governorate HD staff, and HC directors were actively involved in all stages to achieve rapid breakthroughs in FP service delivery, covering access, supply, and quality of FP services. Regular review of FP data by MOH HD and central program managers helped build ownership for this initiative and led to proactive supervision of progress.

![Image](image.jpg)

*Photo 2: Amman Health Director fully engaged in expanding the number of days IUD services are provided at Amman Health centers enrolled in the FP SDIC*

**RESULTS**

1) **HCs in the FP SDIC**

Only six months after the project introduced the FP SDIC approach, 24 of the busiest MOH HCs demonstrated increased uptake of FP services, as illustrated in the wide range of performance indicators shown in the graphs below. Results indicate that the couple years of contraceptive protection (CYP) participating facilities provided to clients each month more than doubled during the project period (Figure 2).

Increased efficiency, awareness, and quality of services led to a dramatic increase in the referral of new clients within the HC to its MCH clinic for FP services (Figure 3). There was also a significant increase in the uptake of long-acting reversible contraceptives such as intrauterine devices (IUDs) and Implanon (Figure 4).
Figure 2: CYP in the 24 FP SDIC participating HCs

Figure 3: Increase in number of clients referred internally in FP SDIC HCs
The combination of intensive data generation and data review, coaching, and regular performance reviews used in the FP SDIC enabled the HC teams to solve some longstanding service delivery problems. Over the six-month intervention period, these teams not only generated impressive gains in the access and quality of services, but also exhibited teamwork and initiative in addressing challenges that had impeded their performance. Comments from facility teams (see text box below) indicated satisfaction from and encouragement for applying their own knowledge and insights to improve their work; the data-driven FP SDIC approach enabled them to witness clearly the results of their efforts. At the HD and central MOH levels, managers praised the use of a common goal to unite the different teams in supporting all aspects of the approach, from design to application to review of results.
2) **Hospital FP SDIC**

The intervention period for the Hospital FP SDIC was January - June 2015. The six hospital teams participated fully in the learning sessions and worked to improve their performance (Figure 5), but they did not achieve results comparable with those in HCs. Grouping them in learning sessions with the surrounding HC teams or dealing with them as a separate group did not make a discernible difference in the results obtained.

![Graph showing % of postpartum women who received family planning counseling and modern methods before discharge from collaborative hospitals]

*Figure 5: Percentage of postpartum women receiving FP counseling and modern methods before discharge from collaborative hospitals*

Several factors made it more difficult for the hospital teams to carry out their change packages and achieve expected improvements than for the HC teams. First, hospital teams faced an inconsistent supervisory system structure between the central MOH Hospital Administration and the individual hospitals. This reduced the opportunities for continuous monitoring and review of progress during the field implementation periods.

Second, the hospital teams that participated in the FP SDIC lacked sufficient autonomy to make substantive changes, given the complexity of the hospital management structure and multiplicity of services they provide.

“Our family planning clients are increasing due to the new initiatives that we started at clinics such as the internal referral, counseling antenatal clients during third trimester, and conducting health educational session to clients in waiting area. For the first time we learned about CYP as an important indicator and start collecting it and monitoring our progress.”

*Midwife Aida Jaradat, Karak Hospital Outpatient Clinic*
SUSTAINABILITY AND FUTURE SCALE UP

The FP SDIC approach and the resulting improvements in HC performance greatly impressed the central WCHD and the program managers in HDs. The positive features of the collaborative approach most frequently cited by FP program managers and HDs included the following:

- Engagement of all stakeholders (Central MOH, HDs, facilities, and the CHCs) from the design of the collaborative through implementation, monitoring, and evaluation of performance improved motivation.
- Uniting facility and HD teams around a common goal allowed them to make rapid progress.
- Reliance on the facility teams themselves for proposed changes, rather than using external resources, increased ownership.
- Joint supervision and program reviews among project staff, HD MCH staff, and the WCHD allowed all parties to feel ownership of the approach and to be proactive in addressing challenges.
- Data use by stakeholders from facility, HD, and central levels for progress evaluation encouraged accurate documentation, prompt feedback of results, and continuous improvement in performance.
- The impressive gains in CYP in the HCs illustrated that marked improvements are possible through the FP SDIC approach.

The central MOH WCHD staff participated actively in the design and implementation of all FP SDIC activities. The WCHD worked closely with HSS II Bridge to lead the second and third learning sessions and provide technical training for staff in participating centers covering the clinical and logistic needs of FP counseling, a critical element for the success of the FP SDIC. The WCHD Director expressed her commitment to support this approach as a key element to achieve the objectives of the MOH FP Strategic Plan. While the WCHD has sufficient technical capacity to continue with the FP SDIC, it requires additional organizational and logistical support from the MOH to organize clinical trainings, host learning sessions, and conduct regular performance reviews.

The role of the HDs proved critical in helping the HC teams improve their FP performance. To illustrate their support, the directors of the seven participating HDs committed to include the FP SDIC in their Annual Operational Plans. In addition, several directors used the close out events to announce commitment not only to maintaining performance in this first group of 24 HCs, but also to scaling up the FP SDIC to additional HCs in the future. They also expressed optimism that this approach could be effective in improving performance of other health service areas.

The project also collaborated with HDs and the MOH Directorate of Administrative Affairs to implement the WHO’s Workload Indicators of Staffing Needs (WISN) assessment tool among participating HCs. This activity allowed stakeholders to generate quantitative data describing gaps or surpluses in the number of technical staff serving an HC. Based on WISN data, the project empowered decision makers at the HD level to make future staffing decisions.
The HDs will need additional technical, organizational, and logistical support to carry out their role in scaling up to additional HCs and in maintaining the progress the HCs have made.

During the FP SDIC closeout events attended by all participating HCs, HDs, Central MOH and USAID, the HC teams expressed their satisfaction and willingness to continue their own performance improvement efforts. While HC staffers have the technical capacity to evaluate performance gaps and plan for changes, they require additional training in data use, including proper documentation, data flow, data review, quality assurance, and data analysis for decision-making.

CHCs addressed community needs, including those related to FP, through their direct collaborative involvement with the HC and HD staff. MOH staff heard specific needs from the community and addressed them while creating change packages. Since the CHC members witnessed improvements in the provision of services, they valued MOH engagement. The project team recommends that MOH staff, especially at the HC and HD levels, continue welcoming CHC involvement through regular attendance at performance evaluation meetings.

**Recommendations and Way Forward**

To improve hospital teams' future provision of FP services, the project team recommends that the MOH undergo more substantive changes to create the necessary enabling environment. These changes include the following:

- The hospital leadership will need a clear mandate to assume more responsibility over FP improvements as an essential part of their services.
- Hospital teams will require more support and supervision from the central MOH and/or HD supervisory staff to continuously plan for, implement, and review improvement in FP services through a collaborative approach.
- The MOH Hospital Administration needs to develop and standardize its orientation and training approach for FP services. This will address the challenge of hospital staff shortages and turnover, as they serve a vital function in the training of new nursing, midwifery, and medical staff.
Deliverable 2: Preparatory phases to introduce a new FP method to target traditional users are completed

BACKGROUND

Between 2002 and 2012, the use of modern contraceptive methods in Jordan was stable at 42 percent of married women of reproductive age (MWRA). During the same period, the use of traditional FP methods (mainly withdrawal) slowly, but steadily, increased (Figure 6). The reasons behind this increase in the use of less effective methods are not clear. FP experts in Jordan have speculated that contributing reasons may include a preference for natural methods, a concern that modern methods are harmful to health, and finally a lack of access to methods that are more effective.

![Modern vs Traditional Use of Family Planning Methods in Jordan (2002 - 2012)](image)

One of the objectives of HSS II Bridge was to help the MOH design and implement programs to increase access to all available modern contraceptive methods in Jordan and to consider adoption of an additional modern method - the Standard Days Method. The project team discovered that when counseling women on FP, service providers consistently cited concerns about the negative side effects of modern contraceptive use. The 2012 Demographic and Health Survey, conducted by the Jordanian Department of Statistics, also cited the perception of “negative side effects” as a main reason for discontinuation of modern contraceptives. At the same time, use of the calendar or “rhythm” method is widely perceived in Jordan as risky and ineffective, so there was considerable resistance among MOH FP managers and providers to introduce Standard Days Method as a modern, natural FP method.
TECHNICAL APPROACH

Given the resistance of the MOH WCHD to introduce a modern natural method, even on a pilot basis, the project developed an alternative approach. The project team collaborated with the WCHD to address the issue of high traditional method use while ensuring the availability of long acting reversible contraceptives (LARC). The objective was to achieve the following:

- Understand and respond to the FP needs of the many users of traditional FP methods in Jordan (19% of MWRA).
- Engage the community, including CHCs, to identify this group and help respond to their needs.
- Engage staff from selected HCs and their supervisors in a systematic approach to improve their responsiveness to this group.

Using some of the processes developed for the FP SDIC, the project worked with the WCHD to analyze the reasons leading couples to use traditional methods. The project team tested strategies encouraging a shift to modern method use among such couples using the following process:

- Identify five urban and rural HCs with a suspected high use of traditional methods.
- Engage HD/ HC staff and community groups in these centers.
- Assist HC and community groups to identify focus group participants according to selection criteria.
- Conduct focus group discussions and analyze results.
- Determine activities to best meet the needs of traditional method users at each site based on the focus group findings.

The WCHD and HD staff worked with the project to select the five HCs and orient their staff and community groups to this activity. The group selected three HCs from the densely populated neighborhoods of eastern Amman, and one each from rural sites in the Mafraq and Tafileh Governorates. The focus group findings identified the following attributes of traditional method users:

- Dissatisfaction with information and services provided in HCs.
- Difficulty in accessing services within the HC.
- Exaggerated fears concerning the safety of contraceptives among both men and women.
- High awareness among the majority of traditional method users of the increased risk of unplanned pregnancies.
- Weak spousal communication related to deciding family size and FP methods.
- Differences among women and men about ideal family size and factors affecting the use of the methods.

Based on the results of the focus groups, the MCH staff in each center worked with community health groups to develop a set of activities addressing the concerns of couples using traditional methods. A general finding was that the reasons for relying on traditional methods were essentially the same as reasons for non-use of any method among those with unmet need for
FP. Therefore, rather than trying to identify and target users of traditional FP, which proved quite difficult when organizing the focus groups, the participating centers worked to increase access to FP information and services more generally in their communities. The participating HC main actions included the following:

- Strengthened the information about modern methods communicated by providers to alleviate concerns about side effects.
- Increased the number of health education sessions on FP within the HCs.
- Increased internal referral within HCs to identify and respond to unmet need for FP.
- Improved the quality of counseling provided to the clients.
- Introduced couples counseling by appointment for those who desired it.

**RESULTS**

These activities varied in their effectiveness at persuading users of traditional methods to switch to more effective modern methods. The project collected and analyzed aggregate data from the five HCs. Table I illustrates the number of couples and women counseled, women referred to MCH clinics within the HCs and from the community, and clients switching to modern methods.

**Table I: Aggregate Data from Traditional Method (TM) Intervention HCs**

<table>
<thead>
<tr>
<th>Couples Counseling</th>
<th>Internal Referral</th>
<th>Health Education</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couples counseled</td>
<td>Switched to</td>
<td>Women reached</td>
<td>TM users</td>
</tr>
<tr>
<td></td>
<td>modern method</td>
<td>TM referred</td>
<td>referred</td>
</tr>
<tr>
<td>49</td>
<td>20 (53%)</td>
<td>208</td>
<td>55</td>
</tr>
<tr>
<td>38</td>
<td></td>
<td>46</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>45 (98%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>545</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>64</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>57 (89%)</td>
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<td>55</td>
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<td></td>
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<td>5</td>
<td></td>
</tr>
</tbody>
</table>

With increased access to information and services, 53 percent of identified traditional method users who received couples counseling switched to more effective modern methods, and 98 percent of traditional method users who received an internal referral switched to a modern method (Table I). In addition, women reached through HC health education resulted in 89 percent of traditional method users switching to modern methods.

One of the major difficulties encountered in all five HCs was accurately identifying, documenting, and distinguishing users of traditional methods from non-users of modern FP methods. MOH medical records do not allow for the capture of information regarding traditional method use; however, they do identify new users by documenting their visit and new method selected. Therefore, the participating clinics focused on tracking the numbers of new users of modern FP methods over the period of the intervention. Figure 7 below documents the number of new visits in the HCs participating in this intervention.
SUSTAINABILITY AND FUTURE SCALE UP

The results of the focus group work show that users of traditional methods had needs and concerns similar to those with unmet need for FP. The HCs developed actions to meet the needs of users of traditional methods in this intervention. The actions were similar to those taken in the FP SDIC, with the additional element of couples counseling. The proportion of identified traditional methods users who switched to more effective modern methods ranged from 53 to 98 percent (Table 1), showing that these interventions did in fact address their concerns.

Therefore, the inclusion of these approaches, including couples counseling, in further iterations of the FP SDIC will be an effective and efficient way to meet the FP needs of users of traditional methods. Participating WCHD and the HD staff agreed that future iterations of the FP SDIC should include both tailored actions to respond to the needs of users of traditional methods and better ways to track them in their standard reports. This would allow MOH facilities to meet the FP needs of all couples, including current users of traditional methods, as part of their overall effort to decrease unmet need and improve access to and quality of FP services.
OBJECTIVE 2: STRENGTHEN THE CAPACITY OF MOH AND RMS HOSPITALS TO CONTINUE IMPLEMENTING BEST PRACTICES FOR MATERNAL AND NEWBORN CARE

Deliverable 1: Documented use of the active management of third stage of labor (AMTSL) for the prevention of postpartum hemorrhage at selected MOH and RMS hospitals

BACKGROUND

Maternal deaths may be the result of both medical and non-medical factors, many of which may be avoidable with better understanding of the contributing systemic and clinical reasons. The five-year, USAID-funded Health Systems Strengthening II project (HSS II) (2009-2014) supported the GOJ with its goal of reducing the incidence of maternal deaths with infrastructure improvements, systems strengthening, and capacity building of service providers. HSS II renovated, expanded, and equipped nine obstetric and neonatal departments in six MOH hospitals, two RMS hospitals, and the Jordan University Hospital to provide infrastructure for safe and advanced maternal care services. In addition, HSS II upgraded the emergency departments in five MOH hospitals.

Coupled with the infrastructure improvements, HSS II provided systems strengthening through operational and technical capacity building of staff at the facility and central levels of the MOH and RMS through 1) the initiation of safe motherhood committees with an interdisciplinary approach to improving maternal care and monitoring progress and 2) standardization of clinical services and integration of evidence-based medicine through the development of clinical guidelines and practical training. For example, HSS II focused on providing magnesium sulfate (MgSO₄) to patients with pregnancy-induced-hypertension (PIH), and partograph to prevent prolonged labor, as these are high-risk cases and are the major causes of maternal mortality in Jordan. With support from HSS II, the MOH developed, approved, and introduced a guideline for the management of PIH in MOH and RMS facilities.

Building on the operational and technical achievements of HSS II, HSS II Bridge tackled the next main contributing factor to maternal mortality: post-partum hemorrhage. HSS II Bridge further refined the approach used during HSS II with interventions focusing on 1) institutionalizing the protocol development process among MOH staff at the hospital and central levels and 2) improving documentation and provision of maternal care.

TECHNICAL APPROACH

Institutionalization of Protocol Development

The development of the AMTSL protocol was based on the latest medical evidence and engaged both clinical and administrative stakeholders at the hospital and central MOH levels. This protocol highlights essential steps of maternal care which, if performed during the third stage of labor by the providers, decreases the incidence of post-partum hemorrhage and therefore maternal mortality.
The MOH head of Ob/Gyn discussed the latest available medical literature during protocol-development sessions organized with HSS II Bridge. A team of obstetricians from the six participating hospitals attended these sessions. Since successful protocol implementation requires a collaborative process in the hospital, protocol development included hospital directors, the hospital nursing staff, and quality-unit staff. These hospital staff members, together with the Ob/Gyn specialists, make-up the hospital’s Safe Motherhood Committees (SMCs) created during the predecessor project.

To engage the central MOH with the hospital activities, HSS II Bridge designed the protocol-development sessions in coordination with key directorates from the MOH’s hospital administration, including the Medical Specialties, Nursing, and Quality Directorates. Therefore, HSS II Bridge helped transfer the knowledge of and capacity for developing and implementing an evidence-based protocol to both the facility and administrative levels of the MOH.

Furthermore, the group of administrators and clinicians produced the AMTSL protocol and obtained its approval through the MOH Hospital Administration in April 2015. The MOH Hospital Administration then disseminated the official, approved protocol, mandating its implementation in all MOH hospitals.

HSS II Bridge produced a poster summarizing the steps of the AMTSL protocol (Figure 8). These posters, exhibited in Ob/Gyn departments, serve as a quick and convenient reference for health care providers and will assist in guiding and orienting new staff to this standard of care.

**Documentation and Clinical Care**

Strengthening maternal care through implementation of the AMTSL protocol required improvements in both the documentation practices and technical capacity of hospital staff.

Without strong documentation practices, resulting indicator data do not reflect actual practices effectively. Therefore, monitoring and evaluation of results cannot effectively show providers and administrators their clinical progress and outcomes.

*Figure 8: The AMTSL Protocol Summary / Job Aid*
HSS II Bridge continued working with hospital staff to strengthen their documentation practices in accordance with the official MOH medical record introduced during the predecessor project. The use of the new maternal medical record strengthened the overall documentation of care in the Ob/Gyn departments as observed during data collection. The maternal section of the medical record contains a page highlighting the main steps of the AMTSL protocol, serving both to document actual practice and to give guidance to the provider. In this regard, the HSS II Bridge collaborated with the MOH Quality Directorate to introduce additional editing to the medical record, further strengthening the capture of relevant information about AMTSL implementation.

Concurrently, technical field support continued through July, the last month to include field activity in the 11-month project. The HSS II Bridge team continued providing practical, on-the-job clinical training and documentation guidance to staff in the six participating hospitals. During field visits, clinical discussions and direct observation of practice continued with hospital staff and included feedback on, and evaluation of, documentation practices.

The HSS II Bridge team ensured that hospital staff recorded in the medical record all uterotonics administered. The administration of methergine, for example, in addition to the correct administration of oxytocin as per protocol, implies deviation from the protocol. Some hospital staff mistakenly believed that as long as they administered oxytocin in addition to the two other protocol requirements (controlled cord traction and uterine massage), then they would have implemented the protocol correctly. The HSS II Bridge team communicated that administering any additional uterotonic signifies lack of protocol adherence. This situation illustrates an example where appropriate documentation is necessary for improving service provision.

By the end of the third quarter, HSS II Bridge completed the training of medical staff in the six hospitals. The average number of trained midwives and physicians ranged from 15 percent to 64 percent, depending on hospital staff numbers.

Sharing of performance data collected through the first and second quarter has motivated some of the hospital staff to invest more effort to improve their performance. In fact, when the project team shared performance data with the MOH head of Ob/Gyn, he initiated swift follow up directly with the hospitals that demonstrated inadequate performance.

RESULTS

Overall, there was significant progress toward the adoption and implementation of the protocol in a limited time. However, there exists some variation from one hospital to another and variation in the implementation of the three AMTSL criteria. Each hospital is discussed separately in this section, with an evaluation and data-based performance analysis.

Al-Bashir Hospital in Amman

Once the MOH head of Ob/Gyn approved the protocol draft, the head of Ob/Gyn in Al-Bashir issued an internal memo to physicians to implement the protocol--long before the protocol
received official approval from the MOH Hospital Administration. This move eliminated the time required for processing an approval in the central MOH and allowed the team to begin implementation sooner, an administrative advantage compared with other hospitals. Al-Bashir Hospital showed significant improvement in the third quarter. Of all the labor cases, 74 percent were treated with uterotonic drugs as per AMTSL protocol (Figure 9), exceeding the project target of 50 percent. For the second and third protocol criteria, controlled cord traction and uterine massage, 72 percent and 67 percent of labor cases were treated according to protocol.

![Percent of deliveries managed according to AMTSL Protocol by QUARTER, Al-Bashir Hospital](image)

**Figure 9: AMTSL Protocol Implementation by Quarter, Al Bashir Hospital**

However, data obtained toward the end of July showed a decrease in AMTSL implementation as illustrated in Figure 10. According to labor room nurses, weekly orders of methergine, an alternative uterotonic, for the labor room continued to decrease, suggesting that oxytocin was becoming the drug of choice per protocol. In addition, the hospital staff reported running out of new medical records, which facilitated documentation through user-friendly check boxes, and ordered a new batch from the supply department. These trends suggest that documentation practices improved during the project period, and the resulting data for July more accurately reflected actual practices. As described above, HSS II Bridge recognized the importance of documentation, and these trends indicate a positive change in provider behavior toward documentation.

![Percent of deliveries managed according to AMTSL Protocol by MONTH, Al-Bashir Hospital](image)

**Figure 10: AMTSL Protocol Implementation by Month, Al Bashir Hospital**
**Al-Mafraq Gynecology/ Pediatrics Hospital (Mafraq)**

Although there is improvement in protocol implementation in Mafraq Hospital compared with the baseline, a significant gap remains in the proper use and documentation of oxytocin. Figure 11 illustrates the overall results for the second and third quarters. While the second and third AMTSL protocol criteria have improved dramatically, the administration of oxytocin as the sole uterotonic remains a challenge.

![Bar chart showing the percent of deliveries managed according to AMTSL Protocol in Al-Mafraq Hospital](chart11.png)

*Figure 11: AMTSL Protocol Implementation by Quarter, Mafraq Hospital*

Physicians at the hospital continue to use mephergent in addition to oxytocin for normal delivery cases and are resisting strict adherence to the protocol citing “fear of post-partum hemorrhage.” While physicians are in fact administering oxytocin per protocol, they are supplementing the oxytocin dose with additional doses of mephergent. Their outcome data for the first protocol criteria therefore remain low since the protocol requires that no additional uterotonic be administered. On a positive note, the physicians are nevertheless documenting this prescribing practice, and therefore the resulting data are accurate. During field visits, the HSS II Bridge team reiterated to physicians the evidence indicating that no other uterotonic is required in addition to oxytocin, but changing provider behavior was slow as illustrated by the monthly data in figure 12.

![Bar chart showing the percent of deliveries managed according to AMTSL Protocol by month in Mafraq Hospital](chart12.png)

*Figure 12: AMTSL Protocol Implementation by Month, Mafraq Hospital*
Furthermore, Mafraq Hospital is one of the MOH hospitals currently implementing the Hakeem Project, the electronic documentation system being integrated in MOH hospitals and HCs. This system does not have a dedicated section for AMTSL similar to that found in the official MOH medical record, adding to the challenges already existing in documentation practices. Service providers must enter the information in text format to document implementation of the AMTSL protocol.

**Karak Hospital (Karak)**

Karak Hospital showed significant improvement in the third quarter with 44 percent of cases receiving uterotonic per AMTSL protocol compared with 21 percent in the second quarter (Figure 13).

![Percent of deliveries managed according to AMTSL Protocol by QUARTER, Karak Hospital](image)

*Figure 13: AMTSL Protocol Implementation by Quarter, Karak Hospital*

However, data for both June and July indicates significant decline relative to the first criteria of the AMTSL protocol: administration of uterotonic per protocol declined from 52 percent in May to 22 percent, then 15 percent in June and July respectively, as illustrated in Figure 14.

When the Hakeem Project began work with the six hospitals, Karak was not one of the hospitals integrating this system. In June, however, the MOH began Hakeem system integration at Karak Hospital. Similar to other hospitals, physicians in Karak had reservations about using oxytocin alone for fear of having subsequent cases of post-partum hemorrhage.

The introduction of the Hakeem system provided an opportunity for less optimal documentation since a dedicated section for AMTSL is not included, and physicians began duplicating uterotonic orders by including methergine. The second and third protocol criteria, however, did not show significant changes as they are not disputed by any physicians.
**Percent of deliveries managed according to AMTSL Protocol by MONTH, Karak Hospital**

- % used IM/IV-Oxytocin (10 units)
- % Received controlled cord traction
- % Received uterine massage

![Chart showing delivery management by month](Figure 14: AMTSL Protocol Implementation by Month, Karak Hospital)

**Al-Hussein Al-Salt Hospital in Balqa**

Al-Hussein Al-Salt Hospital achieved overall improvements similar to the other hospitals between the second and third quarters as illustrated in Figure 15: administration of uterotonics according to protocol improved from 9 percent to 29 percent, while the second and third criteria also improved significantly.

**Percent of deliveries managed according to AMTSL Protocol by QUARTER, Al-Hussein Al-Salt Hospital**

- % used IM/IV-Oxytocin (10 units)
- % Received controlled cord traction
- % Received uterine massage

![Chart showing delivery management by quarter](Figure 15: AMTSL Protocol Implementation by Quarter, Al Salt Hospital)

Analyzing data on a monthly basis revealed a healthy trend in capacity building and improvement in documentation practices. The drop in adherence to the first protocol criteria during March and April was due to improved documentation, while a subsequent upward trend lasted through July (Figure 16). Hospital staff at Al Hussain Salt had some reservations about implementing the AMTSL protocol prior to official MOH approval. Obtaining the approval in April further encouraged the staff and strengthened their commitment.
**Prince Faisal Hospital in Zarka**

Prince Faisal Hospital demonstrated achievements and steady progress similar to that of Al Hussein Al Salt Hospital. Implementation of all three protocol criteria improved significantly in the third quarter, with administration of the uterotonic of choice reaching the project target of 50 percent (Figure 17).

Figure 18 illustrates the progressive capacity building and improvements in documentation through the monthly indicator data for Prince Faisal Hospital. The initial decline in adherence to the first protocol criteria during March and April was due to improved documentation practices, as was observed in Al Salt Hospital. The staff at Prince Faisal Hospital adopted the new medical record more willingly than other hospitals and noted the important relationship between accurate documentation and provision of care. Subsequently, the hospital staff was able to improve gradually, peaking at 70 percent implementation of the first protocol criteria in June.
Princess Bade’a Hospital in Irbid

Princess Bade’a Hospital was unique in two ways: first, the hospital was already integrating the Hakeem system when the HSS II Bridge intervention began; second, the head of Ob/Gyn was not willing to provide appropriate documentation until the MOH Hospital Administration produced an official approval. This came despite repeated efforts from the MOH head of Ob/Gyn. Many physicians cited fear of being held accountable by the MOH if any negative outcomes occurred with patients. While HSS II Bridge provided support during the early months, the extent of implementation was not measurable as the Hakeem system does not yield such data, and the staff were not willing to document using the MOH paper medical record. However, the HSS II Bridge technical team noted that the hospital staff was largely implementing the protocol, though without appropriate documentation. Similar to other hospitals, Princess Bade’a showed less improvement in the first AMTSL criterion compared with the second and third criteria due to providers’ fearing post-partum hemorrhage. Uterotonic prescribed according to protocol increased from 35.5 percent in June to 54 percent in July, while the other two criteria remained at the same level, as shown in Figure 19.
SUSTAINABILITY AND FUTURE SCALE UP

The approach taken during HSS II Bridge focused on 1) institutionalizing the protocol development process among MOH staff at the hospital and central levels and 2) improving documentation and provision of maternal care. While the approach was successful to some extent during the project’s 11 months, additional clinical and managerial capacity building is required for staff in the hospitals and those in the MOH’s Hospital Administration to optimize implementation and supervision of protocol implementation.

Currently, the MOH Hospital Administration includes 12 directorates, mimicking the ideal organizational chart for a hospital. However, the MOH hospitals are not organized according to the same chart, and internal management and clinical governance become inefficient. During the life of HSS II Bridge, the position of “Director” of the MOH Hospital Administration was vacant. This introduced a challenge to the HSS II Bridge team and hospital counterparts in establishing supervisory mechanisms with the central MOH.

In addition, documentation practices are inconsistent from one hospital to another. Several of the participating hospitals were integrating Hakeem’s electronic medical record system. This posed additional challenges to optimal documentation and data analysis. The HSS II Bridge team identified these inconsistencies and discussed them with the Quality Directorate (QD) of the MOH Hospital Administration. Subsequently, the QD formed a committee to oversee and synchronize the process of developing the electronic medical record “pages.”

Therefore, to institutionalize the process of protocol development, implementation, and monitoring and evaluation, the MOH will need to strengthen the clinical governance between Directorates of the MOH Hospital Administration and the corresponding hospital departments.
Deliverable 2: Documented use of continuous positive airway pressure (CPAP) system for managing neonates with respiratory problems at MOH and RMS hospitals

BACKGROUND

The HSS II Activity worked with Jordan’s public hospitals to introduce the NB-CPAP system, an alternative to invasive ventilation, in neonatal intensive care units (NICU).

Research indicates that non-invasive ventilation therapy is superior to invasive methods for the majority of infants with respiratory distress syndrome.¹ Convinced by the advantages of NB-CPAP, 30 hospitals adopted it with support from HSS II. During HSS II Bridge, efforts focused on ensuring proper use of this essential system with increased emphasis on documentation and the use of data to evaluate both the extent of implementation and the impact on service outcomes.

TECHNICAL APPROACH

To standardize clinical practices, the HSS II Bridge team worked with counterparts in the MOH neonatal units and with the MOH head of neonatal to develop the NB-CPAP Protocol based on evidence.

The MOH Hospital Administration approved the resulting protocol and disseminated it to hospitals. The finalized protocol includes full and detailed instructions on how to initiate ventilation, maintain NB-CPAP set-up according to appropriate clinical signs, and monitor outcomes for successful weaning-off or for change of treatment.

In addition to the approved protocol, HSS II Bridge produced a poster during the final quarter summarizing the steps of the protocol (Figure 20). These posters, exhibited in NICUs, serve as a quick and convenient reference to experienced health care providers and a guide to orient new staff to this standard of care.

Along with protocol development, the HSS II Bridge team worked on improving documentation practices and the data flow from NICUs in six hospitals. Accurate documentation and communication of resulting data are crucial for two main reasons. First, indicator data enable health care providers to gauge performance and clinical outcomes of their service delivery to understand where gaps exist and to plan for practical quality improvement changes. Second, managers and procurement specialists can apply usage-data to ensure consistent and sufficient supplies of NB-CPAP consumables for those who need them.

Currently, due to limitations in NB-CPAP consumable availability, MOH staffers re-use available sets after sterilization. However, there are no official, standardized sterilization practices or recommendations for sterilization of consumables, and repeated sterilization undermines the integrity of consumables.

The availability of reliable NB-CPAP usage-data is of particular importance for the provision of this non-invasive ventilation method in MOH hospitals. The lack of reliable usage-data contributes to inconsistent supply of consumables. Without usage data, the MOH is unable to properly estimate and in turn allocate, the needed funds for meeting NB-CPAP demand in its hospitals. Therefore, in spite of hospitals’ endorsement of and preference for non-invasive ventilation support, there are significant supply gaps.

Recognizing this challenge, the HSS II Bridge team worked with MOH counterparts to estimate the annual need and cost of NB-CPAP consumables based on NICU admissions in 20 MOH hospitals. The team then produced a brief technical document titled “Estimating MOH Needs for NB-CPAP System and Consumable” in collaboration with MOH specialists. The document, submitted to USAID as an annex in the HSS II Bridge’s third quarterly report, listed NB-CPAP consumables with an estimated annual cost using real data from the hospitals. Using these estimates, the MOH can now strengthen its procurement practices and ensure that each hospital receives an appropriate quantity of NB-CPAP consumables to meet its needs. The MOH can build on the achievements to date, which include:

- Trained new clinical staff on appropriate use of NB-CPAP system.
- Provided support to strengthen the overall documentation of CPAP practices at the hospitals.
- Provided on-the-job training, which included clinical discussions and analysis of cases placed on the NB-CPAP system.
- Provided orientation for physicians and nurses in the six selected hospitals.
The average number of oriented midwives and physicians on the NB-CPAP protocol ranged from 46 percent to 86 percent in the six hospitals. The following section presents documentation of NB-CPAP system usage in the participating hospitals through documentation of survival rates.

**RESULTS**

**Al-Bashir Hospital in Amman**

Similar to other MOH hospitals, Al-Bashir faces a shortage of NB-CPAP consumables. As a result, the hospital uses alternative methods such as CPAP and re-using available consumables after sterilization. The NB-CPAP neonatal survival rates remained the same during the third quarter, with seven neonates placed on the system.

![Survival rates for neonates placed on NB-CPAP, Al-Bashir Hospital](image)

*Figure 21: NB-CPAP System Use and Survival Rates, Al Bashir Hospital*

Data collection is a particular problem in Al-Bashir Hospital, where a combination of duplicate but incomplete data sources and excessive workload make it difficult to document ventilation support given to infants. HSS II Bridge analyzed the data flow in Al-Bashir Hospital and made recommendations for data completeness. To ensure buy-in, HSS II Bridge worked closely with the Head of Nursing at the hospital, who led a half-day workshop with the NICU nursing staff on the recommended modifications to the data collection system and the importance of adherence to the official MOH medical records.

**Al Hussain Al Salt Hospital in Balqa**

Al-Hussain continues to be one of the best NB-CPAP system users. Hospital staff sterilizes the NB-CPAP consumables to re-use the existing supply. Despite the increased number of neonates placed on NB-CPAP during the HSS II Bridge period, the hospital was able to maintain high survival rates (Figure 22). In July, all 29 neonates placed on NB-CPAP survived.
Princess Bade’a Hospital in Irbid

Princess Bade’a Hospital had a 90 percent survival rate for neonates in the first month of the third quarter. In May and June, the rate dropped to 65 percent and 72 percent respectively, due to complicated cases (Figure 23). Located in the north, the hospital receives patients from among the Syrian refugee camp population. Cases admitted from refugee camps are usually very complicated and arrive with poor prognosis. During August, the hospital underwent an intensive accreditation-survey process, and the HSS II Bridge team was not able to retrieve survival rates for July.

In Princess Bade’a and Al Hussain Al Salt Hospitals, service providers are committed to providing health support to all newborns regardless of their gestational age or weight. The two hospitals are implementing the system for preterm neonates with weights below 1500gm or less than 32 weeks gestation, widening the caseload covered by the protocol, yet retaining good survival rates. Such neonates were previously less likely to survive after receiving mechanical ventilation.
Karak Hospital in Karak

In Karak Hospital, the NB-CPAP survival rate was maintained at 90 percent and 91 percent during the second and third quarters respectively. Six of the nine neonates placed on NB-CPAP during July survived, bringing the survival rate to 67 percent for that month. During the second quarter, the survival rate for the month of March was only 75 percent, yet the overall rate for that quarter (January – March), was 90 percent. It is important to note that with such a small number of cases, even one case of mortality changes the rate for that month dramatically.

![Figure 24: NB-CPAP System Use and Survival Rates, Karak Hospital](image)

Mafraq Hospital in Mafraq

The variation in survival rate noticed in Al-Mafraq Hospital is mainly due to complicated cases admitted from Syrian refugee camps during the second and third quarters (Figure 25). In July, Al-Mafraq retained its survival rate at 100 percent, with all seven cases placed on NB-CPAP surviving.

![Figure 25: NB-CPAP System Use and Survival Rates, Mafraq Hospital](image)
**SUSTAINABILITY AND FUTURE SCALE UP**

The approach to improve neonatal respiratory care in hospitals followed the same approach as that for AMTSL (previous section), namely to 1) institutionalize the protocol development process among MOH staff at the hospital and central levels and 2) improve documentation and provision of neonatal care according to the NB-CPAP protocol. Clinical and managerial capacity building is needed for staff in the hospitals and in the MOH’s Hospital Administration to ensure integration of efforts in protocol implementation and supervision as described in Deliverable 2, Objective 1.

The availability of CPAP consumables, which are required for appropriate administration of CPAP, is a limiting factor for CPAP implementation and for maintaining and improving neonatal survival rates. To address this challenge in a sustainable manner, the HSS II Bridge team worked with MOH specialists and successfully advocated for inclusion of consumables needed for the NB-CPAP system in the annual procurement list of MOH and RMS. This step should secure hospital needs of consumables during the new calendar year. The project team recommends that the MOH Hospital Administration repeat the exercise in subsequent years.

In addition, the HSS II Bridge team directed some of its training and orientation efforts toward medical residents and the continual nursing education committee to amplify the results of transfer of knowledge. Training included the following:

- Orientation of 19 residents in the pediatric units in Princess Bade’a Prince Hussain Al-Salt, and Karak teaching hospital in addition to hospital-assigned physicians and specialists. Since medical residents rotate through different MOH sites, this presents an opportunity to pass on their knowledge.
- Orientation and training of neonatal units’ core trainers and members of the hospital continual nursing education (CNE) committee. Their inclusion will ensure further training for new staff and institutionalization of the NB-CPAP protocol. Prince Faisal Hospital nominated an NICU nurse to train other staff on the protocol under the supervision of the unit head nurse and with the cooperation of the quality department.

In coordination with the MOH Hospital Administration, hospitals will be required to continue with these technical and administrative efforts to ensure that the hospitals maintain and build on the successes achieved.
Deliverable 3: Documentation pertinent to introduction of preconception care model developed

BACKGROUND

Prenatal care and skilled delivery are high in Jordan, yet the MOH does not have any policy or programs related to preconception care. The World Health Organization (WHO) promotes preconception care as a best practice that helps countries reduce the negative behaviors and individual and environmental factors that contribute to poor MCH outcomes. Effective preconception care can help reduce unintended pregnancies, complications during pregnancy and delivery, stillbirths, preterm birth and low birth weight, birth defects, neonatal infections, underweight, and stunting, and lower the risk of type-2 diabetes and cardiovascular disease later in life.

TECHNICAL APPROACH

One of the objectives of HSS II Bridge was to help the MOH and its partners develop a model for preconception care that suits Jordan’s context and specific needs. The project team helped the MOH and its partners develop clinical guidelines, protocols, and job aids relevant to different levels of implementation. Good preconception care is contingent on appropriate counseling and medical advice or treatment provided to women and their partners as part of routine preventive care and through pre-marital testing in a clinical setting. Since many of the behaviors that affect health before conception and during pregnancy are formed well before conception, another important component is to engage youth in improving their health and their behaviors before planning a family.

Given the breadth of topics and potential intervention points for preconception care, the involvement and agreement of a number of stakeholders are essential. Therefore, HSS II Bridge supported the formation of a multi-stakeholder Preconception Care Technical Working Group (PC TWG) to oversee the design of the model and serve as a platform for agreement on service delivery levels and implementation mechanisms. A consultant from the American College of Nurse Midwives (ACNM), Dr. Patrice White, provided technical assistance for this effort through two visits to Jordan to help build understanding and consensus among stakeholders and provide virtual support to develop and refine the model. Between February and April 2015, stakeholders from different directorates within the MOH, HSS II Bridge, and JCAP participated in three meetings to agree on the overall approach, the components, and the opportunities and settings for delivery of preconception care. In May, HSS II Bridge hosted a meeting of key stakeholders from MOH, USAID, the United Nations Family Planning Association (UNFPA), and JCAP to gain consensus and determine next steps. All participants agreed on the content to be covered and three service delivery mechanisms.

HSS II Bridge developed materials, including checklists and guidelines for the two clinical service delivery mechanisms, while JCAP agreed to work with non-governmental organizations (NGOs) on the third, community-based mechanism and to develop a handout that could indicate more resources for clients on specified topics. During their final meeting in August 2015, stakeholders approved the preconception care model, checklists, and guidelines for the clinical sessions.
RESULTS

Given the epidemiology, common behaviors, and socio-cultural context in Jordan, the working group agreed to a list of priority topics for preconception care in Jordan, which include:

- Genetic/consanguinity screening and counseling.
- Fertility plans, healthy timing and spacing of pregnancy, modern FP options, and the normal range of time it can take to become pregnant.
- Healthy weight, diet, and exercise.
- Preventing or managing hypertension, diabetes mellitus, and anemia.
- Folic acid to prevent neural tube defects.
- Vaccines to avoid preventable infections.
- Reducing the use of unhealthy substances (tobacco, alcohol, drugs).
- Reducing environmental risks/exposures.
- Preventing interpersonal violence.

Unmarried youth, couples anticipating marriage, and/or married women who may already have at least one child do not usually perceive pregnancy as a health issue. Therefore, it was important to identify the best opportunities to engage these different target groups to prepare for a successful pregnancy. The PC TWG identified three opportunities to engage the different groups most in need of preconception care:

- Reaching unmarried youth to prepare them for good reproductive health.
- Integrating preconception care into the mandatory premarital visit.
- Providing preconception care to women presenting at HCs for other reasons.

To reach unmarried youth, JCAP plans to build a preconception approach into the youth-oriented NGO activities funded under the project. The approach will focus on youth in universities and out-of-school youth. The JCAP project team will use the content developed under the preconception care model to develop messages to share with this group. JCAP believes that framing FP messages within the broader context of preconception care is a more acceptable and inclusive way to encourage youth to take responsibility for their health, including reproductive health.

The GOJ requires couples to seek premarital physical exams before issuing a marriage certificate. The purpose of the exam is to rule out thalassemia. HSS II Bridge worked with stakeholders to determine the feasibility of adding couples preconception care counseling to the mandatory physical exam.

Based on that analysis, the project prepared a checklist of key topics for providers to discuss with each couple and guidelines to help providers conduct the sessions. The project developed a similar approach for women presenting at HCs for other reasons. The project team shared the provider checklists and guidelines for the two clinical sessions with all counterparts. Guidelines and checklists for both preconception care and premarital testing and counseling are included in Annexes 11, 12, 13, and 14 to this report.
SUSTAINABILITY AND FUTURE SCALE UP

The deliverable under this project was development of the model, not implementation. The introduction, scale up, and sustainability of this intervention will not be assured until the members of the technical working group within the MOH will provide the complete package to senior leadership (the Secretary General and the Minister) for review and approval. In addition to agreeing to this model, the MOH senior leadership will need to do the following:

- Designate the Directorate responsible for each component of preconception care (these may be different for the different delivery mechanisms).
- Incorporate this task into the job description and mandates of health care personnel (for the two service delivery mechanisms).
- Ensure readiness to secure adequate staffing within HCs to address the additional time needed to perform this service (for instance, by including it within the WISN tool used by the Ministry for optimal allocation of staff).
- Demonstrate willingness to continue to support the PC TWG to serve as a coordination body for introduction and scale up of this new service.
- Assume readiness for start-up costs to introduce this service (mainly orientation sessions for service providers).

Once these steps are completed, the PC TWG will need to develop a timeline and roll out process for progressive introduction of preconception care across Jordan. USAID support for this process would significantly increase the likelihood of achievement in a timely and complete fashion.
OBJECTIVE 3: STRENGTHEN THE CAPACITY OF MOH TO USE DATA GENERATED FROM DIFFERENT HMIS TO IMPROVE DECISION MAKING AND PLANNING

Deliverable I: Models for data use established at MOH central, HD and facility levels

BACKGROUND

USAID tasked HSS II Bridge with improving the performance of HCs and hospitals in providing FP services and maternal and neonatal care. In designing activities and interventions, the project used a collaborative approach centered on the core concept of data use for decision-making. Integrating good documentation practices, data aggregation, and data analysis into the routine roles and responsibilities of stakeholders provides a strong basis for identifying gaps and developing suitable solutions.

TECHNICAL APPROACH

Generating operational and performance indicator data requires a thorough understanding of client/patient flow, documentation practices, and the dynamics relating indicators to one another. The project built data models for its main objectives based on these concepts. Field activities engaged stakeholders not only in data production, but also in using data to determine any changes that were needed.

The Monitoring and Evaluation (M&E) Plan, submitted in December 2014 as part of the HSS II Bridge Work Plan, outlines the project indicators. The M&E Plan also includes the performance indicator reference sheets (PIRS), which define each indicator, its method of calculation, and data sources, among other information.

The project reviewed the definitions for each indicator with counterparts at the facility, directorate, and central levels and studied data sources and documentation practices beginning at the facility level. In doing so, the participating HCs and hospitals were able to standardize their documentation and aggregation practices, making the resulting data consistent and comparable across HCs and governorates.

Finally, the project worked with counterparts at all three organizational levels to produce and visualize the data via the ministry’s FP HMIS and other systems designed for the relevant data models. HSS II Bridge worked on the MCH and the FP logistics (LMIS) systems with the WCHD staff to ensure the indicator definitions were up-to-date. The project team also created the FP Decision Support System (FP DSS) and developed two web-based systems to monitor the maternal and neonatal care interventions hospitals implemented.

With the engagement of stakeholders at the facility, directorate, and central levels, the project designed data models for its interventions to improve FP services in HCs and for maternal/neonatal care in hospitals.
The data models rest on three pillars necessary to standardize information and to strengthen reliability of results. They include:

- Client/patient workflow.
- Detailed reference sheets for each indicator, defining unit of measurement, validation criteria, numerator, denominator, and data source.
  
  - A- Indicator list
  - B- Outline of PIRS
  - C- Data flow
  - D- Quality check

- Presentation and visualization of resulting indicator data.

**RESULTS**

**FP SDIC**

**Client Flow Model**

The design of the health-based data model began with the client flow in health facilities. Through visits to health facilities and input from health staff during collaborative learning sessions, HSS II Bridge developed a schematic illustrating a typical FP client’s journey through a HC. The schematic below specifies all the services such a client would receive, the persons responsible for providing the service, and all the data touch points in the process, including a description of records or data sources.
After designing the client flow model, it was possible to understand the data flow from HCs. At the MOH, FP data flow through three levels: HC, HD, and WCHD, with each level having multiple data touch points. A robust data model must consider these multi-layered levels in its design. In addition to the client flow schematic presented above, HSS II Bridge developed a data flow schematic, presented below.
Figure 28: Data flow from HCs

Enhancing Performance of Health Systems

USAID-funded HSS II Bridge EOP Report
**Indicators and reference sheets**

HSS II Bridge worked with MOH counterparts to define and develop performance improvement indicators. The teams developed 21 indicators around four key performance improvement areas:

- **Systems** for FP services
- **Access** to FP services
- **Quality** of FP services
- **Supply** of FP services

![Diagram](image)

*Figure 29: Root cause analysis schematic*

To avoid new data collection burdens on MOH staff, HSS II Bridge developed indicators with existing and functioning data sources at MOH facilities. The project team, in collaboration with the MOH teams from the central, HD, and HC levels, prepared performance indicator reference sheets (PIRS) for each indicator.

For data collection, HSS II Bridge used a web-enabled data entry system. This system enabled simultaneous data entry from multiple staff. Additionally, the system has sophisticated branching and consistency logics to aid in the quality control of the entered data. Below is an example of the data entry page for dispensed FP methods.
Data quality assurance includes logic checks programmed within the system, supervisor comparing between physical forms and the entered data, and field visits by supervisors to ensure that the entered data corresponds with the data sources. During entry, the internal quality system controls alert the user if the data is not in the correct format.

**Display**

Information display was a major activity area in the design of the data models. The project provided two platforms for the display of FP SDIC data. The first platform shows frequency charts of the data entered from HCs, as illustrated below.
Using the above display, stakeholders can monitor the progress of data collection and perform a quick analysis of indicator data. Once data for the month has been entered, the system performs another round of data quality checks. This consists of frequency runs of all the entered data and cross-tabulations to ensure data logic and consistency. Then, users upload clean data to the second information platform, the online FP Decision Support System (FP DSS).

The FP DSS is an online data warehouse that has dashboard and visualization functionalities, allowing any (approved) user with internet access to monitor the progress of the 21 performance improvement indicators. Screenshots and use cases are presented below.

![Web-based dashboard for HCs enrolled in the FP SDIC](image)

**Figure 32: Web-based dashboard for HCs enrolled in the FP SDIC**

With the FP DSS, users can choose from a variety of functionalities. Data visualizations can be by HC, directorate, or time-period. Additionally, users can select from different visualization formats, including bar charts, area graphs, pie charts, line graphs, and tables. These functionalities enable performance improvement monitoring, as the use case example below demonstrates.
In the figure above, the left hand chart shows the CYP trend for Al-Hashmi Al-Shamali, a HC in Amman; the top right chart shows an increase in the number of weekdays in which providers deliver IUD services (in the same HC); and the chart below shows the increase in the number of trained midwives. This chart indicates that training of midwives has increased provision of long-acting FP methods. Through the visual display for multiple indicators, the system displays the dynamic relationships between indicators and intervention for decision makers.

**HOSPITAL MATERNAL CARE**

**Client Flow**
An important indicator during the HSS II Bridge was the percentage of deliveries managed according to AMTSL, a global best practice. To develop the data model that would capture the data on this indicator in an accurate and timely manner, HSS II Bridge began with a detailed mapping of the patient’s journey in the maternity ward. This mapping exercise involved discussions with specialists in the six target hospitals and field visits.
**Indicators and Reference Sheets**

For HSS II Bridge, three out of the 16 project or contract indicators pertained to safe motherhood. These included:

- Percentage of women giving birth in six selected hospitals who received uterotonicics in the third stage of labor as the AMTSL protocol requires.
- Percentage of pregnancy-induced hypertensive women in six selected hospitals managed according to the clinical guideline.
- Selected hospitals using confidential inquiries into maternal deaths and near misses to monitor the quality of maternal care.

Only AMTSL required a new indicator reference sheet, and this is in the M&E plan in Annex I of this report. The other two indicators had reference sheets and have been monitored since the predecessor HSS II project. Collection of the AMTSL data required monthly visits to the six hospitals by HSS II Bridge specialists, with a random sample of medical reports selected and reviewed against an AMTSL checklist from each hospital.

The HSS II Bridge team also used the web-based data collection tool for maternal indicators. The following screenshot shows the AMTSL implementation data entry page.

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*Figure 34: Client flow in the maternity ward*
Display
Data display for maternal indicators used two platforms. The first was the summary of entered data described above (see Figure 35), and the second was an Excel dashboard placed on a shared folder in HSS II Bridge’s server. An example of the Excel dashboard is presented below.

The Excel dashboard displays data by hospital, month, quarter, and aggregate. The dashboard automatically updates once the user enters monthly data for a hospital.
**HOSPITAL NEONATAL CARE**

**Client Flow**
Neonatal survival rate was an indicator in the HSS II Bridge project. Building on the successes achieved in HSS II, the HSS II Bridge focused on the institutionalization and expansion of NB – CPAP as the alternative to mechanical ventilation. The neonatal indicator in HSS II Bridge measured the survival rate of neonates placed on NB – CPAP.

As with the FP SDIC and maternal indicators, the HSS II Bridge created a detailed client flow chart to guide the data collection efforts in NICUs.

![CPAP Flow](image)

**Figure 37: Flow of neonatal patients**

**Indicators and Reference Sheets**
The indicator reference sheet for this indicator is presented in Annex I of this report. Collection of the CPAP data required monthly visits to the six hospitals by HSS II Bridge specialists. The Bridge team collected CPAP data from the NICU logbook, which records admission date, discharge date, and type of ventilation support provided to the neonates. For data collection, the Bridge team developed a web-based form (Figure 38).

**Display**
Data display for this neonatal indicator used two platforms. The first was the summary of entered data described in Figure 38, and the second was an Excel dashboard, and example of which is presented in Figure 39.
Developing data models according to patient flow and documentation resulted in accurate data describing the improvements in the delivery of services based on the project’s objectives. The approach brought the “use of data” closer to the provider and enabled the teams at the facility level to appreciate how their efforts result in progress and quality improvement. Based on performance and results, the supervisory roles of HD and the WCHD staff were beneficial. The data model provided a tool to facilitate interaction between management staff and technical staff. Now that facility staff members have used data to make positive decisions affecting their delivery of services, they can continue tapping into the data yielded through the existing HMIS, namely the MCH and Logistic Systems as described above.
Deliverable 2: Conceptual framework for maternal mortality surveillance and response system designed and ready for implementation

BACKGROUND

Jordan’s maternal mortality information is based on dated, periodic surveys. Maternal mortality ratios differ noticeably depending on the source: GOJ reported 19 per 100,000 in 2008 compared with the WHO’s 50 per 100,000 in 2013.

Previous USAID support for safe motherhood programs through the HSS and HSS II projects contributed to significant quality improvement in maternal health services. The MOH documented dramatic decreases in maternal mortality due to PIH in their surveys and reports. The safe motherhood programs also strengthened the confidential inquiry (CI) into maternal deaths or near misses by establishing reporting mechanisms through SMCs in public hospitals.

The establishment of a maternal mortality surveillance and response (MMSR) system covering both the public and private sectors will therefore produce more current and accurate mortality ratios, provide confidential clinical and logistic information about maternal deaths, and thus improve the use of data for decision making in maternal health interventions.

TECHNICAL APPROACH

The project implemented the Jordan MMSR model according to four guiding strategies:

- Led technical work by appropriate committee of counterparts and stakeholders.
- Gained thorough understanding of all aspects of baseline practices, including policies and procedures.
- Built on existing mechanisms and strengthened their integration.
- Adapted standards and technical recommendations tailored to local needs in a complementary and sustainable manner.

During the project’s work plan preparatory meeting in November 2014, the project team convened a working group to discuss maternal mortality, CI, and the need for a surveillance system. This working group included stakeholders from the MOH, HPC, RMS, and Higher Health Council, among others. The working group discussed the technical and operational needs for a surveillance system and specified the steps to be carried out in collaboration with HSS II Bridge.

Photo 7: The Strategy and Leadership Group during the work planning meeting led by HE the MOH Secretary General
The first step was the creation of the Maternal Mortality Surveillance and Response System Steering Committee by the MOH, chaired by H.E. the Secretary General, with the Director of the MOH Non-Communicable Diseases Directorate committee as rapporteur.

Together with the Steering Committee, the project studied all baseline practices concerning the reporting and documentation of deaths in general and maternal deaths specifically at all organizational levels for each sector. These findings are summarized in the “MMSR Consultant Trip Report, April 2015.”

Field activities included visits and interviews at HCs, hospitals, forensic medicine departments, governorate HDs, and several directorates and administrations in the central MOH. The report also describes pertinent information from the Ministry of Interior’s Civil Status and Passport Department.

This preparatory phase included meetings with other agencies and donors, including UN agencies, to ensure exchange of knowledge and efficient coordination of efforts. The Steering Committee rapporteur coordinated technical meetings for discussions and for dissemination of findings with the entire committee and to the Secretary General. The HSS II Bridge presented a final model and officially presented it to the National Millennium Development Goals Steering Committee on Tuesday, September 15, 2015.

Photo 8: Dr. Malak Al-Ouri during the JMMSRS presentation to the National MDG Steering Committee

RESULTS

Development of the Jordan MMSR Model built on existing structures and procedures. The project used technical information from WHO, USAID, and the Journal of Reproductive Health among other references to strengthen the existing structure and to make recommendations for needed changes. The existing systematic strengths include:
- Almost all childbirths in Jordan take place inside hospitals.
- All cases of death, if not occurring already inside a hospital, are brought to the hospital emergency department and then transferred to the forensic medicine department as appropriate by hospital medical staff.
- “Death Notification Forms” (DNF) and/or “Forensic Medicine Reports” are completed for all deaths.
- DNF include a clause specifying whether the death case is a pregnant woman, a woman who delivered within the previous 42 days, or of a woman of reproductive age (15 – 49).
- Families take DNF to the CSPD for registration of civil information.
- The MOH has existing surveillance systems for other diseases covering all sectors that are monitored through the Non-Communicable Disease Directorate.

While these structures and procedures exist, the challenge is to transform them into a continuous surveillance system that captures, identifies, reviews, analyzes, and responds to every maternal death. The complete Model for the Jordan Maternal Mortality Surveillance and Response System is included in Annex 7.

NEXT STEPS FOR IMPLEMENTATION

Implementation of the model requires several preparatory steps to ensure success and sustainability. First, the MOH should form an evaluation committee comprising all health care sectors to study the needs for model implementation.

The main tasks for the evaluation committee are based on the five key technical components of the Jordan MMSR model:

1. Identification and notification of maternal deaths
2. Maternal death review
3. Analysis and interpretation of aggregated findings
4. Response and dissemination
5. System monitoring and evaluation

For each of the steps above, the evaluation committee will evaluate capacity building programs needed for conducting the different functions of the surveillance system and managing the flow of information at each organizational level. In addition, the MOH must incorporate the surveillance and reporting of maternal deaths into the Public Health Law, mandating its implementation for all sectors.
**Deliverable 3: A list of standard IT equipment is provided to accredited MOH primary healthcare facilities**

Please refer to Annex 8 for the list of IT equipment and official handover documentation.
OBJECTIVE 4: ASSIST THE MOH TO IMPROVE ACCESS TO FAMILY PLANNING AND REPRODUCTIVE HEALTH THROUGH COMMUNITY BASED ORGANIZATIONS

Deliverable 1: Two CHCs transformed into community based organizations that provide FP services

BACKGROUND

Recognizing the community’s essential role in health promotion, over the past decade USAID has partnered with the MOH to institutionalize an effective community health program. This program educates the population on health topics and their rights as healthcare consumers while engaging Jordanians to take responsibility for their health. As a result, Jordanians formed more than 100 CHCs across the Kingdom. These committees raise awareness of and increase demand for FP services at MOH HCs. In 2014, the project partnered with two of these CHCs as they underwent legal recognition to become community based organizations (CBOs) capable of fundraising and providing information and services to their target communities. These two CBOs, Entrepreneurial Association for Health Promotion (Al Nohoud Al Sihhi Pioneer Society, also known as Al Hashmi) in Amman and the Howara Health Society in Irbid both chose FP promotion among their main objective.

TECHNICAL APPROACH

HSS II Bridge partnered with these two new CBOs to accelerate their transformation and promote organizational development, including articulation of an organizational vision, policy development, organizational structure, development of operating systems, and fundraising capacity. HSS II Bridge did not include seed funding for these organizations. The project focused on enabling them to promote FP use, rather than providing clinical services on their own.

HSS II Bridge staff worked directly with the two CBOs with the assistance of an organizational development consultant to build their organizational and technical capacity to be effective advocates for FP in their target communities. In addition, the CBOs were able to access training and other technical support from the SHOPS Jordan (Ta’ziz) project and the Civic Initiative Support (CIS) project to strengthen their capacity to play their roles effectively. HSS II Bridge support included the following elements for each CBO:

Strategic Plan

Each CBO followed a structured process to develop a strategic plan with broad institutional support. This included a workshop and meetings with the administrative board of each CBO to discuss each aspect of its strategic plan followed by approval of a final draft. The strategic plan includes the scope of work, coverage, organization chart, a strengths/weaknesses/opportunities/threats (SWOT) analysis, strategic issues, vision, mission, organization values, strategic goals and objectives, and operating procedures.
Operational Plan

Support from HSS II Bridge enabled each CBO to complete an operational plan, with Year 1 objectives selected by the respective administrative boards. The HSS II Bridge team helped each CBO member participate in developing an operational plan based on the strategic plan. In collaboration with the HSS II Bridge team, CBOs developed two essential documents based on the operational plan:

- Documentation form tracking all CBO activities
- Capacity building form: documentation of all training programs attended by a CBO administrative board member

These forms will enable the CBO to report on its activities and plan for future training needs. They also provide documentation needed for donors to track a CBO’s history.

Marketing Plan

The project worked with each CBO to develop a marketing plan that outlines its marketing methods and fundraising sources. This will allow the CBO to secure funds to sustain its activities, as articulated in the operational plan.

Human Resources System

Each CBO prepared an organizational chart and established an HR management system, although for the time being the CBOs do not have paid staff. This will enable them to articulate and fill their staffing needs concurrently with fundraising efforts.

Financial Plan

Each CBO prepared a financial plan, taking into account the necessary elements to accomplish priority activities and attract and steward funds.

Support for Implementation of CBO Operational Plans

The project provided limited technical and financial support for the CBOs to conduct their initial activities as articulated in their operational plans. Financial support for these groups was contingent on their ability to attract other financial and in-kind support, and was limited to 30 percent of the total amount needed.
RESULTS

Entrepreneurial Association for Health Promotion (Al Nohoud Al Sihhi Pioneer Society or Al Hashmi)

Al Hashmi used support from HSS II Bridge for three activities: development of a profile to increase awareness of the CBO within its catchment area; a two-day event that promoted the use of FP services and launched the CBO; five Reproductive Health, FP, and Breast Cancer Screening sessions in collaboration with the Al Hashmi Al Shamali Comprehensive HC in Marka District.

Photo 9: Al Nohoud Al Sihhi Pioneer Society (CBO) Members

Huwwara Health Society

Huwwara Health Society used support from HSS II Bridge for two activities: a public launch event of the CBO, and Breast Cancer, FP, and Diabetes Screening sessions held in collaboration with Huwwara Primary HC and Nusaibah Al Mazenieh College in four locations in the Society’s target area.

Photo 10: Huwwara Health Society (CBO) Members
SUSTAINABILITY AND FUTURE SCALE UP

As a direct result of project support, two CHCs completed organizational, structural, and legal transformations into official CBOs, laying the foundation for increased impact and community engagement. These organizations have defined their vision, strategy, operational plan, and the systems they will use to support their efforts. They have moved beyond the theoretical desire to improve the health of their communities to having a strategy, practical approaches, and systems to do so. Their improved capacity to define and execute their respective visions will depend on their ability to attract financial support and demonstrate their effectiveness over time.
III. OTHER ACHIEVEMENTS

HSS II Bridge achieved results beyond the project’s stated deliverables. The Bridge team built on the work of previous USAID investments, including HSS and HSS II. These additional accomplishments contributed to the project’s mandate to strengthen the health system in Jordan.

1. EXPANSION OF HOSPITAL FP SERVICES

Two additional public hospitals began providing postpartum, post-miscarriage, and outpatient FP services as a result of HSS II Bridge support. The RMS Prince Hashem Bin Abdullah Hospital in Aqaba began offering FP services in the first quarter of 2015 after receiving training and supervisory support from a joint RMS/HSS II Bridge team. FP services began in June 2015 in the MOH Abi Obaida Hospital in Irbid for postpartum/post-miscarriage clients in the Ob/Gyn ward and for outpatient clients. The project worked with the MOH to provide regular coaching and support for the hospital staff to ensure that this service became a standard part of maternity care at these hospitals. The project also worked with the MOH to build its capacity to oversee hospital-based inpatient and outpatient FP services.

2. REVISED FP COUNSELING CURRICULUM

HSS II Bridge worked with the MOH WCHD to revise MOH training in FP counseling to focus on provider behavior. The updated curriculum will help reduce provider bias and improve providers’ responsiveness to client concerns. A key feature of the revised curriculum is the requirement for several on-site visits by trainers to observe and coach newly trained staff before issuing competency certificates. The visits will verify provider performance following training. The WCHD formally approved the revised curriculum and introduced the revised training in June 2015. The project helped the WCHD prepare 22 MOH trainers to use the revised curriculum and training materials. These trainers then conducted four trainings for HC and hospital staff in Mafraq, Irbid, Zarka, and Capital HDs. The RMS also held a training session using the revised curriculum with logistical support from the project to improve the delivery of FP information and services in their hospitals.

3. EXPANSION OF MOH CLINICAL TRAINING TO INCLUDE PRIVATE PROVIDERS

The project worked closely with the WCHD and the USAID SHOPS Jordan (Ta’ziz) project to obtain unprecedented MOH approval for the WCHD to train private sector providers in clinical FP methods. The agreement made no concessions for additional compensation for the trainers, improving the sustainability of this initiative following the project’s closure. With this agreement, the MOH demonstrates its understanding of the important role of the private sector in FP service delivery in Jordan. This is also illustrated by the MOH provision of contraceptive methods to NGOs and network doctors participating in the national FP program effort.
In June 2015, three physicians from private hospitals and the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) received training from the WCHD in IUD services. Three physicians and five midwives from MOH HCs also received training. All of the physicians finished their didactic and practical training and are providing IUD services for their clients, expanding access to long-acting reversible contraception in the private sector.

4. DEVELOPMENT OF AN AGREED SCOPE OF PRACTICE FOR MIDWIVES IN JORDAN

HSS II Bridge worked closely with the Jordan Nursing Council (JNC) to revise the draft core competencies of midwives in Jordan developed under HSS II. The revised competencies reflect the complete roles of midwives in Jordan, including delivery of clinical FP service. The project then helped the chair of the JNC Midwifery Committee blend the revised core competencies document with a broader document setting out the scope of practice for midwives. To improve the buy-in of other professional associations and stakeholders for a broader professional scope for midwives in Jordan, HSS II Bridge proposed to introduce the document to key stakeholders before obtaining JNC board approval. The JNC Secretary General confirmed that the JNC will work with JCAP to create the nursing and midwifery strategy and advocate for its adoption with stakeholders. This is an important precursor to the revision of midwifery training in Jordan as it will include clinical training in FP. This commitment demonstrates the synergy between USAID’s investments in the HSS II Bridge and JCAP projects.

5. INCREASED USE OF DATA TO DETERMINE STAFFING NEEDS AT THE MOH HUMAN RESOURCES FOR HEALTH TECHNICAL WORKING GROUP (HRH TWG)

Building on progress during HSS II, HSS II Bridge staff worked with the HRH TWG to apply the WHO’s global standard for evidence-based health sector staffing, the WISN tool. The project worked with the TWG to collect data concerning the staffing needs in all 24 HCs participating in the FP SDIC. At the same time, both Balqa and Central HDs applied the WISN tool in additional HCs with limited project technical support, demonstrating increased capacity to implement this tool as a result of work done during HSS II and HSS II Bridge. The project helped participating HDs collect data on the activities of each staff member and then enter and analyze the results using the WISN. The HRH TWG is ready to advocate for systematic use of this tool in all HDs to make adjustments in staff levels. Staffing adjustment based on WISN data will enable the MOH to cover identified staffing gaps and reduce surpluses where they occur, increasing efficiency of the health workforce in Jordan. Efficient allocation will help ensure that trained providers, especially female FP providers, will be well distributed to maximize access to a full range of modern contraceptive methods.

6. REINFORCEMENT OF SUPPORTIVE SUPERVISION FOR MCH/FP SERVICES

The MOH WCHD requested project assistance to revitalize the supervisory processes and procedures used at the central level for MCH programs and to improve tracking of overall supervision of MCH/FP services across the Kingdom. HSS II Bridge staff helped the WCHD launch an updated central supervision process. This process mandates team supervisory visits to all HDs to monitor the key performance indicators and other aspects of MCH services, including the quality of supervision conducted by the MCH supervisory staff at the HDs. HSS II Bridge also developed a data entry tool for use by the WCHD to track the performance of all HD MCH supervisors. This tool enables them to verify the degree to which supportive supervision is functioning in each HD.
7. ENGAGING CHCS IN FP PROMOTION

In the 24 FP SDIC sites in seven HDs, 23 CHCs actively contributed to achievement of the FP SDIC results. In one of the FP SDIC sites, the CHC had already been transformed into a CBO. The project provided technical and in some cases modest logistical support to the CHCs to enable them to be actively involved in the FP SDIC. In June 2015, HSS II Bridge and the MOH Health Communications and Awareness Directorate jointly assessed the effectiveness of these CHCs. The assessment found that the CHCs were a vital part of the collaborative process. All of the 23 CHCs were actively engaged in FP promotion and 21 of the 23 reached the ambitious target of a 30 percent increase in new FP visits over the course of the FP SDIC. These 23 CHCs will need support in the future to update their change packages and continue active FP promotion. CHCs should be considered an intrinsic part of any future scale-up of the FP SDIC.

Photo 12: Group Photo with Ms. Katherine Tilout, HSS II Bridge COR/USAID, Dr. Sabry Hamza, Project COP, Dr. Leil Al-Fayez, Capital Health Director and Staff from MOH Capital HD, HCs and CHCs at the FP SDIC Closeout Event

8. FACILITATING USAID ASSISTANT ADMINISTRATOR OF THE BUREAU FOR THE MIDDLE EAST’s VISIT TO TAFEELAH

On February 12, 2015, the USAID Assistant Administrator of the Bureau for the Middle East, Ms. Paige Alexander, visited the accredited MOH Al-Ees Comprehensive Health Center, which serves a population of 12,000 Jordanians. She was accompanied by USAID Mission Director, Ms. Beth Paige; Tafeelah Health Director, Dr. Ghazi Mrayat; Al-Ees Health Center Manager, Dr. Nihaya Jaradeen; and HSS II Bridge and JCAP project representatives.

Photo 13: Photo with Ms. Paige Alexander, Ms. Beth Paige, Al-Ees HC Manager and MCH Staff
During the part of her visit facilitated by the HSS II Bridge, she was provided with HC service delivery statistics and service delivery improvements implemented by Abt’s HSS II project. She toured various departments at the center, including MCH and FP. She then proceeded to meet with Al-Ees CHC and received highlights of their achievements to date.

“My visit today is very inspiring, I could see how this group of people was able to make the change to improve the health of their community, I look forward to come back and see more successes.”

Ms. Paige Alexander, USAID Assistant Administrator of the Bureau for the Middle East, stated at the end of her tour.

9. RECOGNIZING HC ACCREDITATION

The HSS II project partnered with the MOH to prepare 120 HCs to meet accreditation standards. Compliance with these international standards helps centers provide better quality, cost-effective, and appropriate care. In addition, formal recognition of their compliance assures clients that they will receive high quality services. The successful implementation of this approach resulted in the accreditation of 28 MOH HCs in December 2012, 48 centers in June 2014, and 12 centers in December 2014, for a total of 88 accredited HCs as a result of HSS II support. In March 2015, Her Royal Highness Princess Muna Al-Hussein, the USAID Mission Director, MOH, and Secretary General of the MOH honored the most recent set of 12 HCs for achieving accreditation by the Health Care Accreditation Council (HCAC) and an additional 12 of the first group of centers that achieved reaccreditation.

Photo 14: Group Photo including HRH Pr. Muna Al-Hussein, Senior Leadership of the MOH, USAID and HSS II Bridge Project with Accredited HC Managers
10. REGIONAL REVIEWS OF MOH FP PERFORMANCE IN 2014

HSS II Bridge helped the WCHD hold three regional meetings in Aqaba, Irbid, and Amman in March 2015 to review the 2014 MOH achievements under the MOH FP Strategic Plan. A total of 131 MOH staff from relevant MOH central administrations and directorates, all 12 HDs, and hospitals providing FP services attended at least one of these sessions. Each administration, directorate, and hospital presented its achievements in FP, comparing their 2013 and 2014 results. The project exceeded the 2014 targets in 10 of the 12 primary indicators tracked under the Strategic Plan.

11. NATIONAL FP DAY

In August 2015, HSS II Bridge helped the MOH and its partners in FP activities mark Jordan’s second National FP Day. Those in attendance included Her Royal Highness Princess Muna Al-Hussein, US Ambassador to Jordan, the USAID/Jordan Deputy Mission Director, General Secretaries of the MOH, HPC, and High Health Council, the RMS Director, the UNFPA Country Director, and other representatives from the GOJ and numerous private and NGO organizations that support or provide FP services across the country.

The second National FP Day enabled all parties to assess progress midway through the five-year strategy. Booths set up by the MOH Women and Child Health Directorate and by partner organizations such as the Jordan Association for Family Planning and Protection (JAFPP), UNFPA, HPC, RMS, and other groups that promote or provide FP in Jordan showcased accomplishments.

After opening remarks by the UNFPA Country Director, (see photo 15) the US Ambassador and the General Secretaries of the MOH and HPC reviewed the development considerations that led the GOJ to support provision of voluntary FP.
“The Government of the United States is proud to partner with the Government of Jordan in helping the Kingdom achieve the goals set for this five-year period. Through USAID, we will continue to support the MOH and contribute to this national program as a key component of our support for overall progress in Jordan,” remarked the US Ambassador to Jordan, Alice Wells.

The General Secretary of the MOH extended his deep appreciation to the US Government and other partners for their support and expressed the ministry’s renewed commitment to FP programs. Before she departed, Her Royal Highness Princess Muna Al-Hussein praised the event and project team, saying: “The event is a model, not only because of its great organization but also because of its important topics that addressed impact on national priorities.”

“We must work together with our partners! The HPC is committed to improving national FP performance within the larger demographic context and the importance of moderating population growth to achieve Jordan’s continued economic growth and stability.”

HE Dr. Sawsan Al-Majali, Secretary General of the HPC
IV. CHALLENGES

The project encountered challenges to achieving and sustaining gains in key areas of the health system. The primary challenges are described below.

I. HRH ISSUES

Management of HRH weaknesses within and beyond the MOH present significant obstacles for MOH and USAID FP objectives, safe motherhood, health systems, general community engagement, and the sustainability of HSS II Bridge achievements. HRH challenges in Jordan encompass elements of job requirements, deployment, preparation, and on-the-job performance of staff. These challenges include:

- **Deployment and job requirement issues:**

  There is a dearth of policies and clear criteria at the MOH to guide the allocation of staff to facilities based on the system’s best interests. Current staffers in some areas are either overstretched or lack the core competency to perform a job according to standards. Defining staff allocations based on workload of each facility (using the WISN tool) is very attractive to senior managers of the MOH. HSS II Bridge has worked with the MOH HRH TWG to move this process forward; it now needs and MOH policy change to transform it into a formal requirement for assignment of staff.

- **On-the-job performance of staff:**

  There is a common perception among MOH staff that their performance, good or bad, will not influence their career development, chances of promotion, advancement, or future assignments. This perception affects their attitudes and behaviors, particularly when asked to do additional work to improve quality of care. The FP SDIC showed that sustained support for teamwork within a facility, including planning, implementing, and reviewing performance, can greatly affect staff performance. This approach and other innovative ways to inspire and reward high performance by health staff must be introduced or reinforced at all levels of the MOH system to achieve the GOJ’s goals.

- **Staff preparation and certification issues:**

  There is a large gap between pre-service education for physicians and midwives and the actual skills the MOH needs from these cadres. The continuous need for in-service training strains the capacity and resources of MOH and project staff. Also, there is no continuous medical education (CME) system to regularly update the skills and knowledge of existing health staff. In the absence of a formal CME structure, in-service training is not linked to certification requirements so there is little intrinsic motivation for providers to upgrade their skills. More attention to this issue and coordination among professional associations, the MOH, and other bodies is needed.
II. HOSPITAL OVERSIGHT ISSUES

USAID has expended considerable efforts through HSS II Bridge and predecessor projects to improve the quality and functioning of public hospitals in Jordan. However, there are still constraints to the continued high performance of these hospitals. A mechanism to increase systematic oversight, supervision, and review of performance in hospitals would greatly improve the sustainability of gains achieved to date and support continued improvements in the future. Constraints include:

- **Lack of a functioning central supervisory structure** to monitor and maintain overall quality and performance in individual hospitals. The MOH Hospital Administration at the central level is organized vertically around different functions, mimicking divisions within hospitals. This makes it difficult to supervise overall or program-specific performance in individual hospitals and directly affects the continued performance of FP, safe motherhood, and neonatal services.

- **No intermediary, decentralized structure** exists that could help MOH oversee performance of its individual hospitals, similar to the HD structure for primary health care. Even if the central level had a highly structured supervisory system, monitoring performance of 30 facilities across the whole Kingdom would be a huge logistic and operational challenge.

III. LOGISTIC/FINANCIAL CONSTRAINTS TO PERFORMANCE

There is a large discrepancy between operational planning and actual budget to achieve the planned activities. Central level Directorates and HDs do not have the funds to plan and manage budgets to accomplish their objectives, making them overly dependent on external financing such as project allocations for supervisory visits, meetings, and trainings. Without such external assistance, these directorates are often blocked from accomplishing their goals.

IV. CHALLENGES RELATED TO ACHIEVEMENT OF SPECIFIC HSS II BRIDGE PROJECT COMPONENTS

- **Expand access to equitable and sustainable facility-based FP services**

  The FP SDIC was successful in 24 HCs, with excellent leadership/support from WCHD and HDs. The MCH staff in the HDs will need to sustain these gains through consistent support and supervision. For national impact, they will also need to introduce the FP SDIC in more facilities. Due to the challenges in hospital management described above, the collaborative was not successful in improving hospital FP performance. A different approach will be needed in the future to consolidate gains in both inpatient and outpatient FP service delivery in hospitals. Due to financial and organizational constraints at the central and HD levels, ongoing training and regular performance reviews for FP will continue to depend on external support unless more budgetary and operational control is given to those levels.

  The current requirement that midwives can insert IUDs at HCs only if they are supervised by trained physicians limits access to this method. Clarification of the role of general
practitioners in supervising midwives in IUD insertion could greatly facilitate increased access to this service.

- **Strengthen the capacity of MOH and RMS hospitals to continue implementing best practices for maternal and newborn care**
  
  - Implementation of the preconception care model will require careful roll-out and attention to inter-directorate issues within the MOH since the different components are not within the mandate of any one directorate.

- **Strengthen the capacity of MOH to use data generated from different Health Management Information System (HMIS) to improve decision making and planning**
  
  - While the new data models and innovative visualization tools make it easier for program managers at all levels to use data for decision making, regional reviews of performance and other systematic review processes are still dependent on external support due to the financial constraints described above.
  
  - High staff turnover is a particular problem for IT since skilled IT personnel are highly prized in the private sector. This causes issues for IT and HMIS system maintenance.
  
  - The transition to use of an electronic medical records system in more hospitals and HCs (Hakeem) will create major disruptions for MOH HMIS systems. The MOH is not actively managing the interaction between these two different systems created to solve different problems. More coordination is urgently needed to develop a unified approach that serves the needs of central managers for program data and care of individual patients.

- **Assist the MOH to improve access to FP and reproductive health through CBOs**
  
  - While the project has strengthened the capacity of the two CBOs, they will still be dependent on external funding and possibly some intermittent technical support to accomplish their goals.
  
  - With support from HSS II Bridge, HDs have taken steps to encourage continued performance of CHCs. HDs have also taken steps to improve effective HC/CHC interaction. However, these steps are not consistent across all HDs and are hampered by the lack of logistic and budget support mentioned above.
V. ANNEXES

ANNEX I:
Indicator Monitoring

The performance matrix below presents the final updates on all the indicators for the HSS II Bridge project.
## 1. OVERVIEW OF INDICATORS

### Objective 1: Expand access to equitable and sustainable facility based FP services

<table>
<thead>
<tr>
<th>Objective 1 Indicators</th>
<th>Baseline</th>
<th>Target</th>
<th>Data Source</th>
<th>Collection Frequency</th>
<th>Reporting to USAID Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Number of HCs adopting the FP SDI Collaborative&lt;sup&gt;2&lt;/sup&gt;</td>
<td>0</td>
<td>24&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Project and MOH reports</td>
<td>Monthly</td>
<td>Quarterly</td>
</tr>
<tr>
<td>1.2 Number of hospitals adopting the FP SDI Collaborative</td>
<td>0</td>
<td>6</td>
<td></td>
<td>Monthly</td>
<td>Quarterly</td>
</tr>
<tr>
<td>1.3 % of post-partum women who are counseled on FP before discharge in the six intervention hospitals</td>
<td>71%</td>
<td>75% (+ 4 % from baseline)</td>
<td>Hospital Reports and OBGY logbooks</td>
<td>Monthly</td>
<td>Quarterly</td>
</tr>
<tr>
<td>1.4 % of post-partum women adopt LAM or a modern a FP method before discharge in the six intervention hospitals&lt;sup&gt;4&lt;/sup&gt;</td>
<td>29%</td>
<td>33% (+ 4 % from baseline)</td>
<td></td>
<td>Monthly</td>
<td>Quarterly</td>
</tr>
<tr>
<td>1.5 Number of CYP in the 24&lt;sup&gt;4&lt;/sup&gt; new HCs targeted by the project for adopting the FP SDI Collaborative</td>
<td>1043&lt;sup&gt;5&lt;/sup&gt;</td>
<td>1,543 (+ 10 % from baseline)</td>
<td>Logistic System</td>
<td>Monthly</td>
<td>Quarterly</td>
</tr>
<tr>
<td>1.6 % of MOH HCs providing at least 4 modern FP methods</td>
<td>29&lt;sup&gt;6&lt;/sup&gt;</td>
<td>32% (+ 3 % from baseline)</td>
<td></td>
<td>Monthly</td>
<td>Quarterly</td>
</tr>
<tr>
<td>1.7 % of MOH HCs providing LARC (IUD or Implanon) services</td>
<td>35%&lt;sup&gt;5&lt;/sup&gt;</td>
<td>38% (+ 3 % from baseline)</td>
<td></td>
<td>Monthly</td>
<td>Quarterly</td>
</tr>
<tr>
<td>1.8 % of 24&lt;sup&gt;7&lt;/sup&gt; HCs and 6 hospitals targeted by the project for adopting the FP SDI Collaborative that experience a stock-out of a contraceptive method expected to be available at any time during the reporting period</td>
<td>HCs = 8% Hospitals (outpatient) = 16%</td>
<td>HCs = 0% Hospitals (outpatient) = 0%</td>
<td>Logistic System and facility stock logbooks</td>
<td>Monthly</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

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<sup>2</sup> Family Planning (FP) Service Delivery Improvement (SDI) Collaborative

<sup>3</sup> In order to obtain good coverage of major population centers in each of the health directorates, MOH counterparts at the central and HD levels and the HSS II Bridge agreed to add four more HCs to the FP SDI Collaborative; the total therefore has been increased from 20 to 24 health centers.

<sup>4</sup> The wording of this indicator was improved to clarify that the figure is calculated from all postpartum women, and not only those who receive one-on-one counseling.

<sup>5</sup> This CYP figure for the 24 HCs is an average per month. Accordingly, the target figure is an average per month for the final quarter.

<sup>6</sup> Due to the three month lag between data collection and upload onto the LMIS at the MOH, the baseline period is the months of July, August and September, 2014.

<sup>7</sup> In order to obtain good coverage of major population centers in each of the health directorates, MOH counterparts at the central and HD levels and the HSS II Bridge agreed to add four more HCs to the FP SDI Collaborative; the total therefore has been increased from 20 to 24 health centers.
### Objective 2: Strengthen the capacity of MOH and RMS hospitals to continue implementing best practices for MNC

<table>
<thead>
<tr>
<th>Objective 2 Indicators</th>
<th>Baseline</th>
<th>Target</th>
<th>Data Source</th>
<th>Collection Frequency</th>
<th>Reporting to USAID Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Survival rate of neonates in 6 selected hospitals admitted to the NICUs and placed on CPAP</td>
<td>90%</td>
<td>Maintain</td>
<td>Medical Record/Data Collection Forms</td>
<td>Monthly</td>
<td>Quarterly</td>
</tr>
<tr>
<td>2.2 % of women giving birth in 6 selected hospitals who received uterotonic in the third stage of labor according to AMTSL protocol</td>
<td>0%&lt;sup&gt;8&lt;/sup&gt;</td>
<td>50%</td>
<td></td>
<td>Monthly</td>
<td>Quarterly</td>
</tr>
<tr>
<td>2.3 % of pregnancy-induced hypertensive women in 6 selected hospitals managed according to the clinical guideline</td>
<td>92%&lt;sup&gt;9&lt;/sup&gt;</td>
<td>95% (+3% from baseline)</td>
<td>CI Data Collection Form</td>
<td>Monthly</td>
<td>Quarterly</td>
</tr>
<tr>
<td>2.4 Selected hospitals using confidential inquiries into maternal deaths and near misses to monitor the quality of maternal care</td>
<td>0</td>
<td>3</td>
<td></td>
<td>Monthly</td>
<td>Quarterly</td>
</tr>
<tr>
<td>2.5 Preconception care model designed (Milestone Indicator)</td>
<td>0</td>
<td>1</td>
<td>Project records</td>
<td>End of project</td>
<td>End of project</td>
</tr>
<tr>
<td>2.6 Conceptual framework for Maternal Mortality Surveillance system developed (Milestone Indicator)</td>
<td>0</td>
<td>1</td>
<td></td>
<td>End of project</td>
<td>End of project</td>
</tr>
</tbody>
</table>

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<sup>8</sup> The period for the baseline figure of this indicator is January, 2015.

<sup>9</sup> The period for the baseline figure of this indicator is April-June, 2014.
<table>
<thead>
<tr>
<th>Objective 4 Indicators</th>
<th>Baseline</th>
<th>Target</th>
<th>Data Source</th>
<th>Collection Frequency</th>
<th>Reporting to USAID Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Number of CBOs established with project support that are ready to provide FP services</td>
<td>0</td>
<td>2</td>
<td>Project records</td>
<td>End of project</td>
<td>End of project</td>
</tr>
<tr>
<td>4.2 Percent of CHCs participating in the FP SDI Collaborative that are promoting FP and healthy life styles in their catchment areas</td>
<td>0</td>
<td>24 CHCs</td>
<td>CHC action plans and activity records, monitoring visits</td>
<td>End of project</td>
<td>End of Project</td>
</tr>
</tbody>
</table>
2. PERFORMANCE MONITORING MATRIX

The grid below presents updates for indicators that are reported quarterly.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Definition</th>
<th>Data Source, Method &amp; Frequency</th>
<th>Baseline</th>
<th>Bridge Target</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Number of HCs adopting the FP SDI Collaborative</td>
<td>This is a quantitative indicator that measures the number of HCs that adopt the FP SDI Collaborative approach. An HC is considered an adopter of the collaborative approach if it fulfills the following criteria: 1. Participates in the Learning Sessions 2. Prepares a Change Package 3. Reports on its action period using the “storyboard”</td>
<td>Data Source: 1- Attendance sheets 2- Change packages 3- Storyboards Method: Data sources are reviewed by M&amp;E staff. Frequency: Collected after each learning session.</td>
<td>0</td>
<td>24</td>
<td>Q1 24</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q2 24</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q3 24</td>
</tr>
</tbody>
</table>
Result: IR 3.1.1: Access to, and quality of, family planning reproductive health and maternal health services improved.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Definition</th>
<th>Data Source, Method &amp; Frequency</th>
<th>Base Line</th>
<th>Bridge Target</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2 Number of hospitals adopting the Collaborative Approach for improving FP services</td>
<td>This is a quantitative indicator that measures the number of hospitals that adopt the FP SDI Collaborative approach. A hospital is considered an adopter of the collaborative approach if it fulfills the following criteria: 1. Participates in the Learning Sessions 2. Prepares Change Package 3. Reports on its action period using the “storyboard”.</td>
<td>Data Sources: 1 - Attendance sheets 2 - Change packages 3 - Storyboards Method: Data sources are reviewed by M&amp;E staff. Frequency: Collected after each learning session.</td>
<td>0</td>
<td>6</td>
<td>Q1 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q2 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q3 6</td>
</tr>
</tbody>
</table>
## Performance Indicator: IR 3.1.1

**Access to, and quality of FP reproductive health and maternal health services improved.**

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Definition</th>
<th>Data Source, Method &amp; Frequency</th>
<th>Base Line</th>
<th>Bridge Target</th>
<th>Results</th>
<th>Quarters</th>
<th>Data</th>
</tr>
</thead>
</table>
|                      | This is a quantitative indicator that measures the percentage of post-partum clients receiving counseling for FP before discharge from selected public hospitals. | **Data Source:** OB/GYN FP logbooks  
**Method:** Aggregate data are collected from the FP logbooks by the FP Specialist & EOC Specialist  
**Frequency:** Collected on monthly basis and reported quarterly. | 71% | 75% | Q1 | Baseline=71% |
|                      | Numerator: Number of post-partum clients receiving FP counseling before discharge at selected public hospitals during the quarter | | | | Q2 | 77% |
|                      | Denominator: Total number of post-partum clients at selected public hospitals during the quarter | | | | Q3 | 70%<sup>10</sup> |

<sup>10</sup> This figure includes the month of Ramadan, which usually records a dip in FP performance indicators.
**Result: IR 3.1.1: Access to, and quality of, family planning reproductive health and maternal health services improved.**

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Definition</th>
<th>Data Source, Method &amp; Frequency</th>
<th>Base Line</th>
<th>Bridge Target</th>
<th>Results Quarters</th>
<th>Data</th>
</tr>
</thead>
</table>
| 1.4% of all post-partum women who adopt LAM or a modern a FP method before discharge in the six intervention hospitals | This is a quantitative indicator that measures the percentage of postpartum clients receiving modern FP methods before discharge from selected public hospitals. Modern methods include: LAM, pills, IUD, Implanon, tubal ligation, condoms. A postpartum client is included in the numerator of this indicator if she receives any of the aforementioned modern methods before discharge from the hospital. **Numerator:** Number of post-partum women receiving modern FP methods before discharge at selected public hospitals during the quarter **Denominator:** Total number of post-partum women at selected public hospitals during the quarter | **Data Source:** OB/GYN FP logbooks  
**Method:** Aggregate data are collected from the FP logbooks by the FP Specialist & EOC Specialist  
**Frequency:** Data are collected on a monthly basis and reported quarterly. | 29% | 33% | Q1 | Baseline=29% |
|  |  |  |  |  | Q2 | 33.6% |
|  |  |  |  |  | Q3 | 30%\textsuperscript{11} |

\textsuperscript{11} This figure includes the month of Ramadan, which usually records a dip in FP performance indicators.
## Result: 3.1.2: Demand for family planning and reproductive health services increased

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Definition</th>
<th>Data Source, Method &amp; Frequency</th>
<th>Base Line</th>
<th>Bridge Target</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.5 Number of CYP in the 24 new HCs targeted by the project for adopting the FP SDI Collaborative</strong></td>
<td>CYP is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period.</td>
<td><strong>Data Source:</strong> Logistics System data collection forms.  <strong>Method:</strong> CYP figures are based on the numbers of FP methods dispensed in each HC that are recorded in the logistics logbook. The reported figure for each quarter is the average CYP per month for the quarter in question. The figures are calculated using USAID’s CYP factors per method.  <strong>Frequency:</strong> Data are collected monthly and reported to USAID quarterly.</td>
<td>1,403&lt;sup&gt;12&lt;/sup&gt;</td>
<td>1,543</td>
<td>Q1: Baseline=1,403  Q2: 2,003  Q3: 2,216</td>
</tr>
</tbody>
</table>

---

<sup>12</sup> The baseline calculation is the average CYP in October, November and December of 2014. The Bridge began in November.
### Result: IR 3.1.1: Access to, and quality of, family planning reproductive health and maternal health services improved.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Definition</th>
<th>Data Source, Method &amp; Frequency</th>
<th>Base Line</th>
<th>Bridge Target</th>
<th>Results</th>
</tr>
</thead>
</table>
| 1.6 % of MOH HCs providing at least 4 modern FP methods | This is a quantitative indicator that measures the percentage of all MOH HCs providing a range of modern FP methods, with a minimum of 4 modern methods. This indicator assures that clients have a wider choice of method selection that meets their needs and desires. A HC will be considered if at least four modern FP methods are provided to FP clients; modern methods are IUD, OCs, Condom, injectables and implants. **Numerator:** Number of HCs providing at least 4 modern FP methods during the quarter **Denominator:** Total number of MOH HCs providing FP services during the quarter | **Data Source:** Logistic information system  **Method:** Data are accessed from the online LMIS. **Frequency:** Data are collected quarterly. | 29% | 32% | Q1 Baseline=29%<sup>13</sup>  
Q2 34%<sup>14</sup>  
Q3 33%<sup>15</sup> |

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<sup>13</sup> Due to the three month lag between data collection and upload onto the LMIS at the MOH, the months of July, August and September, 2014 were used to calculate the baseline.  
<sup>14</sup> Q2 data are for the months of October, November and December, 2014.  
<sup>15</sup> Q3 data are for the months of January, February and March, 2014.
**Result: 3.1.1: Access to, and quality of, family planning reproductive health and maternal health services improved.**

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Definition</th>
<th>Data Source, Method &amp; Frequency</th>
<th>Base Line</th>
<th>Bridge Target</th>
<th>Results</th>
<th>Quarters</th>
<th>Data</th>
</tr>
</thead>
</table>
| 1.7 % of MOH HCs providing LARC (IUD or Implanon) services | This is a quantitative indicator that measures the percentage of HCs providing long-acting FP methods. This indicator assures that clients are able to receive long-acting (and more secure) FP methods.  

A HC will be considered providing long acting methods if it is providing IUDs or implants.  
**Numerator:** Number of HCs providing long acting FP methods (IUD or Implanon) during the quarter  
**Denominator:** Total number of MOH HCs providing FP services during the quarter  
**Frequency:** Data are collected quarterly. | Data Source: Logistic information system  
Method: Data are accessed from the online LMIS. | 35% | 38% | Q1 | Baseline=35% |
<p>| | | | | | | | |
|                       |                                                                                                                                             |                                 |           |               |         |          |            |
|                       |                                                                                                                                             |                                 |           |               |         | Q2       | 39%        |
|                       |                                                                                                                                             |                                 |           |               |         | Q3       | 38%        |</p>
<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Definition</th>
<th>Data Source, Method &amp; Frequency</th>
<th>Base Line</th>
<th>Bridge Target</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.8 Percent of 24 HCs and 6 hospitals targeted by the project for adopting the FP SDI Collaborative Approach for improving FP services that experience a stock out of a contraceptive method expected to be available</td>
<td>This indicator measures the number of centers that experience a stock-out of FP methods at the HC. A stock out is defined as one day in which a method was not available. A center has to experience at least one incident of stock-out to be counted in the indicator. A center is counted once even if it experiences more than one stock-out per period. <strong>Numerator:</strong> Number of HCs and hospitals providing FP methods that experience a stock-out during the quarter <strong>Denominator:</strong> Total number of HCs and hospitals participating in the collaborative and which are providing FP services during the quarter. (The denominator for the target is 24 HCs and 6 hospitals)</td>
<td><strong>Data Source:</strong> Inventory forms (already in use) at the HCs and inventory forms at hospitals <strong>Method:</strong> Data are aggregated from the inventory forms and entered into a data tool created by HSS II Bridge. <strong>Frequency:</strong> Data are collected monthly and reported to USAID quarterly.</td>
<td>HCs = 8% Hospitals (outpatient) = 16%</td>
<td>HCs = 0% Hospitals (outpatient) = 0%</td>
<td>Q1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q2</td>
</tr>
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<td>Q3</td>
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</table>
Result: 3.1.1: Access to, and quality of, family planning reproductive health and maternal health services improved.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Definition</th>
<th>Data Source, Method &amp; Frequency</th>
<th>Base Line</th>
<th>Bridge Target</th>
<th>Results Quarters</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Survival rate of neonates in 6 selected hospitals admitted to the Neonatal Intensive Care Units and placed on CPAP</td>
<td>This is a quantitative indicator that measures the percentage of neonates admitted to the intensive care units at selected hospitals that are placed on CPAP and discharged alive. This includes inborn and referred cases. A surviving newborn is a neonate admitted to the NICU for any medical or surgical intervention and discharged home alive after completing the required hospitalization period. <strong>Numerator:</strong> Neonates discharged alive after being admitted to the NICU and placed on CPAP during the quarter <strong>Denominator:</strong> Total neonates admitted to the NICU who are placed on CPAP during the quarter</td>
<td><strong>Data Source:</strong> Neonate Log Book <strong>Method:</strong> The logbook is reviewed and the relevant numbers are aggregated. <strong>Frequency:</strong> Data are collected monthly and reported quarterly.</td>
<td>90%</td>
<td>92%</td>
<td>Q1</td>
<td>Baseline= 90%(^{16})</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q2</td>
<td>78%(^{17})</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q3</td>
<td>86%</td>
</tr>
</tbody>
</table>

\(^{16}\) Excludes two hospitals: Badia and Karak. These hospitals did not have appropriate documentation of survival rate numbers for CPAP cases for those months in order to include in the baseline.

\(^{17}\) Please refer to section 2.3 in the Q2 narrative report for an explanation of the drop in neonatal survival rates for CPAP cases.
Result: 3.1.1: Access to, and quality of, family planning reproductive health and maternal health services improved.

<table>
<thead>
<tr>
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<th>Data Source, Method &amp; Frequency</th>
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<th>Results Quarters</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2% of women giving birth in 6 selected hospitals who received uterotonic in the third stage of labor according to AMTSL protocol</td>
<td>This is a quantitative indicator that measures the percentage of women giving birth in the selected hospitals who are managed according to the AMTSL protocol. A women is managed according to the AMTSL protocol if all the following criteria are met: 1- Administration of uterotonic agents 2- Controlled cord traction 3- Uterine massage after the delivery of the placenta</td>
<td>Data Source: Medical record  Method: A sample of medical records are collected and reviewed. Results of each reviewed record are recorded in a data collection form prepared by HSS II Bridge. Frequency: Data are collected monthly and reported quarterly.</td>
<td>0%</td>
<td>50%</td>
<td>Q1 Baseline = 0%</td>
<td>Q2 20%</td>
</tr>
</tbody>
</table>

18 While AMTSL protocol includes three criteria, the HSS II Bridge is required to report on the first criteria only (% of cases receiving uterotonic drug according to AMTSL protocol) in this section. Please note that the results of the other two criteria are reported in the report narrative (see chart in section 2.1)
### Result: 3.1.1: Access to, and quality of, family planning reproductive health and maternal health services improved.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Definition</th>
<th>Data Source, Method &amp; Frequency</th>
<th>Base Line</th>
<th>Target</th>
<th>Results</th>
</tr>
</thead>
</table>
| 2.3 % of pregnancy-induced hypertensive women in 6 selected hospitals managed according to the clinical guideline | This is a quantitative indicator that measures the percentage of PIH patients managed according to the clinical guidelines. A PIH patient will be considered as managed according to the clinical guidelines if the following management procedures were performed:  
- Examination: Checked blood pressure, reflexes, FHS according to guidelines.  
- Investigations: Checked for urine albumin upon admission.  
- Active Management: Administered Magnesium Sulfate according to guidelines.  
**Numerator:** Number of women admitted to hospital with PIH who are managed according to clinical guidelines during the quarter  
**Denominator:** Number of women admitted to hospital with PIH during the quarter | Hospital obstetric records, PIH form, PIH Logbook | 92% | 95% | Q1 99%  
Q2 100%  
Q3 97% |
## Result: 3.1.1: Access to, and quality of, family planning reproductive health and maternal health services improved.

<table>
<thead>
<tr>
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<th>Base Line</th>
<th>Bridge Target</th>
<th>Results</th>
<th>Quarters</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4 Selected hospitals using confidential inquiries into maternal deaths and near misses to monitor the quality of maternal care</td>
<td>This is a quantitative indicator that measures the percentage of hospitals utilizing confidential inquiries into maternal deaths and near misses according to guidelines. A hospital will be considered as implementing CI into maternal deaths and near misses if it fulfills the following criteria: 1) All cases of maternal deaths are audited according to the CI inquiry surveillance cycle 2) 75% of cases of obstetric: hemorrhage, severe-preeclampsia and eclampsia are audited according to the near misses review cycle 3) data should be collected and investigation done on monthly basis. <strong>Numerator:</strong> Number of hospitals utilizing CI into maternal deaths and near misses <strong>Denominator:</strong> Total number of hospitals trained on using the Confidential Inquiries into maternal deaths and near misses.</td>
<td><em>Data Source:</em> CI Data Collection Form / Hospital SMCs minutes of meetings&lt;br&gt;&lt;br&gt;<em>Method:</em> CI forms are received from the hospitals for each month.&lt;br&gt;&lt;br&gt;<em>Frequency:</em> Forms are completed monthly and reported to USAID quarterly.</td>
<td>0/6&lt;sup&gt;19&lt;/sup&gt;</td>
<td>3/6</td>
<td>Q1</td>
<td>Baseline = 0/6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q2</td>
<td>0/6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q3</td>
<td>4/6</td>
<td></td>
</tr>
</tbody>
</table>

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<sup>19</sup> Three out of six hospitals reported they met the first criterion for this indicator, but none reported that they audited near misses (criterion 2).
### Result: 3.1.1: Access to, and quality of, family planning reproductive health and maternal health services improved.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Definition</th>
<th>Data Source, Method &amp; Frequency</th>
<th>Baseline</th>
<th>Bridge Target</th>
<th>Results</th>
</tr>
</thead>
</table>
| 2.5 Preconception care model designed | Preconception care is care received before a woman becomes pregnant. It involves identifying and addressing problems that might affect the woman and her child, including diabetes or high blood pressure. It also involves steps which can be taken to reduce the risk of birth defects; for example addressing anemia and encouraging the use of iron and folic acid. Birth spacing is one of the key elements of this model. This is a binary indicator: model for MMSR system developed / model for MMSR system not developed. | **Data Source:** The final Preconception Care Model.  
**Method:** The model will be delivered to USAID as one of the contract deliverables.  
**Frequency:** Once. Delivered at the end of the project. | 0 | 1 | 1 |
<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Definition</th>
<th>Data Source, Method &amp; Frequency</th>
<th>Baseline</th>
<th>Bridge Target</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.6 Conceptual framework for Maternal Mortality Surveillance System developed</td>
<td>The Material Mortality Surveillance and Response (MMSR) system includes maternal death identification, reporting, review and response and can provide the essential information to stimulate and guide actions to prevent future maternal deaths and improve the measurement of maternal mortality. This is a binary indicator: Model for MMSR system developed / model for MMSR system not developed.</td>
<td><em>Data Source:</em> The final Conceptual Framework for the Maternal Mortality Surveillance System. <em>Method:</em> The Conceptual Framework for the Maternal Mortality Surveillance System will be delivered to USAID as one of the contract deliverables. <em>Frequency:</em> Once. Delivered at the end of the project.</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Performance Indicator</td>
<td>Definition</td>
<td>Data Source, Method &amp; Frequency</td>
<td>Baseline</td>
<td>Bridge Target</td>
<td>Results</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------</td>
<td>---------------------------------</td>
<td>----------</td>
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<td>--------</td>
</tr>
<tr>
<td>4.1 Number of CBOs established with project support that are ready to provide FP services</td>
<td>This is a quantitative indicator that measures whether the number of new community based organizations that were established for the purpose of providing FP services. A CBO meets is counted as part of this indicator if the following criteria have been fulfilled: 1- The CBO has been officially established. This means that the CBO has the necessary registration documents from the MOH and Ministry of Social Development. 2- The CBO has a clear Scope of Work specifying its functions. 3- The CBO has defined Standard Operating Procedures that govern the way the CBO is managed. 4- The CBO has a business plan outlining its funding source and marketing approach.</td>
<td>Data Source: CBO documentation  Method: Review of CBO documentation  Frequency: Once; end of project deliverable</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
## Result: 3.1.1: Access to, and quality of, family planning reproductive health and maternal health services improved.

<table>
<thead>
<tr>
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<th>Definition</th>
<th>Data Source, Method &amp; Frequency</th>
<th>Baseline</th>
<th>Bridge Target</th>
<th>Results</th>
</tr>
</thead>
</table>
| 4.2 Percent of CHCs participating in the FP SDI Collaborative that are promoting FP and healthy life styles in their catchment areas | This is a quantitative indicator that measures the percent of active CHCs in HDs from 24 focal CHCs. | **Data Source:** Review of CHCs records and the MCH system at the respective HC. (The MCH system is needed to measure new family planning visits.)  
**Method:** On-site review of CHC documentation  
**Frequency:** Annually | 0 | 24 | 23/24 or 96% |
## ANNEX 3:

### IN-COUNTRY PARTICIPANT TRAINING ACTIVITIES FOR HSS II BRIDGE

<table>
<thead>
<tr>
<th>Title of the Training Activity</th>
<th>Training Provider</th>
<th>Start Date</th>
<th>End Date</th>
<th>Duration (in Days)</th>
<th>No. of Males</th>
<th>No. of Females</th>
<th>Total No. of Participants</th>
<th>Estimated Cost in US$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning Service Delivery Improvement Collaborative (FP SDIC) in HCs / Learning Session 1</td>
<td>HSS II Bridge</td>
<td>15-Dec-14</td>
<td>16-Dec-14</td>
<td>2</td>
<td>5</td>
<td>23</td>
<td>28</td>
<td>693</td>
</tr>
<tr>
<td></td>
<td></td>
<td>22-Dec-14</td>
<td>23-Dec-14</td>
<td>2</td>
<td>6</td>
<td>17</td>
<td>23</td>
<td>500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>22-Dec-14</td>
<td>23-Dec-14</td>
<td>2</td>
<td>11</td>
<td>23</td>
<td>34</td>
<td>785</td>
</tr>
<tr>
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<td>22-Dec-14</td>
<td>23-Dec-14</td>
<td>2</td>
<td>13</td>
<td>12</td>
<td>25</td>
<td>550</td>
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<tr>
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<td>22-Dec-14</td>
<td>23-Dec-14</td>
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<td>3</td>
<td>19</td>
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<td>1</td>
<td>5</td>
<td>15</td>
<td>20</td>
<td>218.93</td>
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<tr>
<td>FP SDIC in HCs / Learning Session 2</td>
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<td>270.34</td>
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<td>19</td>
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<td>10</td>
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<td>262.71</td>
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<td>FP SDIC in Hospitals / Learning Session 1</td>
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<td>7-Jan-15</td>
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<td>Duration (in Days)</td>
<td>No. of Males</td>
<td>No. of Females</td>
<td>Total No. of Participants</td>
<td>Estimated Cost in US$</td>
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<td>145.34</td>
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<td>15</td>
<td>36</td>
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<td>Estimated Cost in US$</td>
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## ANNEX 4:
### TDY SCHEDULE FOR QUARTER 4

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<th>Name of Consultant</th>
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<th>Estimated LOE (work days)</th>
<th>Purpose of the Visit (SOW)</th>
<th>Status</th>
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<tr>
<td><strong>Patrice White</strong></td>
<td>Components 1 and 2</td>
<td>January 15-24, 2015, May 3-12, 2015</td>
<td>20 (2 visits)</td>
<td>- Support institutionalization of midwifery core competencies as MOH policy; assist with AMTSL approach</td>
<td>Completed</td>
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</table>
| **Adel Hakim**    | Component 3 | January 4 - 12, 2015, April 1 – 9, 2015 | 18 | - Identifying the current, baseline steps in the Jordanian health sector regarding the diagnosis, documentation, and investigation of maternal mortality cases at facilities or in homes and the respective procedures at the district, governorate, and central levels.  
- Review of both local and international material, documents, and technical guidance related to MMSR.  
- Assist in outlining the required policies, procedures, resources, mandates, data models, and a national maternal mortality register to transform the designed MMSR model into an implemented and monitored system across the Kingdom. | Completed first visit; second visit cancelled |
<table>
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<tr>
<th>Name of Consultant</th>
<th>Component</th>
<th>Proposed Dates</th>
<th>Estimated LOE (work days)</th>
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<td>Rebecca Sheridan</td>
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<td>July 15-24, 2015</td>
<td>10</td>
<td>▪ Assist with review of project systems and processes, including budgeting and reporting</td>
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<tr>
<td>Senior Finance and Contracts Manager / Abt Associates Inc.</td>
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<tr>
<td>Abigail Donner</td>
<td>Cross Cutting</td>
<td>August 21-30, 2015</td>
<td>7</td>
<td>▪ Assist in preparation of technical reports</td>
<td>Cancelled</td>
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<td>Technical Project Officer / Abt Associates Inc.</td>
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## Annex 5:

List of HSS II Bridge Project Counterparts

### MOH Central Administrations

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<th>1. Planning Administration</th>
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<tr>
<td>3. Health Directors Administration</td>
</tr>
<tr>
<td>4. Administrative Affairs Administration</td>
</tr>
<tr>
<td>5. Hospital Administration</td>
</tr>
</tbody>
</table>

### MOH Central Directorates

| 1. Planning and Information Department |
| 2. Chief of OB/Gyn Specialty |
| 3. Chief of Pediatrics Specialty |
| 4. Chief of Midwifery and Nursing Specialty |
| 5. Training Programs Coordinator |
| 6. Human Resources Development Directorate |
| 7. Information Technology Directorate |
| 8. Project Management Department |

### Royal Medical Services

| 1. Communicable Disease Directorate |
| 2. Legal Affairs Directorate |

### Higher Population Council

| 20. Planning and Information Department |
| 21. Chief of OB/Gyn Specialty |
| 22. Chief of Pediatrics Specialty |
| 23. Nursing Director |
| 24. Training Programs Coordinator |

25. Secretary General
<table>
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<td>Al-Yarmouk Hospital</td>
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**ANNEX 6:**

*Family Planning Service Delivery Improvement Collaborative*

List of Health Centers and Hospitals Participating in the Governance (FP SDIC)
(JMMRS)
AND RESPONSE SYSTEM
JORDBAN MATERNAI MORTALITY SURVEILANCE
MODEL FOR THE

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Minister of Health

Given that maternal mortality continues to be a global issue, through this system Jordan is taking a clear stand and making the decision that every mother’s life counts, and with this decision not only mothers’ lives are saved, but also the lives and well-being of families.

The model of the Jordan Maternal Mortality Surveillance and Response System (JMMRS) Bridge Project and supports from the USAID-funded Health Systems Strengthening II (HSS II) Bridge project and different partners and stakeholders at all levels of the health care system, will be a driving force to eliminate preventable maternal deaths in Jordan.

This model was developed and prepared for implementation by the Ministry of Health within other key stakeholders.

“Jordan Maternal Mortality Surveillance and Response System” with the aim to further enhance performance of Health Systems

As a preliminary step towards implementing such a system, a model was developed for the first time in Jordan. The model has been structured to monitor maternal deaths and other’s life counts, and how they should be tackled.

The Fifth Millennium Development Goal and although the maternal mortality ratio has decreased, there are still challenges to achieving the past few decades, Jordan has made substantial progress in improving maternal health,

MINISTRY OF HEALTH (MOH)
THE HASHEMITE KINGDOM OF JORDAN

FOREWORD
We would like to express our deepest gratitude to the "Maternal Mortality Surveillance and Response System Steering Committee" particularly His Excellency Dr. Deifallah Al-

Special acknowledgement is dedicated to the international organisations who have provided the needed references and technical guidelines to develop this model for Jordan. Particularly the WHO, UNFPA UNICEF, UN Population Fund and the World Bank.

Their cooperation and this document was critical to meet Jordan national goals in the coming years. Their service providers working in maternal and forensic medicine departments at hospitals, with the process a national effort.

We would also like to acknowledge the positive interaction and remarks we received from other stakeholders who have truly made it valuable the significant contributions of our key stakeholders who have contributed, in particular the experts and enthusiasts who have completed this model. We also extend our sincere appreciation to all the committee members, mentioned in the we also extend our sincere appreciation to all the committee members, mentioned in the

We would like to express our deepest gratitude to the "Maternal Mortality Surveillance and Continuous Improvement System Steering Committee", particularly His Excellency Dr. Deifallah Al-Louzi, MOH.

ACKNOWLEDGMENT
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Head of National Institute of Forensic Medicine
DR. Qais Qous

Director of Information Technology Directorate
Ms. Samar Samounh

Director of Legal Affairs Directorate
DR. Radwan Abu Damis

Director of the Quality Directorate
DR. Ri\a Khater

Director of Women and Child Health Directorate
DR. Malik Al-Ouri

Director of Health Directors Administration
DR. Khaled Al-Odwan

Director of Primary Health Care Administration
DR. Bashir Al-Qassem

Director of Hospital Administration
DR. Ali Sal\ad

Director of Planning Administration
DR. Mohammad Al-Tarawneh

Director of the Non-Communicable Diseases Directorate and Committee Reporter
DR. Ayo\d Al-Sa\ied

MOH Secretary General and Committee Chair

HE DR. Delilah Al-Lozzi

Ministry of Health (MOH)

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Research and Information Team Leader
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Health Management Information Systems Expert
Eng. Reid Resess

Performance Management and Quality Improvement Lead
Dr. Salih Camoun

USAID-Funded HSS II Bridge System Strengthening II (HSS II) Bridge Project

Enhancing Performance of Health Systems

Annex 7: The JHPIEGO Model
US$471.4M Bridge OP Report
ACRONYMS

WRA
WHO
NCD
NAG
MOI
MOH
MDR
MGE
JMRSS
HD
RMD
MNP
DAG
CSPD

World Health Organization
National Advisory Group
Ministry of Interior
Ministry of Health
Maternal Death Review Monitoring and Evaluation
Jordan Maternal Mortality Surveillance and Response System
Health Directorate
Forensic Medicine Department
Directorate Advisory Group
Civil Status and Passport Department
Issue a death notification form.

5. The hospitals and Forensic Medicine Department (FMD) are the only entities entitled to

4. All deaths are reported to hospitals as per General Health Law 231/12, 2013.

3. Almost 99% of births take place in hospitals.

2. Jordan has multiple well-established surveillance systems. The Jordan National Registry,

1. The health system has well recognized interaction among Central MOH and its directorates.

Support the establishment of MMR:

is national goals. In addition to the aforementioned, Jordan has many systemic pillars that

healed, all improved maternal health indicators and positioned the country to achieve some of

establishing and strengthening a cluster of health systems to support and enhance maternal

instruction of 20 observatories departements in public hospitals, improve maternal and
defining health care essential elements in health areas. The challenge of physical,

and mortality have achieved successful healthcare measures in many areas. That is why in

improving maternal health and reducing maternal morbidity.

Jordan’s collective efforts towards improving maternal health and reducing

material death case continuously to guide the health system strategies and monitor the impact.

Therefore the need for a continuous surveillance process is recognized. There is a gap where in

the currently available national data.

world’s percentage change and other neighboring countries, in addition to its own potential on

23% is (-4%). Jordan experienced changes in MMR between 1990 and 2013, estimated by WHO, UNICEF, UNFPA. The World Bank


00000/1/1990 to 00000/1/2002 (year 1995 to 1999). Jordan maternal mortality rate was reduced from 44/1000 (year 1995) to

Jordan is part of the countries that have incomplete data. According to local estimates, Jordanian and mortality have achieved successful healthcare measures in many areas. The challenge of physical,

What we don’t know limits us from eliminating preventable maternal deaths. The

many settings where we don’t know, limits us from eliminating preventable maternal deaths. The

Therefore the need for a continuous surveillance process is recognized. There is a gap where in

the currently available national data.

world’s percentage change and other neighboring countries, in addition to its own potential on

23% is (-4%). Jordan experienced changes in MMR between 1990 and 2013, estimated by WHO, UNICEF, UNFPA. The World Bank


00000/1/1990 to 00000/1/2002 (year 1995 to 1999). Jordan maternal mortality rate was reduced from 44/1000 (year 1995) to

Jordan is part of the countries that have incomplete data. According to local estimates, Jordanian

incomplete.

all births occur in countries where maternal causes of death data do not exist or are

180 countries. 72% have no data, 88% lack complete data. Over 80% of

proportion of deaths is caused by a greater extent. The data availability varies between countries and

producer block only in terms of maternal deaths recorded. The also refers to the

absence of many causes of death for the available data. As a result, the health planning and

A record of the world’s maternal deaths are not documented. This provides a

more than half of the world’s maternal deaths are not documented. This provides a

incomplete.

300 000 women die annually due to maternal causes. According to the Institute for Global Health,

300 000 women die annually due to maternal causes. According to the Institute for Global Health,

Background

Annex 7: The JMRAS Model
USADF-funded HSS II Brigade EOP Report

Enhancing Performance of Health Systems
A health facility:

This assessment was the basis to design the JMMRS and its first step is to capture all deaths of

Research and studies for coding, data entry, and analysis.

by the family, while the second copy is sent by the hospital to the Directorate of Information,

being completed by hospitals or forensic medicine department, one copy is taken to the CSDP
distributed to all health institutions and physicians in Jordan. The DNF has two copies, and after
directive were developed on completion of death notification forms and these were

Commitment of pregnancy

whether the death is of a woman or reproductive age, pregnant or within 42 days of
disease Directorate). The updated DNF includes a specific section where a Physician records

non-communicable national registry for diseases and mortality department in the MoH

Directorate of Information. Research and studies at the Ministry of Health (Circularity to

Directorate of Information, Research and Studies at the Ministry of Interior (MOI) and to the

States and Passport Department (CSDP) of the Ministry of Interior (MOI) and to the

system was implemented in Jordan in which death notification forms are reported to the Civil

reported from the 12 governorates of Jordan. In June 2003, a new death notification reporting

in Jordan. Mortality Reporting is based on information from death notification forms (DNF)

Baseline Situation of Recoding Deaths in Jordan


2. Identify the underlying factors contributing to death.

1. Measure and track all maternal deaths in real time.

Specific Objectives:

t heir impact.

The primary goal of the JMMRS is to eliminate preventable maternal mortality by obtaining and

GOALS AND OBJECTIVES

model of such a system.

JMMRS is a

and how they should be addressed. Maternal Mortality Surveillance and Response „MMSR“ is a

number of deaths, but also provides information about the underlying contributing factors

component of any elimination strategy is a continuous surveillance system that not only tracks

Jordan is now ready for the next step in eliminating preventable maternal deaths. A vital
1. Identification and notification of maternal deaths
2. Maternal death review (MDR)
3. Analysis and interpretation
4. Response and dissemination of results and recommendations
5. Monitoring and evaluation

Each of the four main components includes:

The JMRAS framework consists of four main components and a fifth which integrates with

Annex 7 - Figure 1: MMR Model for Jordan

Key Components of MMR Model
The framework addresses these main levels of responsibility and distributes roles accordingly. Components of WMSR Model

(1) Identification and Notification of Maternal Death

(NCD), Non Communicable Diseases department and level three at the central MOH – Non Communicable Diseases department. Those levels are recognized as level one at the facility, level two at Health Directorates in each hospital, and level three at JMRS. Detected case of WRA deaths from both the

According to the current system, DNFs are issued either by hospitals or FMDs. Despite having a compulsory system of

on weekly basis. The accumulated list of all deaths during the week is then sent also to the Health

directorate in the respective governorate. Refer to Figure 7. The investigation of deaths of women of Reproductive age (WRA), between 15 and 49 years, are regularly documented, aggregated and reported.

The first step in documenting and reporting a death is completing the death notification form.
A suspected maternal death is defined, according to WHO, as the “death of any woman while ...or 42 days of the end of a pregnancy, the death will be noted as a suspected maternal death. This step will result in a listing of deaths of all WRA to ensure no maternal deaths are missed. If there is evidence that the woman was pregnant or within 42 days of the end of a pregnancy, the death is recorded as a maternal death. The health facilities are advised to report the death to the central MOH on a monthly basis to begin the maternal death review process.

Non-communicable Diseases Directorate will trigger the start of a full maternal death review process. The health facilities are completed accurately and received from all respective health providers, and PNDs from the previous 24 hours, and checking on daily basis the death logs and other records reported from both hospitals and health centers.

At the HD level, the process of identifying maternal deaths starts by:

- Using the data collected from the emergency rooms, hospitals, and other health facilities, the HD sends the accumulated list of the suspected maternal deaths from all health facilities to the central MOH. This will send the death to the next higher level (Central MOH).
The steps are illustrated in Figure 4: Review Process.

Relevant steps for review are:

1. Review the case summary of each death, including key findings, is prepared and presented to the DIC that discusses the case, reviews all pertinent data, and completes a brief report on the death. (including relevant cases, if deaths are coded and analyzed outside health facilities.)

2. Review findings, and preventability, including risk factors, and recommendations addressed and evaluated.

3. Consider the case report and any existing MDR reports on the community, health facilities, and the availability of data sources.

4. Consider a combination of methods that may be used to assess the risk factors and their contributions to the death.

5. Review the case summary of each death, including key findings, is prepared and presented to the DIC that discusses the case, reviews all pertinent data, and completes a brief report on the death. (including relevant cases, if deaths are coded and analyzed outside health facilities.)

The review should be done at the facility level or the HD level by multidisciplinary committees.

1. Verify completeness and accuracy of the MDR report and request additional information if needed.

2. Determine causes of death: Identify preventable factors and associated factors, and suggest interventions.

MDR priorities include comprehensive and participatory approaches that aim to improve quality of care rather than to blame or punish. WHO recommends that each case of maternal deaths be reviewed with the following objectives:

1. Stated MDR priorities include contributing factors and communities.

2. Stated MDR priorities include contributing factors and communities.

3. Stated MDR priorities include contributing factors and communities.

4. Stated MDR priorities include contributing factors and communities.

5. Stated MDR priorities include contributing factors and communities.
The aim of agregated data analysis is to identify causes of death, groups at highest risk, and data in the MDR and in improving practices.

A successful MDR will:

6. Enable provision of recommendations for immediate (short-term) action
5. Determine if the death was avoidable
4. Assess the quality of medical care provided
3. Determine non-medical factors contributing to the death
2. Confirm if the case is a maternal death
1. Identify medical causes of death

Successful MDR and their involvement at each step in the process is essential.

No blame, participatory environment is essential in ensuring the quality of information.

National guidelines for MDR will be developed and will include information on processes, elements for MDR, and data in the MDR and in improving practices.

Key Polies Reated to MDR.

Ance 7: The IMMRS Model
USAI0 Funden HSS Epidemi Report
Enhancing Performance of Health Systems

(3) Analysis and Interpretation of Aregated Findings from Reviews:

6. Enable provision of recommendations for immediate (short-term) action
5. Determine if the death was avoidable
4. Assess the quality of medical care provided
3. Determine non-medical factors contributing to the death
2. Confirm if the case is a maternal death
1. Identify medical causes of death

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6. Enable provision of recommendations for immediate (short-term) action
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Ance 7: The IMMRS Model
USAI0 Funden HSS Epidemi Report
Enhancing Performance of Health Systems
Response and Dissemination of Results and Recommendations

4. Priority in the analysis phase.

Systematic response. Therefore, documentation of the contributing factors and their frequency
Understand which factors are contributing to maternal deaths provides guidance for a
factors are generated.

Previous steps in information aggregation ensure that maternal mortality ratios and rates,

3. Analysis of causes, factors, and preventability

2. Indicator analysis

1. Descriptive analysis

national level. This data will be used to conduct
The next level of NAG analysis is based on aggregated data for directorate, sectors, and the
confirmation of the cause of death, which will be made on the final page of the MDR.
Each single-department MDR report submitted by the DAG. This process will result in a final
At the central level, the NAG will perform analysis at two levels. First, the NAG will analyze
interactions to improve care as well as overall system efficiency.

Interventions will improve care at both levels. This analysis will show trends and allow stakeholders to monitor and evaluate both
contributing factors. Preventable causes and descriptive analysis for directorate and national
level additional analysis is performed at the last level of the analysis process. At the central

MDR conducted by the DAGs is the first part of the overall analysis process. At the central
information about which problems are most common and assists in prioritizing responses.
4. Grouping the findings from death reviews and reviewing them quantitatively provides

3. Health facilitators with large-volume deliveries should also perform analyses of facility-based

2. Analytical skills at the directorate level, at the minimum.

1. A data management plan with a clear framework for data flow, aggregation, processing, and

Key Points Related to this Step:

Annex 7: The IMRAS Model
USAIID-funded HSS II Bridge EOP Report
Enhancing Performance of Health Systems
A real difference towards saving the lives of mothers:

1. Legal safeguards should be in place to prevent the use of the review findings in litigation.
2. The DAG and HD assist hospitals and families in the implementation of recommendations, and findings and recommendations are communicated with the HD and is DAG in agreement.
3. Legal safeguards should be in place to prevent the use of the review findings in litigation.

Key points referred to this step:

1.Using evidence-based approaches
2. Starting with the avoidable factors identified during the review process
3. Prioritizing actions (based on prevalence, feasibility, resource, health-system readiness)
4. Establishing a timeline (immediate, short, medium, and long-term)
5. Deciding how to monitor progress, effectiveness, and impact
6. Integrating recommendations within annual health plans and health-system packages
7. Monitoring to ensure recommendations are being implemented

Guiding Principles for Response include:

Element of response at the health facility:

The type of action taken will depend on the level at which the decisions are being made, the facility, and health-care system, as well as at the inter-sectoral level.

Response will be tailored to address the problems identified in the community, health-care facility, and health-care system.
The JHMSRS, in such cases, a more detailed evaluation may be needed to assess how the system really functions. More efficient and effective responses under different circumstances.

4. Facilities, community and district health level reviews, data quality, and percentage of reports timely and appropriately completed.

3. Reporting forms are completed correctly and communicated timely.

2. Case reports from all sectors nationally.

1. Maternal deaths as a notifiable event.

The framework of M&E includes standard indicators based on the JHMSRS principles:

(1) Monitoring and Evaluation (M&E) for JHMSRS

Monitoring of the JHMSRS will be carried out primarily at the national level. Indicators are developed and will be implemented to evaluate the main functions of the system. Steps in the monitoring are adequately planned and the JHMSRS framework that includes standard communication of results and communication for advocacy and resource mobilization.

An important dimension whilst implementing JHMSRS is related to communication. It is

Enhancing Performance of Health Systems

Annex 7: The JHMSRS Model
USADF-Funded HSS II Bridge OP Report
References:


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Central MOH Directories IT Equipment Procured by the US AID-Funded HSS II Bridge Project

List of MOH Central Directories, HPS, Health Facilities and CBOs That Received IT Equipment Through HSS II Bridge Project

Annex 8: Enhancing Performance of Health Systems

US AID-Funded HSS II Bridge EOP Report
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### IT Equipment Procured by the USAID-Funded HSS II Bridge Project for the Ministry of Health (MOH) Hospitals

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FOR NEONATAL DEPARTMENTS AT MOH HOSPITALS

Medical Equipment (CPAP) Procured by the USAID-Funded HSS II Bridge Project

THROUGH HSS II BRIDGE PROJECT
LIST OF MOH HOSPITALS THAT RECEIVED CPAP UNITS

ANEX 9:

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in calculating the TFR. Regular calculation of the TFR is a summary of the steps taken by HSS II Bridge to assist and support the GO's calculation of the TFR using vital statistics and Passport Department (CSPD) supported the GO's calculation of the TFR using Civil Status data.

Developments affecting the population in Jordan, USADF through its Active HSS II Bridge stakeholders, partners, and donors in better understanding national efforts and recent regional developments. Obtaining a current TFR value and assessing recent trends in fertility will assist national services.

The TFR is affected by many societal, educational, health, and economic factors; and in turn, affect the rate over the past decade.

For those years showed a sharp decline in fertility in the 1990s followed by minor changes in performed in 1990, 1997, 2002, 2007, 2009, and 2012 to determine the national TFR. The TFR were over her reproductive years. In Jordan, Population and Family Health Surveys (PFH) were used for the total fertility rate (TFR) is the average number of children that would be born to a woman

The Total Fertility Rate (TFR) using CSPD data

Elections to Assist the GO to Calculate TFR

Annex 10: Efforts to Assist the GO to Calculate TFR
dissemination to other stakeholders (MOPIC, DOS, CSpP).

On August 16, the project shared the concept note with HPC for revision and

developed and sent a memo to this office for approval.

When we learned that the Minister of MOPIC must approve the process, the project

On August 9 and 10, follow-up emails were sent to the MOPIC to check on progress.

On July 30, USaid and the project had their first meeting with MOPIC, which included

meetings with MOPIC.

On July 8, the project had its first meeting with HPC. During this meeting, Dr. Sawan

obtaining the data.

The project then discussed and agreed with USaid to seek assistance from the HPC in

aggregated them appropriately. However, the MOH did not end up sharing the data

(NCD) Directorate. The meeting outlined which data variables are needed and how to

which resulted in some progress and a meeting with counterparts within the

The project followed up with the MOH through multiple telephone calls and meetings,

On May 21, MOH II Bridge formally requested the MOH’s assistance in obtaining the data.

USaid recommended formally requesting the data from project counterparts (either

CSpP had the data.

After careful discussion and consultation, the project team agreed to assist in the

calculating the national TFR without carrying out an entire DHS.

The efforts were initiated by a request from USaid on May 17, 2015 for suggestions for

Annex 1: Efforts to assist GO to calculate TFR

USaid-funded HSS II Bridge FOP Report

Enhancing Performance of Health Systems
Annex I: Efforts to Assist Go to Calculate TFR

US Aid-Led HSS II Bridge EOP Report

Enhancing Performance of Health Systems
DHS-reported data files available for Jordan, and it gave exactly the same results as reported in the three-year results. This was not observed with the first run of the tool. The validation tool is called TPR and uses Poisson regression analysis for calculation of TPR. The program is designed to run only under Linux for DHS data files and was developed by the new SPSS tool, while also being used in a well-recognized program.

To validate the new SPSS tool, Ababli developed a more detailed and comprehensive SPSS tool that removed all inconsistencies discovered in the first tool. According to Dr. Ali Ababli, the tool was developed to calculate TPR beyond the three years of the survey so that the CSPD could do the run monthly and even every month. The tool was developed to calculate TPR beyond the three years of the survey so that the CSPD could do the run monthly and even every month.

The tool was developed to calculate TPR beyond the three years of the survey so that the CSPD could do the run monthly and even every month.

The tool was developed to calculate TPR beyond the three years of the survey so that the CSPD could do the run monthly and even every month.
Month of December:

We expect that the HPC will send the letter to HE the Minister of MOPIC and equipment that will enable CSPD to pursue this important task on an annual basis.

The committee also requested that CSPD to define its needs for capacity building tools, duties on an annual basis.

- Formally assign CSPD as the entity to regularly do the calculation for the TFR.
- Provide advice on sharing and disseminating the results.
- Endorse the results of calculation.
- Approve the methodology followed to calculate the TFR.

Consensus and signed meeting minutes, and get this approval to:

1. Get all committee members to sign off on meeting minutes detailing the above.

Following action steps:

22. Under the leadership of the HPC Secretary General, the committee also agreed on the following:

The TFR using the CFR data. The TFR using the calculated and verified SPSS tool. The results of calculating the TFR using the TFR using the calculated and verified SPSS tool. The results of calculating the TFR using the calculated and verified SPSS tool. The results of calculating the TFR using the calculated and verified SPSS tool.

The committee agreed on the following:


Dr. Al expressed to the committee the TFR calculation using CSPD data, for all DHS first calculation.

The committee appreciated Dr. Al’s innovation to modify and validate the SPSS tool.

The committee appreciated Dr. Al’s innovation to modify and validate the SPSS tool.

The presented was 3.1.

His logic was clear and the group understood it.

The DR also showed the TFR results for the SPSS tool produced.

Several runs of CSPD data with 23 produced results identical to those he had used.

Dr. Al explained the TFR calculation and presented to the committee the

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Dr. Al explained the TFR calculation and presented to the committee the
was submitted to the HPC in November. The methodology followed to calculate the TFR, the main findings, and conclusions. This report at the conclusion of this activity, a report was prepared by Dr. Ali Arbab highlighting details of

RESULTS
The Health Systems Strengthening II (HSS II) Bridge project, contract number AID-278-C-15-00002, is funded by the United States Agency for International Development (USAID) through a grant to the American People. The Health Systems Strengthening II Bridge project is implemented by the Health Systems Strengthening II (HSS II) Bridge Network (EMPATH), in partnership with the American College of Nurse-Midwives (ACNM) and the Eastern Mediterranean Public Health Network (EMPHNET). The author’s views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development.
Unhealthy Activities’ Harmful Effects On Pregnancy

1. Concluding the Session

10. Explain Damage That Violence at Home Causes to Adults and Children

9. Counsel On Exposure To Environmental Risks Before or During Pregnancy

8. Unhealthy Activities’ Harmful Effects On Pregnancy

7. Other Medications

6. Encourage Client to Review Vaccination Status With Health Professional

5. Explain Importance of Taking Folic Acid Supplements Before Pregnancy

4. Discuss Importance of Healthy Weight, Good Diet and Exercise

3. Importance of Breast Feeding

2. Explain Good Timing and Spacing of Pregnancy, Family Planning Methods

1. Review Family Histories, Consanguinity, Genetic Disorders, Chronic Disease

INTRODUCTION

TABLE OF CONTENTS
**Introduction**

**Use of Counseling Checklist**

Service Provider Guidelines for Preconception Care

Annex 1: Service Provider Guidelines for Preconception Care

USaid-funded HSS II Bridge EOP Report

Enhancing Performance of Health Systems
Explain the importance of breast feeding
2. Explain good timing and spacing of pregnancies; explain consequences of not counseling.
If the woman's history reveals suspected genetic disorders, refer her to a qualified genetic counselor.

Discuss implications for subsequent pregnancies if her answers to any of the above raise health
- Any tests performed/reasons if known
- Dates of miscarriages
- Number of miscarriages
  - Missed miscarriages
  - Age of oldest and youngest child
- Infant size at birth; any newborn admitted to NICU; any stillbirths or neonatal deaths
- Any type of abnormality in any of the babies, including notable low birth weight or
- Total number of babies
- Birth outcomes:

If the woman is in need of family planning counseling and services, please refer her to the desired. If the woman is in need of family planning counseling and services, please refer her to the fetal. Avoiding pregnancies that are not wanted, increasing the duration of the previous birth, avoiding pregnancy at either becoming pregnant for at least two years after the previous birth (not general, optimal outcomes are associated with three to five years spacing between births (not for herself, for the developing baby, she will be carrying, and for the children she already has). In order to explain to the woman that planning her pregnancies carefully will help her to avoid risk factors.

Explain to get them, explain importance of breast feeding
2. Explain good timing and spacing of pregnancies; explain consequences of not counsel.
<table>
<thead>
<tr>
<th>Health</th>
<th>Increased risk of adverse health effects on infant and child</th>
<th>Increased risk of adverse health effects on infant and child</th>
<th>Complications during pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perinatal death, low birth weight</td>
<td>Social and emotional problems</td>
<td>Complications in pregnancy</td>
<td>Complications in pregnancy</td>
</tr>
<tr>
<td>Mortality and morbidity for childhood</td>
<td>Mortality and morbidity for maternal</td>
<td>Mortality and morbidity for maternal</td>
<td>Mortality and morbidity for maternal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk factors / Behaviors</th>
<th>Pregnancy too early</th>
<th>High parity</th>
<th>(24 months) Short birth intervals</th>
<th>Any time in the Reproductive age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prematurity, low birth weight, small size for gestational age (associated with birth intervals of 6-18 months), increased risk of death (death, neonatal and post-neonatal death); increased risk of severe complications during pregnancy and delivery</td>
<td>Four or less children: hemorrhage; or have failed blood transfusion during delivery; experienced another need for childbirth; or birth of a child with adverse outcomes during pregnancy or childbirth</td>
<td>Complications during pregnancy</td>
<td>Complications during pregnancy</td>
<td></td>
</tr>
</tbody>
</table>
difficult delivery, and other complications. Obesity and overeating may also increase the risk of stillbirth.

Greater risk of developing gestational diabetes mellitus or may have pre-existing Type 2 diabetes. Also persistent disorders during pregnancy such as hypertension or pre-eclampsia. They are also at greater risk of developing

3.3. Overweight (BMI >25 kg/m2) or obese (BMI >30 kg/m2): mild exercise (e.g., walking, healthy diet and good exercise routine. (Handing house hold activities, going for a walk and maintaining her weight, encouraging her to keep monitoring her weight and follow

3.2. Healthy weight (BMI = 18.5 and <25): nutritions is feasible. It's advised to try to improve their diet and weight before becoming pregnant and refered to a

3.1. Underweight (BMI <18.5 kg/m2): Evaluate the woman’s status according to her BMI and discuss the situation as appropriate: reduction or increase if indicated by BMI

3. Discuss the importance of healthy weight. Good diet and exercise, and weight

.to skin tonching and eye contact all help the baby bond with mother and feel secure.

Birth: Breastfeeding also lowers mother's risk of breast and ovarian cancer. Breastfeeding also returns to its pre-pregnancy size and reduces uterine bleeding after birth. Accuses ensure women return to its pre-pregnancy size and reduces uterine bleeding after spot, and decreased maternal fat stores. The composition of breastmilk is the ideal nutrition for infant as it contains all the nutrients needed for growth and development with the composition
Explain the CBC test result if she has RA risk of anemia. Explain risks of anemia.

4.3. Anemia:

Perform a HbA1c test should be performed. If she is overweight or obese or hypertensive, and has a family history, a fasting blood glucose measurement according to the protocol for hypertension. If the HbA1c is greater than 5.7% refer the woman to the PHC Clinic for a secondary care center.

If the anemia is severe, explain the risks of gestational diabetes in pregnancy. If there are no complications of gestational diabetes in a previous pregnancy, ask woman if she has a family history/history of diabetes/or history of gestational diabetes. If she has a positive family history, consider genetic counseling.

4.2. Diabetes Mellitus:

Diabetes Mellitus Diagnosis:

4.1. Hypertension:

Hypertension: Preconception counseling until she lowers her BMI. Obese woman should be referred to a nutritionist if she is overweight or obese. Consider declaration before becoming pregnant. A woman who is overweight or obese should be offered counseling on diet and exercise to reduce the risks of developing obstetric diabetes. Overweight women are at increased risk of developing diabetes and type 2 diabetes. Children and adolescents are at increased risk of developing obesity and type 2 diabetes. In addition, overweight women tend to be born larger and may be at increased risk of developing hypertension. Social determinants of health: social and economic factors that have a significant impact on health outcomes.
If the woman discloses use of tobacco or alcohol or exposure to second-hand smoke, discuss:

8.1 Tobacco & alcohol use. Second-hand smoke:

Drug counseling on harmful effects on pregnancy

she asks to ensure they are safe to take before or during pregnancy.

Before becoming pregnant, the woman should review her prescription medications and over-thecounter medications. Risks

8. Ask about unhealthy activities: tobacco & alcohol use, second-hand smoke, alcohol and

7. Other Mediations

the transmission of infectious diseases and to improve maternal and newborn outcomes.

If rubella vaccination status is uncertain, preconception screening for rubella (IgG),

If is recommended that women avoid pregnancy for at least 1 month after vaccination.

*Table 2: Vaccinations needed before a woman becomes pregnant

<table>
<thead>
<tr>
<th>Primary Health Care Center</th>
<th>Hepatitis B vaccination</th>
<th>Tetanus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Care Center</td>
<td>or previous pregnancies</td>
<td></td>
</tr>
<tr>
<td>Primary Health Care Center</td>
<td>among-immunized in childhood</td>
<td></td>
</tr>
<tr>
<td>Primary Health Care Center</td>
<td>among-immunized</td>
<td></td>
</tr>
<tr>
<td>Primary Health Care Center</td>
<td>previously in MMR (rubella, measles, mumps, rubella</td>
<td></td>
</tr>
<tr>
<td>Primary Health Care Center</td>
<td>for rubella</td>
<td></td>
</tr>
<tr>
<td>Vaccination Facility to get</td>
<td>Required Vaccine</td>
<td>Vaccine</td>
</tr>
</tbody>
</table>

6. Review/Encourage client to review vaccination status with health professional

should use folic acid supplements to further reduce the risk of these defects.

Higher prevalence of neural tube defects in addition to other genetic causes and a higher prevalence of folate deficiency in mothers of infants with a

Pregnancy to reduce risk of neural tube defects (NTD)

5. Explain the importance of taking folic acid supplements for 3 months before

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During pregnancy, as well as the risks of having a heavy drinker in the home.  
If the answer to either question is positive, counsel on the importance of avoiding alcohol.

her health and that of her baby.
If the answer to all questions is negative, confirm that this is an important way to preserve
drinks, occasionally or heavily.
Ask the woman if she herself ever drinks alcohol or if there is someone in her home who

8.2. Use of alcohol and drugs or medications:  

ear infections and sinus infections: care for in deciduous teeth.
Frequency of asthma, colds, bronchitis, pneumonia, and other lung diseases: middle

○ Children exposed to secondhand smoke are more likely to experience increased
  Syndrome (SIDS).
○ Smoking during and after pregnancy is a risk factor for Sudden Infant Death
  (SIDS) health problems.
○ Smoking during pregnancy is more likely to cause the baby will be sick and have to stay in
  the hospital longer.
  A baby to be born too early or to have low birth weight or have certain birth defects
  Smoking or exposure to second-hand smoke during pregnancy can cause:

- Effect of smoking on the newborn and child:
  - Mother and baby.
  - Smoking and pregnancy.

- Effect of smoking during pregnancy: women who smoke during pregnancy are more
  likely to have a miscarriage.
- Effect of smoking before conception: women who smoke may have a harder time getting
  pregnant and are more likely than other women to have a miscarriage.
- Effect of smoking before conception: women who smoke may have a harder time getting
  pregnant.
- Effect of smoking in pregnancy: include increased risk of the following: mental
  health effects specific to women: include increased risk of the

Anex I 1: Service Provider Guidelines for Pre-conception Case
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8. Counsel on the risks of exposure to radiation, pesticides, lead and indoor air pollutants (coal use) before or during pregnancy.

If the woman reports a heavy drinker in the home, provide advice on referring the individual for counseling.

Violence or abuse in the home:

Alcohol abuse (any member of the family):

Alcoholic liver disease, especially the heart and kidneys.

Intoxication, especially loss of balance and ability to judge distance and time.

Happy families due to domestic violence.

Injuries caused by drunk driving during pregnancy.

Due to alcoholism, certain disorders of the body that can last a lifetime, a range of health conditions are linked to chronic heavy drinking, including:

Alcoholism:

Heart disease:

Other effects:

Note that the indoor use of charcoal for Argile is toxic and poses risks for pregnant women and newborns. If the ever uses charcoal or wood for heating indoors, counsel her on the

strong chemicals to avoid harm to the fetus.

Also explain the importance of minimizing exposure to pesticides, lead-based paints and other

in the period before and during pregnancy since radiation can harm the fetus.

Advise the woman to avoid exposure to X-rays, CT scans, etc. for any non-emergent reason.

Alcohol abuse (any member of the family):

Alcoholic liver disease, especially the heart and kidneys.

Intoxication, especially loss of balance and ability to judge distance and time.

Happy families due to domestic violence.

Injuries caused by drunk driving during pregnancy.

Due to alcoholism, certain disorders of the body that can last a lifetime, a range of health conditions are linked to chronic heavy drinking, including:

Alcoholism:

Heart disease:

Other effects:

There is no known safe amount of alcohol use during pregnancy or while trying to get

Pregnant:

Alcohol consumption in pregnancy (any amount):

Annex 1: Service Provider Guidelines for Preconception Care

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mother for triggering the abuse. The abuse would not have occurred. They may also become angry at their siblings or their parents.

Children who are exposed to battering become fearful and anxious. They may feel worthless and powerless. They may feel threatened and humiliated, and they may feel

10.2. Risks to Children in the Home:

reactivity and other difficulties. Newborns that can persist through their lives.

Prematurity, real growth, prematurity, respiratory distress syndrome, cancer, chronic obstructive pulmonary disease, lung cancer, stillbirth, miscarriage

10.1. Risks during Pregnancy:

where she can get help. Before becoming pregnant and provide her with a handbook showing where she can get help.

Emphasis that she is experiencing abuse or any concerns about the health of her child. Parents have shown that stress reducing the ability of care for herself and her children. Studies have shown that stress is dangerous to the woman, increasing risk of depression and even psychological violence is dangerous to the woman, increasing risk of depression and even psychological violence can cause miscarriage and other dangerous conditions for the mother such as hemorrhage.

Family violence is particularly dangerous for a mother and her fetus. Physical aggression can

10. Explain the damage that violence at home causes to adults and children, and

### Risks to Children in the Home:

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Health Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prematurity</td>
<td>Reduced growth</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Distress syndrome</td>
</tr>
<tr>
<td>Cancer</td>
<td>Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>Stillbirth</td>
<td>Miscarriage</td>
</tr>
<tr>
<td>Miscarriage</td>
<td>Preterm birth</td>
</tr>
<tr>
<td>Preterm birth</td>
<td>Reduced growth</td>
</tr>
<tr>
<td>Childbirth</td>
<td>Cancer</td>
</tr>
<tr>
<td>Cancer</td>
<td>Early spontaneous abortion</td>
</tr>
<tr>
<td>Spontaneous</td>
<td>Early abortion</td>
</tr>
<tr>
<td>Abortion</td>
<td>Increased risk for childhood cancers</td>
</tr>
<tr>
<td>Childhood</td>
<td>Cancers</td>
</tr>
<tr>
<td>Cancers</td>
<td>First trimester miscarriage</td>
</tr>
<tr>
<td>Miscarriage</td>
<td>Preterm birth</td>
</tr>
<tr>
<td>Preterm birth</td>
<td>Reduced growth</td>
</tr>
<tr>
<td>Growth</td>
<td>Impaired brain function, microcephaly</td>
</tr>
<tr>
<td>Microcephaly</td>
<td>Increased mortality and morbidity</td>
</tr>
<tr>
<td>Mortality</td>
<td>And morbidity for childhood</td>
</tr>
<tr>
<td>Morbidity</td>
<td>Increased mortality and morbidity for maternal</td>
</tr>
<tr>
<td>Mortality</td>
<td>Increased risk for maternal</td>
</tr>
<tr>
<td>Morbidity</td>
<td>Increased risk for maternal</td>
</tr>
<tr>
<td>Mortality</td>
<td>Risk factors</td>
</tr>
<tr>
<td>Morbidity</td>
<td>Problem behaviors</td>
</tr>
<tr>
<td>Mortality</td>
<td>Health problems</td>
</tr>
<tr>
<td>Morbidity</td>
<td>Increased mortality and morbidity</td>
</tr>
<tr>
<td>Mortality</td>
<td>Increased risk for maternal</td>
</tr>
<tr>
<td>Morbidity</td>
<td>Risk factors</td>
</tr>
<tr>
<td>Mortality</td>
<td>Problem behaviors</td>
</tr>
<tr>
<td>Morbidity</td>
<td>Health problems</td>
</tr>
<tr>
<td>Mortality</td>
<td>Increased mortality and morbidity</td>
</tr>
<tr>
<td>Morbidity</td>
<td>Increased risk for maternal</td>
</tr>
<tr>
<td>Mortality</td>
<td>Risk factors</td>
</tr>
<tr>
<td>Morbidity</td>
<td>Problem behaviors</td>
</tr>
<tr>
<td>Mortality</td>
<td>Health problems</td>
</tr>
<tr>
<td>Morbidity</td>
<td>Increased mortality and morbidity</td>
</tr>
<tr>
<td>Mortality</td>
<td>Increased risk for maternal</td>
</tr>
<tr>
<td>Morbidity</td>
<td>Risk factors</td>
</tr>
<tr>
<td>Mortality</td>
<td>Problem behaviors</td>
</tr>
<tr>
<td>Morbidity</td>
<td>Health problems</td>
</tr>
</tbody>
</table>

### Table 2: Specific environmental risk factors before or during pregnancy

Annex 11 - Table 3: Specific environmental risk factors before or during pregnancy

Annex I: Service Provider Guidelines for Contraception Care

Annex II: Health Systems

Annex III: Health Systems
topic. With links to online information if available.
hand out these materials where more information on services can be obtained concerning each

center. Explain that she is ready to become pregnant. Provide her a

Further questions or concerns. Explain that she is always welcome to come back to the health
After completing the different sections of the counseling session, ask the woman if she has any

11. Concluding the session

AL-Sharq Institute for Development
Noor Al-Hussaini Foundation - Institute for Family Health - and The Queen Zein
Jordan River Foundation, Family Guidance and Awareness Center, Women’s Union,

Ministry of Justice, Ministry of Awqaf, Ministry of Education, National Media Center

Ministry of Social Development-Women Affairs

Ministry of Health-Protection Against Violence

Public Security Directorate-Family Protection

Inform on available help centers:

is also the number one reason children run away from home.

domestic violence is the single best predictor of juvenile delinquency and adult criminality. It

alcohol/drugs, post-traumatic stress disorder, and juvenile delinquency. When children
become self-injuring. In later life, children from violent homes have higher risks of

They may also use violence to express themselves with their mother and peers and they can

attainment. They may experience developmental delays in speech, motor or cognitive skills.

Children who witness domestic violence may act out, withdraw or show anxieties to

Annex 1: Service Provider Guidelines for Reconciliation Care
USADF-Funded HSS II Bridge EO Report

Enhancing Performance of Health Systems
Date of marriage:__________________


1. Laboratory tests:
   Complete Blood Count (CBC): Hemoglobin (Hb) (g/dL): ________ (12-16)

2. Woman physical exam:
   Blood pressure _______/_______
   Height______ Weight ______ BMI ______
   Underweight (< 18.5)        Normal (18.5-24.9) Overweight (>25)             Obese (> 30)

Other tests, specify: ___________________________

3. Counseling session ensuring privacy
   Review previous pregnancy outcomes and any complications, discuss implications for subsequent pregnancy.
   If hypertension, diabetes or anemia is detected, manage/follow client as per MOH protocol.
   Explain the importance of taking folic acid supplements for 3 months before pregnancy to reduce risk of neural tube defects (NTD).
   Explain the importance of birth spacing, explain briefly about family planning methods and where to go, explain good timing and spacing for pregnancy, if applicable; explain consequences of not following

Other issues of concern, specify:

Help and care:

Handout with summary of topics and links for further information provided to couple.

Name of provider:  __________________________________________________________

Signature: __________________________________Date of Counseling: ___ /___ /______
The Health Systems Strengthening (HSS II) Bridge project, contract number AID-274-C-15-00002.

Disclaimer: The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) through Abt Associates Inc., 4550 Montgomery Avenue, Suite 800 North, Bethesda, MD 20814-3343, USA. Tel: +1-301-913-0500; fax: +1-301-652-3916

World Health Organization (WHO) and the Eastern Mediterranean Public Health Network (EMPHNET) and the Eastern Mediterranean Public Health Network have partnered with the American College of Nurse-Midwives (ACNM) by Abt Associates Inc. in partnership with the American College of Nurse-Midwives, the United States Agency for International Development, and implemented the Health Systems Strengthening II Bridge project. A consultation was conducted by the Health Systems Strengthening II Bridge project.

August 30, 2015

Annex 13: Health Systems Strengthening II Bridge (HSS II) Bridge and Counseling Premenatal Testing Guidelines for Service Provider

Health Systems Strengthening II Bridge (HSS II)
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Annex 1: Service Provider Guidelines for Premarital Counseling

Enhancing Performance of Health Systems

USaid-funded HSS II Bridge EOP Report
Introduction

- Use of Counseling Checklist
- Premarital Testing and Counseling

Service Provider Guidance For
<table>
<thead>
<tr>
<th>Pregnancy too late (≥24 weeks)</th>
<th>High parity</th>
<th>Short birth intervals (&lt;24 months)</th>
<th>Unintended pregnancy (any time in the woman's reproductive age)</th>
<th>Pregnancy too early (&lt;18 when the woman's body is not fully mature)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased risk of: chronic diseases such as gestational diabetes and hypertension, placenta previa, breech presentation, CS delivery, postpartum hemorrhage</td>
<td>Increased risk of adverse outcomes during pregnancy or childbirth after birth of fifth child</td>
<td>Increased risk of adverse outcomes during pregnancy</td>
<td>Increased likelihood of complications during pregnancy, morbidity or mortality related to complications of unsafe abortion</td>
<td>Complications in pregnancy and delivery, miscarriage, increased risk for delivery through caesarian section and for adverse maternal, fetal, and neonatal outcomes</td>
</tr>
<tr>
<td>Increased risk of congenital abnormalities especially Down syndrome, stillbirths and low birth weight</td>
<td>Increased risk of neonatal tachypnea and tachyphagia</td>
<td>Increased risk of neonatal morbidity and mortality (e.g., preterm labor, miscarriage)</td>
<td>Increased risk of neonatal morbidity and mortality</td>
<td>Perinatal death, low birth weight, small size for gestational age  (associated with birth intervals of 6–18 months), increased risk of premature birth and stillbirth (≤1 year) death, increased risk of adverse effects on infant and child health</td>
</tr>
<tr>
<td>Prematurity, low birth weight, small size for gestational age  (associated with birth intervals of 6–18 months)</td>
<td>Psychosocial consequences, less attention to care during pregnancy and childbirth, more attention to care during postpartum period</td>
<td>Less attention to care of unborn child during pregnancy, with adverse effects on infant and child health</td>
<td>Less attention to care of unborn child during pregnancy, with adverse effects on infant and child health</td>
<td>Increased risks for childhood mortality and morbidity</td>
</tr>
<tr>
<td>(≤6 months)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Hospital longer.

3.2. Harmful effects of tobacco use, second-hand smoke, alcohol and drugs' harmful effects on pregnancy

3. Unhealthy activities: tobacco & alcohol, second-hand smoke, alcohol and

Health effects specific to women include increased risk of the following:

- \[ \text{Smoke} \]
- \[ \text{Second-hand smoke} \]

- \[ \text{Compromised respiration.} \]

- \[ \text{Health effects specific to women} \]

- \[ \text{Women development depression.} \]

- \[ \text{carer's:} \text{Smoking weed, complications of pregnancy including poor foetal health, increased risk of the following complications:} \text{anemia, decreased bone density, morning sickness, prematurity,} \]

- \[ \text{General health effects of smoke on adults men and women:} \text{include increased risk of the following:} \]

- \[ \text{Second hand smoke, discuss the following:} \]

- \[ \text{If either the man or woman, or both, discontinue use of tobacco or alcohol or exposure to} \]

- \[ \text{drugs, harmful effects on pregnancy} \]

- \[ \text{problems can be a result of factors in the man or woman, or both.} \]

- \[ \text{health provider to determine if there are any fertility problems. If the couple is concerned, they are unable to conceive after a year, at which time they should consult a fertility clinic, and they can discuss which method may suit them best. Explain that the family planning clinic at the national and child health unit can provide family planning counseling and services whenever they wish to learn more.} \]
indoor, counsel her on the importance of avoiding this practice.

Exposure to radiation, pesticides, lead and indoor air pollution (coal use) before or during pregnancy

Provide advice on removing the individual for counseling.

Alcohol exposure, especially the heart and kidneys.

Pregnancy, as well as the risks of having a heavy drinker in the home.

When any use of alcohol is suspected, counsel on the importance of avoiding alcohol during pregnancy.

3.2 Use of alcohol and drugs
disease, middle ear infections and sinus infections; caries in deciduous teeth.

Effect of smoking on children: children exposed to secondhand smoke are more likely to

- Babies born to women who smoke are also more likely to have children born with
  - Syndrome (SIDS).
- Smoking during and after pregnancy is a risk factor for sudden infant death

Annex 1: Service Provider Guidelines for Prenatal Counseling

Enhancing Performance of Health Systems

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Explain to the couple that it is important to do a brief physical exam of the woman including their childhood and/or in later life. Children who are exposed to parenting may experience developmental delays in speech, motor or cognitive skills and have numerous behavioral or psychological problems during the perinatal period. 

5.2 Risks to children in the home:

- Family violence is particularly dangerous for a mother and her fetus. Physical aggression can cause miscarriage and other serious conditions for the mother such as hemorrhage. Early psychological violence is dangerous to the woman increasing risk of depression and even psychological violence is dangerous for the child and her children. Studies have shown that stress during pregnancy negatively affects the physical growth of newborns. 

### Table 1.3 - Table 2: Specific environmental risk factors before or during pregnancy

<table>
<thead>
<tr>
<th>Environmental Risk Factor</th>
<th>Indoor Air Pollution</th>
<th>Pollution</th>
<th>Lead or Mercury</th>
<th>Pesticides</th>
<th>Ionizing Radiation</th>
<th>Health Problems / Risk Factors / Problem Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia, Respiratory infection, Pneumonia, Respiratory infection</td>
<td>Choking, Chronic obstructive</td>
<td>Pollution</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prematurity, Respiratory distress, Prematurity, Respiratory distress</td>
<td>Choking, Chronic obstructive</td>
<td>Pollution</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cerebral palsy, Cerebral palsy, Early spontaneous abortion</td>
<td>Cerebral palsy, Cerebral palsy, Early spontaneous abortion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood cancers</td>
<td>Early spontaneous abortion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood cancers, First-trimester miscarriage</td>
<td>Early spontaneous abortion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First-trimester miscarriage</td>
<td>Early spontaneous abortion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased risks for childhood</td>
<td>Increased risks for maternal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If she is overweight or obese, also advise her to be tested for her blood glucose level.

Reversible.

conception until she lowers her BMI. Obese woman should be referred to a nutritionist if

A woman who is overweight or obese should be offered counseling on diet and exercise

proportionately with the degree of obesity:

Obesity is associated with an elevated risk of type 2 diabetes, heart disease, gallbladder disease;

in particular, a higher risk of developing obesity and type 2 diabetes as children and adolescents,

increased risk of developing obesity and type 2 diabetes before conception. Overweight and

overweight, and/or have pre-existing type 2 diabetes before conception. Overweight and

overweight may also increase the risk of stillbirths, difficult delivery, and other complications.

If her BMI is above 25, discuss the following: Women who are overweight or obese before

6.3. Overweight (BMI ≥ 25 kg/m²) or Obese (BMI ≥ 30 kg/m²):

healthy diet and good exercise routine. (Handing house hold activities, going for a walk and

If the woman has a healthy weight, encourage her to keep monitoring her weight and follow

6.2. Healthy Weight (BMI < 18.5 and ≥ 19.5):

Pregnant, and referred to a nutritionist if feasible.

underweight should be advised to try to improve their diet and weight before becoming

Growth retardation and low birth weight, which can increase the newborn risk of

critical at risk of complications during pregnancy and delivery. Women under nutrition deficits

A low BMI, especially if associated with short stature (<145 cm), can put the mother and

6.1. Underweight: Body Mass Index (BMI) <18.5 kg/m²:

couples should decide whether the man stays with her or each completes it alone.

Conduct a short physical exam and counseling session for the woman (the

Annex 13: Service Provider Guidelines for Premarital Counseling

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Enhancing Performance of Health Systems
The following vaccinations should be performed before a woman becomes pregnant:

Encourage client to review her vaccination status with health professional before trying to become pregnant.

6.8 Vaccination Status

To further reduce the risk of these defects, pass, commercial or white rice, but all pregront women should use folk and supplements with a higher prevalence of neural tube defects. In addition to supplements, folk and can be found in breakfast cereals, breads, fruits, and vegetables. Folk and supplements can help to reduce the risk of neural tube defects in pregnancy and during early pregnancy can help to reduce the risk of neural tube defects in pregnancy. Another risk is linked to an increased risk of preterm delivery and low birth weight. This also associated with a higher risk of stillbirth, neonatal death and postpartum hemorrhage. If the woman is anemic, educate her to take iron supplements to treat the anemia before she becomes pregnant and to eat foods rich in iron to prevent anemia. Explain the risks of anemia, explain the benefits of iron in the diet. The CDC tests for folate levels, explain the risks of anemia, explain the benefits of iron in the diet.

6.7 Discuss Folic Acid Supplements

During pregnancy, refer for further diagnostic or treatment if indicated.

6.6 Anemia

To the PHC clinic for a fasting blood glucose of HbA1c test, and follow-up as indicated. Ask woman if she has a family history of diabetes or gestational diabetes. If she is diabetic or prediabetic or if she is overweight, please or hypertension and has a family history of or prediabetic. If she is overweight, please or hypertension and has a family history of diabetes, explain the risks of diabetes in pregnancy such as very large babies, hypoglycemia, and premature delivery and low birth weight. This also associated with a higher risk of stillbirth, neonatal death and postpartum hemorrhage. If the woman is anemic, educate her to take iron supplements to treat the anemia before she becomes pregnant and to eat foods rich in iron to prevent anemia. Explain the risks of anemia, explain the benefits of iron in the diet.

6.5 Diabetes Mellitus

To the PHC clinic for management according to the protocol for hypertension.

Reinforce that the goal is becoming pregnant until her hypertension is under control. Refer her to the PHC clinic if management according to the protocol for hypertension. Explain the risks of diabetes in pregnancy such as very large babies, hypoglycemia, and premature delivery and low birth weight. This also associated with a higher risk of stillbirth, neonatal death and postpartum hemorrhage. If the woman is anemic, educate her to take iron supplements to treat the anemia before she becomes pregnant and to eat foods rich in iron to prevent anemia. Explain the risks of diabetes in pregnancy such as very large babies, hypoglycemia, and premature delivery and low birth weight. This also associated with a higher risk of stillbirth, neonatal death and postpartum hemorrhage. If the woman is anemic, educate her to take iron supplements to treat the anemia before she becomes pregnant and to eat foods rich in iron to prevent anemia.
After completing the different sections of the counseling session, ask the couple if either of

7. Concluding the session

Provide information on sources of support should she ever experience violence in the

6.11. Violence in the Home

Briefly explain the benefits of breast feeding for both mother and child. Breast milk is the

6.10. Breastfeeding:

Any medications she takes to ensure they are safe to take during pregnancy.

6.9. Other Medications:

Transmit information on infectious diseases and to improve maternal and newborn outcomes.

If Rubella vaccination status is uncertain, vaccination screening for Rubella (Rubella IgM,

* If it is recommended that women avoid pregnancy for at least 1 month after vaccination

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<tr>
<th>Primary Health Care</th>
<th>Hepatitis B Vaccination</th>
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<td>Pregabacine</td>
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Annex 13 - Table 3: Vaccinations needed before a woman becomes pregnant

Enhancing Performance of Health Systems

USADF-funded HSS II- Endline EOP Report
Checklist for Pre-Marital Screening and Counseling

ANNEX 1.4:

Enhancing Performance of Health Systems

USaid Funded HSS II Bridge EOF Report

For couples who are planning to get married

1. Laboratory Tests:

- Complete Blood Count for:
  - Male: MCV (fL) =_________<80, Hb g/dL =_________ (14-18)
  - Female: MCV (fL) =_________<80, Hb g/dL =_________ (12-18)

Review results and refer client as appropriate according to the protocol.

2. Counseling session with couple:

- Review results and refer client as appropriate according to the protocol.

3. Woman physical exam:

- Blood pressure _______/_______
- Height______ Weight ______ BMI ______
  - Underweight (< 18.5)
  - Normal (18.5-24.9)
  - Overweight (25-29.9)
  - Obese (> 30)
- Women Age: _______ yrs.
- Spouse Age: _______ yrs.
- Other tests, specify: ___________________________

4. Discuss the laboratory tests, physical exam results and provide counseling session ensuring privacy:

- Importance of healthy weight, good diet and exercise, weight reduction/increase if indicated.

5. Domestic violence, its consequences on family, health, children and economic aspects.

6. Reproductive plans, healthy living/sleeping, prenancy, advantages of delaying first pregnancy.

7. Family history: contraceptive failure, genetic diseases, and chronic disease tendencies.

8. Handout with summary of topics and links for further information provided to couple.

Name of provider:  _______________________ Signature: ________________ Date of Counseling: __  /__ /____
Dear Mr. Woman,

I refer to the case of the health facility in the MOH. The project has processed, distributed, and insured medical and equipment.

Subject: Medical and Equipment Handled Over to MOH

Name of Health (MOH)
Director of Planning and Project Implementation
Hereafter, Project Implementation Division

Date: July 07, 2015
Ref: 1210515

Kindly note that the MOH Bridge Project has processed, distributed, and insured medical and equipment.

Please find enclosed the following:
- MOH II Bridge Project Statement
- MOH II Bridge Project Form

Best regards,

Project Director
Dr. Shady Elmess
<table>
<thead>
<tr>
<th>No.</th>
<th>Title</th>
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<tbody>
<tr>
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<tr>
<td>2.</td>
<td>Director of Planning and Project Management</td>
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<tr>
<td>3.</td>
<td>Director of Primary Health Care Administration</td>
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<tr>
<td>6.</td>
<td>Eng. Muna Hezalih</td>
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<tr>
<td>7.</td>
<td>Dr. Mohamad Al-Tawawnee</td>
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<tr>
<td>8.</td>
<td>Dr. Ali Al-Saad</td>
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<tr>
<td>9.</td>
<td>Dr. Waheeb Al-Omari</td>
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<tr>
<td>10.</td>
<td>Ms. Samah Sammoun</td>
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<tr>
<td>11.</td>
<td>Dr. Khaleed Al-Debey</td>
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<td>12.</td>
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<td>13.</td>
<td>Dr. Ghadeb Gammash</td>
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<tr>
<td>14.</td>
<td>Director of Employee Affairs Directorate</td>
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<td>18.</td>
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<td>Dr. Hadihun Muhseb</td>
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**List of MOH Counterparts**

Annex 1: Project Deliverables Handover to MOH

USADF-funded HSS II Bridge MOH Report

Enhancing Performance of Health Systems
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<th>Title of Deliverable</th>
<th>Project Component</th>
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<td>1. FP SDIC Report</td>
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<td>2. FP SDIC Final Report</td>
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