USAID
FROM THE AMERICAN PEOPLE

POPULATION AND FAMILY HEALTH OFFICE

REVIEW OF PFH PROGRAM AND PROJECT EVALUATIONS (2005-2019)

UPDATED JULY, 2020

This publication was produced for review by the United States Agency for International Development by XL Associates Inc. under the Middle East Regional Platform (MERP) contract.

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

REVIEW OF PFH PROGRAM AND PROJECT EVALUATIONS (2005-2019)

Table of Contents

ACKNOWLEDGMENTS

This review builds on many evaluations written for USAID/Jordan's Population and Family Health Office between 2005 and 2019. Many of the recommendations are included in this review and have been transcribed verbatim or as near to the original as possible. This summary therefore builds on the work of many individuals and organizations who have contributed to evaluating and sharpening Jordan's programmatic response over the past fifteen years.

The report was initiated and reviewed by Andrea Halverson, Deputy Director of the Population and Family Health Office. Additional feedback was John Callanta, Monitoring and Evaluation Specialist with PFH.

The following authors are named in the evaluations or final reports referred to in this document; their previous diligence is acknowledged.

Midterm Performance Evaluation of the USAID/Jordan Health Service Delivery Activity (2019): Dr. Adriane Hilber Martin; Dr. Fouad Fouad; Dr. Hildy Fong Baker; Yusef Srouji; Cara Nolan; Marvy El Moujabber; Huda Murad; Mary Sayej; Hannah Mufti and Sabreena Kazem (Link)

Human Resources for Health In 2030 (HRH2030) Midterm Activity Evaluation (2018): Alanna Shaikh, Raed Azmi, Hamouda Hanafi, Khaled Hasan, and Wisam Qarqash (Link)

Health Finance and Governance Internal Assessment (2017): Caroline Ly; Arin Dutta and Kate Britton

Jordan Family Planning Assessment (2016): Dominick Shattuck, Esther Spindler, Julie Solo, Nisreen Bitar, Jordan Tompkins, Lizzy Menstell and Victoria Jennings (Link)

Strengthening Health Outcomes through the Private Sector Evaluation (2015): Pamela Putney, Nedjma Koval-Saifi, Huda Murad and Wisam Qarqash (Link)

Health Systems Strengthening II Midterm Evaluation (2012): Thomas Park, Kelly O'Hanley, Jennifer Peters, and Muntaha Gharaibeh (Link)

Jordan Health Communication Program Evaluation (2011): Gary Lewis, Carolyn Barnes, and Inaam Khalaf (Link)

Enhancing Performance of Health Systems. End of Project Report. USAID-funded Health Systems Strengthening II Bridge Project (2015): Submitted by Dr. Sabry Hamza (Link)

Private Sector Project for Women's Health (2012): Submitted by Reed Ramlow (Link)

Expanding HIV Prevention in Jordan Final Report (2008): Submitted by Dr. Lina Al Hadid (Link)

Finally, my thanks to Holly Penfold for proof reading.

ACRONYMS

AWSO	Arab Women Speak Out
BCC	Behavior Change Communication
CAT	Critically Appraised Topic
CBO	Community Based Organization
CPD	Continuing Professional Development
CYP	Couple Years of Protection
DHS	Demographic Health Survey
EBM	Evidence Based Medicine
EHP	Enhancing HIV Prevention
EQuiPP	Enhancing Quality in Private Providers
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender Based Violence
GOJ	Government of Jordan
HC	Health Center
HCP	Health Care Provider
HCSI	Health Competent Schools Initiative
HFG	Health Finance and Governance [program activity]
HRH2030	Human Resources for Health 2030 [program activity]
HSD	Health Service Delivery [program activity]
HSS	Health Systems Strengthening
IP	Implementing Partner
IRH	Institute for Reproductive Health
IUD	Intra-uterine Device
JCAP	Jordan Communication and Advocacy Project [program activity]
JHCP	Jordan Health and Communication Partnership [program activity]
JOD	Jordanian Dinar
KII	Key Informant Interview
MENA	Middle East and North Africa

MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health
PFH	Population and Family Health [Office]
PLHA	Person Living with HIV/AIDS
PSP	Private Sector Project for Women's Health
RH	Reproductive Health
(R)MNCH	(Reproductive) Maternal Newborn and Child Health
RMS	Royal Medical Services
SBC(C)	Social and Behavioral Change (Communication)
SDIC	Service Delivery Improvement Collaborative
SHOPS	Strengthening Health Outcomes through the Private Sector [program activity]
VAW	Violence Against Women
WHO	World Health Organization

EXECUTIVE SUMMARY

OVERVIEW OF PROGRAMS

This review captures key findings from seven program evaluations, supplemented by three final reports (where no evaluation was available). The main part of the report groups the findings into themes under the broad headings of (i) Family Planning, (ii) Maternal, Newborn and Child Health, (iii) broader Health Systems Strengthening and finally (iv) issues and recommendations related to monitoring and evaluation of USAID's program activities. Evaluations demonstrated a large number of issues and recommendations for (i) and (iii), with fewer recommendations specific to maternal health. There was a notable scarcity of recommendations specifically relating to newborn and child health, where most gains appear to be related to capital building projects, although these are not quantified in any of the documents.

FAMILY PLANNING

Contraceptive effectiveness rather than contraceptive use was identified as the key determinant of stagnation of the fertility rate, according to the Institute for Reproductive Health's (IRH) 2016 Assessment. Assuming this is still correct, then many other key recommendations still hold true. Counseling bias was a consistent theme across most evaluations, pointing to a need for far greater emphasis on working with professionals to reduce misconceptions. At the same time positive interventions included "internal referral within a health center"; "increased education in health centers"; "couples counseling with CHWs"; and campaigns such as *Together for a Happy Family* (1996-2000) which demonstrated significant improvements in the numbers considering IUDs and pills to be safe.

Social and cultural barriers feature in most evaluations. The IRH stressed the need to focus on the "social" component of SBC. Some interventions targeting youth, such as the Health Competent Schools Initiative which was handed over to RHAS and the Ministry of Education were described as "cost effective and low maintenance". In contrast approaches such as the "University Ambassador [Peer] Initiative" was not recommended for continuation because it was considered too labor intensive, with a relatively small reach that required audience-specific messages and material. Other approaches, such *Mabrouk* which targeted newlyweds through the Civil Service and Passports' Department were praised by evaluations during the life of the activity, but failed the sustainability test once a program ended. (Annex B provides a list compiled by IRH of FP-related interventions in Jordan that were not scaled up or were discontinued soon after a program activity ended.)

Access to FP, and in particular to both female doctors and IUD-trained staff has been a recurrent issue in multiple evaluations and most recently it was described as inconsistent. This also relates to post-graduate training opportunities for Ob/Gyn staff. Naturally, the importance of midwives being able to take on the fitting of IUDs featured repeatedly, after practices became more restrictive in 2010.

Service delivery quality improvement for FP, such as SDIC, in some cases doubled the uptake of family planning in health centers, yet due to lower levels of autonomy, fell flat in hospitals. Helping to expand post-partum FP into public hospitals with a dedicated clinician to provide phone call follow-ups, was part of IRH's recommendations (2016). Conversely, an initiative to improve post-partum FP in private hospitals produced results with negligible gain, that itself was attributed to women coming from a more educated background rather than as a direct impact from the program.

Vouchers and subsidizing the cost of FP commodities and services was identified as unsustainable long term, yet necessary until a critical mass has been built for prolonged social change in attitudes to FP.

MATERNAL, NEWBORN AND CHILD HEALTH

Recent findings from the Health Service Delivery (HSD) evaluation found that there is a lack of clarity on how many antenatal visits are required. In addition, some women were found to not be receiving the full range of tests, while iron and folic acid were not always available. They also identified a lack of respect, dignity and humanity in childbirth. Previous evaluations noted concerns about a lack of privacy in clinics.

The introduction of Evidence Based Medicine for different professions and at varying times appears in several evaluations. While it was described as "valued by MOH" in one document, a subsequent evaluation by IRH stated that the stand-alone EBM approach did not improve knowledge or practice.

In one of the references to improvements in newborn care, the HSS II Bridge final report documented the introduction of the Active Management of the Third Stage of Labor, which introduced cord-clamping 1-3 minutes after birth. However, this could be worth revisiting because WHO guidelines recommend delaying clamping until 2-3 minutes, which can lead to significant increase in newborn hemoglobin and higher serum ferritin concentration at 6 months of age and other research found is associated with a 39% reduction in need for blood transfusion and a lower risk of complications after birth. Meanwhile staff shortages were identified as a key reason why there was little support for breastfeeding post-partum.

HEALTH SYSTEM STRENGTHENING

Several evaluations identified issues with how programs work with MOH and other stakeholders. For example, the HSD evaluation found that Health Directorates were "not engaged" and HAD Directors felt "overstepped and ignored". The HSS II Bridge final report stressed the benefits of "uniting a health facility and their health directorate teams in a common goal" which allowed them to achieve rapid progress, while engagement with central and mid-level stakeholders improved ownership. Meanwhile HRH2030's evaluation noted the need for communication strategies with both high- and mid-level officials had been "woefully underestimated". The need for communications strategies among project stakeholders rather than simply to their beneficiaries, appears to be a key lesson, particularly for harder-to-achieve activities.

Accreditation as a mechanism for raising the quality of care in primary and secondary care in both the public and private sector, was described as sustainable and "the shortest and best way to improve [services]". Leveraging gains through accreditation increased CYPs by 13% in participating HCs compared to 5% increases in non-participating ones. It was also cited as a crucial incentive in motivating private hospitals' participation a violence against women (VAW) initiative.

The role of CHWs features as part of a broader HSS approach, although evaluation findings were variable. IRH described home visits as one of the most effective methodologies to raise awareness and encourage women to seek services. In contrast the HSD evaluation noted that anemia testing vouchers were issued to under 5% of households visited, and of these only one third of vouchers were then used. Some CHWs had trouble mastering a host of health topics, and consequently spent less time on challenging issues while gravitating to easier topics.

Staffing is a recurrent issue in most of the reviewed documents, with turnover rates of up to 60% in some hospitals, bringing into question the sustainability of training clinical staff. This was also a particular problem for IT staff in MOH, who are frequently offered higher salaries in the private sector once their skills are improved. Recommendations included focusing on systems and processes that have longevity, and strengthening the role of mid-level staff who are MOH leaders of the future. Several documents referred to gaps between pre-service training and actual need and deficiencies in the Ob/Gyn residency programs.
Health financing and fiscal reform featured little in earlier evaluations, although its importance has risen due to unsustainable pressures created by rapid population growth. This will require closer work with EDE and DRG to harmonize approaches at central and decentralized levels and avoid duplication of efforts.

While development of Information Systems such as HMIS, was described as helpful, the HSS II evaluation observed that USAID had left a "legacy of multiple, parallel information systems". This continues with HSD's recent evaluation identifying data collection running in parallel to government systems such as HAKEEM. In contrast, IRH identified a study in 2014 that used existing data from birth registries to estimate the TFR rather than waiting for DHS.

Other evaluations pointed to a lack of engagement with stakeholders such as UN agencies which limited both learning from other countries and acceptance of systems as anything other than a USAID initiative. HFG's review proposed a shift in priority towards generating data-demand and enhancing information use.

MONITORING AND EVALUATION

Despite high levels of reported compliance for clinical pathways for FP, ANC, delivery and PPC, the HSD evaluation did not find the same high-standards of care reflected in client experiences. This points to a need for better routine triangulation of outputs and outcomes.

Finally, it is worth remembering that End of Project evaluations typically report during the life of an activity, (although ADS 201 permits evaluations to be done at any time). In doing so, they are unable to assess the degree of sustainability of individual components. Annex B (originally compiled by IRH) lists seven significant pilot projects that were either not scaled up, or were discontinued after the project activity ended. As PFH works with the GoJ on the journey to self-reliance, learning how to ensure country ownership for interventions that offer the greatest impact will surely be the most important lesson for programming in this new decade.

INTRODUCTION

BACKGROUND

USAID's work in Jordan has spanned over five decades, resulting in many significant improvements in health. Much of the programming has been focused on improving maternal health and reducing fertility rates. In recent decades the Total Fertility Rates has remained almost unchanged until the most recent Jordan Population and Family Health Survey (2017/18). In the meantime, the population has grown 112% between 2000-2018 (GOJ figures). Much of this increase has been attributed to the influx of refugees from neighboring conflicts, although live births accounted for 60% of the population increase between 2000-2018. Nonetheless, this represents a heavy and unsustainable burden on a country with very limited financial and natural resources. Therefore, learning lessons from previous programs, to maximize USAID's input is essential.

This document is one of a number of background documents intended to inform and shape USAID/Jordan's forthcoming Project Appraisal Document (PAD) which provides the strategic framework for the Mission's investment in health programming over the next five years.

PROCESS

USAID's internal systems in country were checked for both final and mid-term evaluations. Where these could not be identified, PFH team members were asked to check their own files. Where this still did not identify evaluations, the Jordan Knowledge Management Portal was searched. In October 2019 a request was submitted to USAID's Knowledge Service Center to track down any missing evaluations through the Development Experience Clearing House.

Either mid-term or final project evaluations were identified for the following:[1]

- Health Service Delivery (2019)
- Human Resources for Health 2030 (2018)
- Health Finance and Governance (2017)
- Strengthening Health Outcomes through the Private Sector (2015)
- Health Systems Strengthening II (2013)
- Jordan Health Communication Program (2011)

Between 2015-2016, USAID tasked the Institute for Reproductive Health (Georgetown University) with undertaking a Family Planning assessment to review previous USAID activity and make recommendations for future projects. This is included and categorized as an evaluation.

Where neither mid-term nor final evaluations were identified, information has been sought from the program activities' Final Report for the following projects:[2]

- Health Systems Strengthening Bridge (2015)
- Private Sector Project for Women's Health (2012)
- Enhancing HIV Prevention (2008)

[1] In the Thematic Review section evaluations are noted as [*project*/**Eval**], reports are shown as [*project*/**Rep**] and assessments are [*project*/**Assessment**]

[2] These were written by the Implementing Partner and therefore offer limited objectivity

LIMITATIONS

Lessons and recommendations are based on those identified by previous evaluations; they may not necessarily reflect changes implemented since then. Furthermore, the absence of some mid-term or final evaluations inevitably means that lessons are incomplete. Evaluations and Reports are taken at face value, although historically USAID might not have accepted all the findings, recommendations or conclusions at the time. Only one evaluation systematically identified previous interventions that were not sustainable, therefore some promising activities that were praised in evaluations written before the close-out of a project, might have subsequently failed to survive the transition to local ownership. Nevertheless, where themes emerge, they are captured in this Review.

THEMATIC ANALYSIS OF EVALUATIONS AND FINAL REPORTS

FAMILY PLANNING (FP)

OVERALL LESSONS

- Contraceptive effectiveness, rather than contraceptive use, is the key determinant of fertility stagnation in Jordan [IRH/Eval]
- Community Outreach needs to go beyond information sharing to active engagement of community members [HSD/Eval]
- The USAID strategy should focus at HC level, where the bulk of FP interactions take place. Interventions could include HC renovations, supervision, referrals and accreditation [HSS II/Eval]
- Engagement with stakeholders at central and health directorate level, and facility level improved ownership [HSS II Bridge/Rep]

BEHAVIOR CHANGE COMMUNICATION

Changing Social Preferences and Gender Norms:

- Include the "social" aspect of social and behavior change communication (SBCC) to deconstruct gender and social norms, rather than targeting or correcting specific behaviors [IRH/Eval]
- The need to address the cultural preference for male children, which often results in families continuing to have children until a sufficient number of male children are produced, was not part USAID's programming or design. Changing deeply-seated social preferences for male children is likely to require considerable social research to identify messaging that is culturally acceptable and not perceived to be based on a foreign agenda [SHOPS/Eval]
- In a 2009 study, only two-thirds (65%) of women thought that modern methods were more effective than traditional methods [IRH/Eval]
- Opposition from husbands only account for about 2% of method choices, and a similar percent for discontinuation [IRH/Eval]
- A lack of attention to gender differentials in messaging and engagement "may have diluted achieving objectives" [SHOPS/Eval]
- BCC should be preceded by research to carefully identify messaging and segment audiences, recognizing the sensitivities relative to the perception of imposing Western agendas [SHOPS/Eval]
- The *Together for a Happy Family* campaign targeted over 2 million people (just under half the population at the time) and was the first-ever national campaign to specifically target men. From 1996 to 2000 – when the campaign was conducted – the number of men who considered the IUD safe for their wives rose from 34% to 50%, respectively; while the number of men considering the pill safe increased from 25% to 36% [IRH/Eval]
- Use of Social Workers (1996-2015): Interviews conducted in Jordan showed that the social worker outreach program may be an effective and targeted way to promote behavior change and communication, in particular among husbands and mothers-in-law [IRH/Eval]

BCC targeting Youth:

- MOH school health and sports programs are excellent channels for youth engagement and could be used to encourage youth to delay having children after marriage and plan for their lives [IRH/Eval]
- The Health Competent Schools Initiative (HCSI) was described as "cost effective and low maintenance", and subsequently institutionalized in the Ministry of Education through the Royal Health Awareness Society. Once materials were distributed to schools and the teachers trained, there was limited continuing involvement needed with individual schools [JHCP/Eval]
- Behavior change and expanded awareness of health competency issues among students was "substantial" suggesting a long-term impact on student health [JHCP/Eval]
- The University Ambassador Initiative was "not recommended for continuation" for multiple reasons. These included: the training for ambassadors was insufficient to address student shyness about FP; it failed to give them tools for addressing FP issues (e.g., gender-specific groups, instructional DVDs or protected Web sites, external expert speakers); there was irregular follow-up from JHCP; and the lack of a longer-term plan reduced impact and institutionalization. Student peer approaches, while effective, were considered labor intensive, with a relatively small reach that required audience-specific messages and material.

BCC for Newly Married and Parents of Newborns:

- *Mabrouk* was identified as a cost-effective, innovative way to reach a primary audience for FP messages through the Civil Status and Passports Department, achieving national scale. *Mabrouk I* was aimed at newly-married couples and *Mabrouk II* targeted those who came to register a birth [JHCP/Eval]. However, a subsequent evaluation called into question the actual content and messaging. The intervention ceased when the JHCP activity ended [IRH/Eval]

BCC through Workplaces:

- Despite low levels of exposure to interventions (8% to18%), behavior change related to stigma showed a substantial improvement among those exposed to the program compared to those not part of the intervention showed [EHP/Rep]

Religious Leaders:

- The involvement of religious leaders in addressing FP issues was a powerful intervention that increased the impact of all other activities and FP projects, by opening up public dialogue on an otherwise taboo topic. Not all trained leaders integrated FP messages into their sermons [JHCP/Eval]
- Participating religious leaders had a high opinion of USAID, despite earlier misgivings [JHCP/Eval]

Mass Media:

- Despite a well-planned media campaign, evaluation results suggest that coverage was not as far-reaching as expected, probably due to the fragmented nature of Jordanian media [JHCP/Eval]

FP ACCESS

Vouchers:

- CHWs provided vouchers for free FP to women, but their value was diminished by the lack of free transport and the locations where it could be exchanged [SHOPS/Eval]
- Increased access to FP, commodities and services requires subsidized vouchers for FP consultation products until a critical mass has been built for sustained social change in attitudes and decision-making for long-term, continuous use of FP [SHOPS/Eval]

FAMILY PLANNING COUNSELING

- Provider bias in counseling is a repeated theme in most evaluations [HSD/Eval]. Health programming should focus heavily on addressing misconceptions about the side effects of contraceptives, targeting medical practitioners, clinic staff, pharmacists, CHWs, and the general public [SHOPS/Eval] The IRH (2016) report recommended a specific focus on the "social" aspect of SBC to tackle cultural issues
- Counseling was normally only on request [HSD/Eval]
- Some clinics lack appropriate privacy [HSD/Eval]
- "Internal referrals within a health center" that identified unmet need, alongside "increased health education sessions in health centers" generated far higher rates of switching to modern methods (98% and 89% respectively) than couples counseling or referrals to a health center. Both of the successful approaches reached far larger numbers of women in the study of 858 women [HSS II bridge/Rep]

Community Health Workers (*see also HSS – CHWs)*

- In-home couples counseling through CHWs increased uptake of modern methods by around 59%, compared to a 48% increase for women counseled alone, compared with those who received no counseling [SHOPS/Eval]
- USAID should strengthen CHW-clinic collaboration and create direct and active CHW linkages to UNRWA and other NGO clinics in the target catchment areas in order to increase FP demand [SHOPS/Eval]
- Community outreach efforts have been shown to be effective in increasing uptake of modern methods and should be expanded as they serve a dual role of behavior change and service provision [IRH/Eval]

METHOD MIX AVAILAIBILITY

- The increases in use of traditional methods and decreases in the use of more effective methods suggest that much more needs to be done to change strong social norms and behaviors of all women, men, family members, health service providers, in addition to the political will of policy-makers [IRH/Eval]
- Expanding the method mix and encouraging shifts from traditional methods to more effective modern methods is an important priority. This will require improving service providers' counseling biases, in addition to increasing community outreach activities involving women, men, mothers-in-law, and other influential opinion leaders [IRH/Eval]
- Campaigns for oral contraceptives and Intrauterine Device (IUDs) boosted the uptake of IUD insertion services, the effect on demand was transient [SHOPS/Eval]

Method-Specific Issues

- IUDs are the most popular FP method in Jordan; they have the lowest discontinuation rates and the greatest impact on CYPs [HSD/Eval] [HSS II/Eval]

- Access to IUD-trained staff was reported as patchy in multiple evaluations, and dropped 12% between 2010 and 2012 due to legal ambiguity prompting many midwives to stop fitting IUDs. Prior to this 47% of IUDs were fitted by midwives (2009); in 2011 this dropped to 26% [HSS II/Eval]
- The Women and Child Health Directorate at MOH were "resistant" to the introduction of a modern natural method of FP [HSS II Bridge/Rep]

FP COMMUNITY-BASED SERVICE DELIVERY

Quality Improvements within Clinics

- Use of the Service Delivery Improvement Collaborative (SDIC) in the busiest Health Centers, resulted in uptake of FP more than doubling. This was attributed to "increased efficiency, awareness and quality of services" [HSS II Bridge/Rep]
- A similar approach in hospitals had minimal impact, which the evaluation ascribed to lower levels of autonomy [HSS II Bridge/Rep]
- For religious or cultural reasons most Syrian and Jordanian husbands were against allowing their wives to seek services from male doctors, except (i) in emergencies or (ii) for lack of an alternative female doctor [IRH/Eval]

JAFPP and other NGOs:

- Between 2002 and 2012, the percentage of women accessing modern contraceptive methods from JAFPP virtually halved, while the percentage relying on a private doctor dropped by almost two-thirds (although uptake through private hospitals/clinics doubled) [IRH/Eval]
- SHOPS was tasked with assisting Jordan Association of Family Planning and Protection (JAFPP) to become more sustainable. Despite the recommendation to raise prices three times, JAFPP did so only once, generating a 40% rise in revenue. However increased salaries and overheads meant that cost recovery remained stubbornly at 58%. The evaluation concluded that "JAFPP's leadership is not inclined toward sustainability" [SHOPS/Eval]
- This was supported by an OIG finding (2014): "JAFPP did not make progress toward its financial sustainability target", noting it lost money on every client [OIG report cited in SHOPS/Eval]
- Provide TA and financial support to a wider range of NGOs, such as the Institute for Family Health [IRH/Eval]

Private Sector:

- Interventions such as Public Private Partnerships (PPP) did not have a tangible partnership mechanism for sustainability built into the design [SHOPS/Eval]
- Training should be expanded to pharmacists to improve FP counseling on contraceptive effectiveness and correct use [IRH/Eval]
- A Public Private Partnership grant fund should be established for implementation of joint FP-related activities [SHOPS/Eval]
- A private sector partnership with Bayer Schering Pharma (BSP), enabled the introduction of EBM approach. More than 1,790 private sector physicians participated in one or more PSP-Jordan training programs [PSP/Rep]

- To better engage the private sector, the curriculum was expanded to include topics of interest to providers, including cancer and diabetes, and sessions were scheduled in short segments in order to meet providers' competing demands [PSP/Rep]
- A range of incentives motivated private providers to deliver FP, including opportunities to update clinical skills and knowledge and to earn CME credits [PSP/Rep]

HOSPITAL-BASED POST-PARTUM FP

- A pilot initiative offering post-partum FP counseling through private hospitals demonstrated significant potential for increasing FP access to women [SHOPS/Eval]. This was contradicted by a subsequent evaluation which found modern contraceptive use was at 46% three months postpartum compared to a national average of 42%. The difference could also be attributed to more educated women using the private sector [IRH/Eval]
- In the public sector, sustainability was affected by a lack of staff; the requirement for existing staff to take on additional work, and the need for hospitals to supply IEC material [SHOPS/Eval]
- Expand post-partum/post-miscarriage FP to all public hospitals, and follow up PPFP with a phone call [IRH/Eval]

REPRODUCTIVE & MATERNAL HEALTH (RMH)

OVERALL LESSONS

- Pursuing an integrated MCH/FP program is important going forward. This might include allowing projects to tackle previously un-identified issues in order to aide ownership by the health facility and their staff [HSS II/Eval]
- Improvements in MNCH can be challenging because they do not fall within the mandate of any one Directorate within MOH [HSS II Bridge/Rep]

SAFE MOTHERHOOD

- Although Jordan has some of the highest levels of ANC uptake, there remains a lack of clarity about how many visits are required [HSD/Eval]
- Some women do not receive the full range of tests; while iron and folic acid not always available [HSD/Eval]
- The introduction of Evidence Based Medicine (EBM), updating of clinical guidelines and creation of Centers of Excellence were highly valued by the MOH [HSS II/Eval]. Despite it being "valued" the stand-alone evidence-based medicine (EBM) HSS approach was found not improve knowledge or practice scores [IRH/Eval]

CHILDBIRTH

- A lack of respect, dignity, and humanity during their delivery is a significant issue [HSD/Eval]
- Active Management of the Third Stage of Labor introduced cord clamping 1-3 minutes after birth.[3] Implementation across six hospitals was patchy because of a need for additional clinical and management capacity [HSS Bridge II/Rep]

[3] WHO guidelines recommend "Waiting to clamp the umbilical cord for 2–3 min, or until cord pulsations cease" (WHO 2014)

NEWBORN AND CHILD HEALTH (NCH)

- One HSS activity supported the introduction of a nasal-bubble continuous positive airway pressure (NB-CPAP) protocol at 30 MOH and RMS hospitals. Later six hospitals were provided more intensive support. Results proved variable, in part due to data collection issues. Ongoing availability of CPAP consumables was described as a limiting factor for sustainability [HSS II Bridge/Rep]
- A pre-conception component for unmarried youth in universities and out-of-school youth. (*This appeared to not learn the lessons from the evaluation of JHCP's project activities in Universities*) [HSS II Bridge/Rep]
- The JMMSR conceptual framework built upon existing structures and procedures. Almost all births are in health facilities, which lends itself to a facility-based follow-up. Requiring all births to be recorded correctly and reported to DOS would aid the tracking of all births [HSS II Bridge/Rep]
- Substantial investments were made to improve infrastructure for maternal and newborn care and emergency services in public hospitals around the country [HSS II/Rep]

NUTRITION

INFANT AND YOUNG CHILD FEEDING

- More than half of respondents did not receive support with breastfeeding because of staff shortages and a focus on the newborn rather than the mother [HSD/Eval]
  Recommendation: Identify staff who can assist with the early initiation of BF

HEALTH SYSTEMS STRENGTHENING (HSS)

OVERALL APPROACH

- Health Directorates were not engaged and HAD directors felt "overstepped and ignored" [HSD/Eval]
- Uniting a health facility and their Health Directorate teams in a common goal allowed them to achieve rapid progress [HSS II Bridge/Rep]
- There is insufficient priority to components to improve access (e.g. Client Service Station, mitigating gender barriers) [HSD/Eval]
- The need for communication strategies to ensure buy-in among both high- and mid-level officials for the activities was woefully underestimated and is a fundamental lesson for the future [HRH2030/Eval]
- The health systems approach may not be enough as a standalone approach to address contraceptive effectiveness, in addition to clients' and providers' strong social norms around fertility and family size. For instance, while the health systems approach has been successful in increasing family planning use, it has had a weaker effect on reducing method discontinuation and provider bias, both of which are strongly affected by social norms and can ultimately affect the national mCPR [IRH/Eval]

SERVICE DELIVERY

Accreditation

- Accreditation was perceived as sustainable, and described as "the shortest and best way to improve [ourselves]" [IRH/Eval]
- Supporting accreditation of Primary Healthcare facilities was found to have raised service quality, while accreditation activities related to FP standards led to a 13% increase in CYPs in participating HCs, compared with 5% in non-participating HCs [IRH/Eval]
- The Private Hospital Association's hospital accreditation requirement for family protection was a critical incentive in motivating private hospitals' participation in the VAW initiative [PSP/Rep]

Community Health Workers/Social Workers: *(see all FP – Community Health Workers)*

- Home visits are one of the most effective methodologies to raise awareness and encourage a woman to identify her needs for family planning and seek services [IRH/Eval]
- Women find CHW visits beneficial, but >259,000 visits yielded just 12,000 anemia vouchers issued and only one-third were used for tests [HSD/Eval]
- Women visited by CHWs adopt modern methods following visits three, four, seven, and eight, with the largest number of women adopting following the fourth and eighth visits. Once a new user adopts an FP method, she requires continued counseling and support in the first three to six months of use to help reduce the likelihood of discontinuation [PSP/Rep]
- Some CHWs had trouble mastering a host of health topics while others spent less time on challenging topics such as family planning and instead gravitated to other health messages [PSP/Rep]
- Community Outreach needs to go beyond repeating health messages and embrace active engagement of community members [HSD/Eval]
- Link and strengthen service delivery components with community-based approaches (for example social worker outreach and HSS II Bridge models) [IRH/Eval]
- The outreach program should be continued and expanded to reach areas with underserved and very rural and Bedouin areas [IRH/Eval]

Community Health Committees:

- Potentially effective at raising key issues, while some "perpetuate misinformation about FP", although Health Directorates had minimal knowledge of their activities [HSD/Eval]
- CHCs were previously measured on activities, rather than how effective they were [HSS II/Eval]
- **Mitigating gender barriers**: one CHC works with the community to provide information for husbands at Mosques and through events to refer them to the hospital for STD screening, and to help them recognize the importance of ANC and FP for their wives. They also discuss GBV in the community. Such efforts are led by active CHC leaders/providers [HSD/Eval]
- Increase civil society engagement and feedback for improved health sector accountability, especially related to improved access and quality, and enhancing gender-responsive service delivery [HFG/Review]

- In 2014, two CHCs were supported legally transition into community-based organizations (CBOs) capable of fundraising and providing information and services to their target communities

Community Scorecards:

- The use of Community Scorecards should be reformed or USAID should cease using them because community members are not aware of or empowered then [HSD/Eval]

HUMAN RESOURCES

Supportive Supervision and Mentoring:

- USAID-funded supportive supervision and mentoring needs to be aligned with MOH's system (not in parallel) [HSD/Eval]
- The current system was found to be a monitoring tool/check box unless managers were truly engaged, and not considered to be well-aligned with MOH's MCH supportive supervision [HSD/Eval]

Staffing Levels and Turnover:

- Turnover rates of between 50-60% brought into question the sustainability of training clinical staff in some of the main teaching hospitals [HSS II/Eval]
- High staff turnover is a particular problem in IT for MOH, because of recruitment of staff into the private sector. This creates challenges for IT and HMIS system maintenance [HSS II Bridge/Rep]
- There must be a focus on systems and on processes strengthened that will have longevity past individuals; and on strengthening the role of mid-level staff who will be MOH leaders of the future [HFG/Review]
- There is an absence of clear criteria for the allocation of staff to health facilities, resulting in some Health Centers being over-stretched while others had staff that lacked core competencies [HSS II Bridge/Rep]

Staff Training and CPD:

- There is a "large gap" between pre-service education for physicians and midwives and the actual skills the MOH needs from these cadres [HSS II Bridge/Rep]
- Improve Ob/Gyn residency programs [IRH/Eval]
- Focus training on reducing provider bias and misconceptions about modern methods [IRH/Eval]

HR Management Practices:

- Training, facilitating policy development, and drafting various tools used in HR management, would not lead to change on their own; they were necessary but not sufficient for change [HRH2030/Eval]
- Where supervisors also attended the training, there were more positive outcomes in areas such as sharing information, day-to-day management, showing flexibility, conducting more meetings with agendas and minutes, and commitment to regular attendance [HRH2030/Eval]
- The need for an enabling environment was under-estimated. Old hiring practices and improper selection of training participants continued after USAID's HR management training [HRH2030/Eval]

- The MOH and Civil Service Bureau compensation systems did not recognize or reward innovation or increased performance [HRH2030/Eval]
- Recommendation: USAID should also consider combining service delivery and infrastructure projects with interventions that are more challenging to stakeholders, including HRH interventions. This would allow the more challenging interventions to leverage the relationships and goodwill created by infrastructure activities. Last, USAID should consider a multisectoral approach to HRH that includes the Ministries of Finance, Higher Education, and Public Sector Development [HRH2030/Eval]

FINANCE

Programming Considerations:

- PFH needs to work closely with EDE and DRG to avoid duplication on fiscal reform [HFG/Review]

Specific Activity Issues:

- Capacity building at subnational governorate level in both financial management and planning is critical given ongoing decentralization of capital funds [HFG/Review]
- The private sector will be critical in Jordan's mixed health system and USAID needs to engage through key initiatives, e.g., the Mandatory Insurance bylaw facility construction
- Recommendation: Integrate a result-driven purchasing mechanism to drive efficiencies and quality improvements into Jordan's health financing system [World Bank (2017) in HFG/Review]
- Strategic planning of new health facility construction is important because of decentralization of budgets to those who lack experience in handling such substantial budgets [HFG/Review]

INFORMATION SYSTEMS

System-Specific Recommendations:

- While development of HMIS was helpful, USAID has left a legacy of multiple, parallel information systems [HSS II/Eval]
- Systems such as ISDIC needs to re-orientate beyond clinical pathways to systemic changes in accountability, supervision, leadership and ownership [HSD/Eval]
- Data is not always used effectively for decision making and sometimes data collection ran in parallel to government systems (e.g. HAKEEM), resulting in increased workload [HSD/Eval]
- Multiple evaluations found USAID-funded systems were perceived as "owned" by the IP rather than MOH (e.g. ISDIC) [HSD/Eval]
- Accountability for the JMMSR was poorly defined, and without consultation/cooperation with UN agencies, which limited learning from other countries [HSD/Eval]
- Feedback loops need to be tightened to help make data more valuable to providers (e.g. JMMSR) [HSD/Eval]
- HSS II worked on developing an off-line version of the Perinatal Information System to improve system flexibility and increase efficiency of facility staff in collecting data [HSS II/Rep]

Data Use:

- Priority should be given to activities that create Data Demand and enable Information Use [HFG/Review]
- Set long-term FP use as a clear project target and track discontinuation [SHOPS/Eval]
- Log-frames should reflect outcome data to improve project focus [HSS II/Eval]

LEADERSHIP AND GOVERNANCE

- The IRH evaluation of FP in Jordan identified three specific failures of commitment: expressed, institutional and financial. Earlier desk reviews identified the "lack of government funding as the key limiting factor in family planning program sustainability" (HPI 2009) [IRH/Eval]

ISSUES AND RECOMMENDATIONS RELATED TO MONITORING AND EVALUATION

MONITORING

- Despite high levels of reported compliance for clinical pathways for FP, ANC, delivery and PPC, the same high-quality of care was not mirrored in client perceptions. This points to a need for better routine triangulation of outputs and outcomes [HSD/Eval]
- The M&E plan did not have a documented theory of change to tell the story of how activities will lead to outcomes (at multiple levels), nor did it list assumptions upon which the design was based [SHOPS/Eval]
- Indicators should measure outcomes (or at least outputs) and targets should be ambitious rather than based on a slight increase in the baseline position [HSS II/Eval]
- One study from 2014 used existing data from birth registries to estimate TFR rather than waiting for a DHS [IRH/Eval]

EVALUATION

- End of program evaluations typically report during the life of an activity. In doing so, they are unable to assess the degree of sustainability of individual components. Annex B originally compiled by IRH reviews lists seven significant pilot projects that were either not scaled up, or were discontinued after the project activity ended.
- Field visits identified the importance of a functioning referral system among MOH staff, however the same staff indicated that the referral system was not well established and achievements were slow. This reinforces the need for field-level evaluation to assess actual achievements, rather than reported progress [HSS II/Eval]

ANNEX A - SUMMARIES OF INDIVIDUAL EVALUATIONS AND REPORTS

(in reverse chronological order for Evaluations, followed by IP Reports)

HEALTH SERVICE DELIVERY (HSD) (Evaluation)

Start	March 2016
End	March 2021
Value	$50,254,872
Focus	Health Systems Strengthening; RMNCH; Family Planning
Implementing Partner	Abt. Associates

The 2019 mid-term evaluation used four categories (Quality of Care; Barriers to Access; HSD Components; and Engaging the Community).

ISSUES AND THEMES IDENTIFIED IN THE EVALUATION:

Quality of Care

Clinical Pathways: although HSD monitoring information and a Provider survey for the mid-term evaluation found high levels of compliance for FP, ANC, delivery care and PPC, this was not mirrored in client perceptions.

- FP counseling not consistently delivered; evidence of provider bias or misinformation in FP advice; counseling often not delivered in a private place (described as “rated: red”)
- Fewer ANC visits than the expected 8 visits (between 3 – 6). There was a lack of clarity about how many visits were required. Some women did not receive full range of tests; iron and folic acid not always available (rated: amber)
- Most women reported not being treated with respect, dignity, and humanity during their delivery (rated: red)
- More than half respondents did not receive support with breastfeeding (challenge with staff shortages). The focus was on the newborn, not the mother. (rated: amber)

Barriers to Access

Lack of engagement at Health Directorates meant that HAD directors felt “overstepped and ignored” by HSD. The report also identified that the program had not given sufficient priority to components to improve access (e.g. Client Service Station, mitigating gender barriers).

Access to IUDs and FP counseling was reported as “inconsistent”. Counseling was normally only on request, and access to IUD-trained staff was unreliable.

HSD Components

- Supported Supervision: appears to be a monitoring tool/check box unless managers are truly engaged, and not considered to be well-aligned with MOH’s MCH supportive supervision
- Client Service Stations: the idea is welcome but few clients were aware of CSS, and waiting times (30 mins to 3 hrs).

- JMMSR: Accountability has been poorly defined, and without consultation/cooperation with UN agencies, which limited learning from other countries

Engaging the Community

- Community Health Committees: Potentially effective at raising key issues, while some "perpetuate misinformation about FP". Minimal knowledge of their activities at Directorate level
- Community Scorecards: community members are not aware or empowered by Community Scorecards; providers are "equally not engaged"
- Community Outreach: most women found the visits beneficial, but >259,000 visits yielded just 12,000 anemia vouchers issued and only one-third were used for tests

Program-Management Issues

- M&E data was reported as being "important" but not "always used effectively for decision making". In some instances, HSD data collection ran in parallel to HAKEEM, resulting in increased workload.
- Ownership was also an issue for ISDIC, which was still perceived to be "owned" by HSD rather than MOH
- There were limited uses of outcome measures. These need to be measured more systematically
- ISDIC needs to re-orientate beyond clinical pathways to systemic changes in accountability, supervision, leadership and ownership

RELEVANT LESSONS

RMNCH - general

- KII and FGDs are required to verify clinical pathways
- Involve beneficiaries [more effectively] in the design of interventions
- Tighten accountability and feedback loops for JMMSR
- Supportive supervision & mentoring needs to be aligned with MOH system (not in parallel)
- Community Outreach needs to go beyond information sharing to active engagement of community members

Family Planning

- Misinformation and misconceptions continue about FP causing infertility; validation of quality of care indicators is required to identify where a provider is spreading misinformation
- Clinics lack privacy [for FP]

Antenatal Care

- Communication about the number of visits needs improving
- Access to tests, iron & folic acid needs improving

Childbirth:

- Look at ways to improve the consistency and quality of care ("humanized")

Postnatal Care:

- Identify staff who can assist with the early initiation of BF

Child Health:

- Ensure CHWs are engaging with mothers, not simply repeating health messages

Community Engagement

- More engagement with CHCs can maximize the benefits of RMNCH+
- Review facility & population needs to identify the basis of the change package required
- Syrians in particular do no understand service eligibility, free coverage or availability
- Either substantially reform community scorecards, or cease using them

Engagement with GOJ

- Work directly with Health Directorates: at a minimum MOH should be partners, but under J2SR they should be taking more of a lead

NOTED EXAMPLES OF BEST PRACTICE

Accountability for quality of care

RMS hospital manager and health facility manager that using the indicators each week or each month (periodically) to review staff and facility progress and offer support for improvements or help in addressing challenges. This resulted in better performance by staff with measurable effect on health outcomes. They demonstrate accountability through the data on a day-to-day basis.

Reaching the most vulnerable

In one facility, the doctor and midwife make visits to the community to bring health care to remote areas for women who cannot access the facility.

Mitigating gender barriers

A CHC works with the community to provide information for husbands at Mosques and through events to refer them to the hospital for STD screening, and to help them recognize the importance of ANC and FP for their wives. They also discuss GBV in the community. Such efforts are led by active CHC leaders/providers.

Functioning CSS is appreciated by clients and staff

Good example in a facility working in one of the poorest regions. In this facility, direction cards are being used for example to the appreciation of staff and clients

JORDAN HUMAN RESOURCES FOR HEALTH 2030 (HRH 2030)
(Midterm Evaluation)

Start	2015
End	February 2019 (ended prematurely)
Value	10,848,000
Focus	HSS - Human Resources
Implementing Partner	Chemonics

This was the first HSS activity in Jordan to be solely focused upon human resources in the health sector. The goal of HRH 2030 Jordan was to work with the MOH to increase the accessibility to a higher-quality health workforce to boost service quality and coverage, helping Jordan to achieve its goal of universal health coverage. The activity aimed to support 30,000 MOH staff – including 16,000 service providers – to better meet the needs of the population. The activity initially had four key objectives:

1. Optimize performance, productivity, and efficiency of the health workforce
2. Increase competency, distribution, and number health workers
3. Improve public sector stewardship and leadership
4. Increase sustainability of health workforce investments

A mid-term evaluation identified significant challenges, resulting in a recommendation to narrow the focus of the work to two priorities. Around the same time as the review findings were announced, a very substantial overspend was identified, resulting in the activity being terminated a few months later by the Implementing Partner, a year earlier than anticipated.

ISSUES AND THEMES IDENTIFIED IN THE EVALUATION:

The evaluation asked seven specific questions.

Evaluation Question 1: To what extent are HR practices at the MOH improving and why?

Fundamentally, the review found that HRH2030's inputs, such as training, facilitating policy development, and drafting various tools used in HR management, would not lead to change on their own; they were necessary but not sufficient for change. Only those managers colleagues or staff regarded as intrinsically motivated attempted new management approaches or used new tools. The MOH and CSB compensation systems do not recognize or reward innovation or increased performance.

Evaluation Question 2: To what extent are staff receiving training and using their newly acquired skills? Why or why not?

HRH2030 trained between 300 and 400 people. Participants trained in HR management, HR development, and health management and leadership only applied their training to a limited degree due to a lack of time and management support. Where supervisors also attended the

training, there were more positive outcomes in areas such as sharing information, day-to-day management, showing flexibility, conducting more meetings with agendas and minutes, and commitment to regular attendance.

Evaluation Question 3: To what extent are capacity, knowledge management, transparency, and accountability in planning, managing, and retaining Jordan's health workforce increasing? Why or why not?

The review found some signs of improvement in policies and procedures, although FGDs and KII frequently noted the continuation of old hiring practices, improper selection of training participants, lack of transparency in employee appraisals, and lack of fairness in assessing employee performance and determining promotions and incentives. FGDs and key informant interviews also indicated an absence of transparency and accountability.

Evaluation Question 4: To what extent is the Jordan HRH2030 Activity influencing women's management and leadership in the health workforce?

At the time of this evaluation, therefore, HRH2030 had not had any influence on women's management and leadership in the health workforce, though this appears to be due to the Activity's timeline rather than the quality or appropriateness of its interventions.

Evaluation Question 5: What are the next steps for institutionalizing the new law that requires CPD for Jordan's health workforce?

The reviewers identified the need for: dissemination; development of CPD capacity for remote areas; monitoring and registration, and coordination

Evaluation Question 6: How can USAID best sustain the achievements and reforms accomplished under HRH2030 in Jordan?

Three aspects were identified: (1) Supporting the relicensure bylaw; (2) Engaging with the Civil Service Bureau, to assist in revising bylaws and notably articles relating to promotion and training and (3) Supporting the Women in Leadership Network to support women leaders

Evaluation Question 7: What does the evaluation team recommend regarding any potential follow-on HRH activity? If a follow-on is necessary, should it be similar to HRH2030, or be combined with another existing USAID/Jordan activity, or take the form of direct support to the government of Jordan through the utilization of partner government systems?

USAID should consider reducing the number of awards but implementing larger activities in the period following HRH2030. It should also consider combining service delivery and infrastructure projects with interventions that are more challenging to stakeholders, including HRH interventions. This would allow the more challenging interventions to leverage the relationships and goodwill created by infrastructure activities. Last, USAID should consider a multisectoral approach to HRH that includes the Ministries of Finance, Higher Education, and Public Sector Development.

The conclusion noted the following themes:

- Activity documents do not mention scaling up; furthermore, scale-up is not possible using approaches that rely solely on the Activity's own resources and staff without engaging the capacity and resources of the host country

- Knowledge about HRH2030 and its interventions was poorly disseminated. There was an absence of a clear strategy for communication within the MOH at central and directorate levels. This lack of communication proved detrimental to participation and to the visibility of MOH achievements, and to garnering support for change and new policies. It perpetuates the current perception that little or nothing has changed for the better at the MOH.

RELEVANT LESSONS

- HRH2030 needed to develop a sustainability plan across the activity as a whole, rather than at the intervention level
- The need for communication strategies to ensure buy-in for the activities were "woefully underestimated". This applied at high-level and with mid-level officials and is a fundamental lesson for the future
- Prioritize local expertise and institutions where possible. This resulted in local consultants being contracted rather than local institutions.
- HRH2030 succeeded in training only around 300-400 individuals, and crucially had under-estimated the need to establish an enabling environment that would facilitate changes in practice. "Old ways" of doing things continued. Training a supervisor and a manager provided a more supportive environment for changes to be implemented

Additional notes:

- HRH2030 was unclear whether their client(s) were MOH or the staff in MOH. This fundamental issue affected how they developed their program activity. The focus on the latter for training led to a minimal legacy. Had they sought to develop courses in conjunction with the CSB or Institute for Public Administration, they may have created something more culturally appropriate that outlasted the activity

HEALTH FINANCE AND GOVERNANCE (HFG) (Internal Assessment)

Start	November 2016
End	TBC
Value	TBC
Focus	HSS - Finance (UHC; health insurance); Governance
Implementing Partner	Palladium

USAID Washington and staff from Palladium's Headquarters undertook a review to refine the scope of work for the HFG project at the end of the first year.

ISSUES AND THEMES IDENTIFIED IN THE REVIEW:

The review identified a two-track focus to HFG's work. The first addressed high-level legal and regulatory reforms that would have "major structural impact on the health system". The second track focused at sub-national level to deliver tangible, short- and medium-term gains in health sector efficiency and governance.

The review provided specific feedback on the following:

- Improved enabling environment for UHC: engagement is critical to continuing high visibility partnership with MOH to strengthen enabling environment
- Efficiency in public health sector resource use, including cost containment and increased resources for preventive/primary health care: We advise enhancing PHC focus as a priority
- More equitable and sustainable health coverage is expanded: Developing true insurance functions may not be feasible in current environment. There seems to be very limited political will for an EPHS. Proposals for coverage expansion to the uninsured need to rely on better data and strategies based on the CIP, and align with ensuring sustainability
- Capacity to use financial and performance data in budgeting, monitoring and policymaking is strengthened: The USAID Fiscal Reform Project is undertaking work to support Results Orientated Budgeting (ROB). Given the described pace of pilot ministry implementation and limited ability to drive efficiencies through ROB, we do not see this as a critical area for engagement
- Innovative public private partnership financing mechanisms for achieving UHC are implemented: We did not find any defined plans or models [for private sector finance in UHC] and hence it is unclear what JHFG support should focus on. The private sector will be critical in Jordan's mixed health system and JHFG should engage through key initiatives, e.g. the Mandatory Insurance bylaw
- Improved HHC and MOH health sector leadership, coordination and multi-sectoral engagement: JHFG should build capacity at the MOH but HHC-related project investments will have to be highly focused to ensure relevance. Governance and decentralization will be addressed at a lower level. It was not apparent how the project plans to strategically engage media to advocate for UHC at the current stage of the project

- Strengthened capacity and authority to act at mid- and subnational levels: Capacity building at subnational governorate level in financial management and planning is critical given ongoing decentralization of capital funds.
- Strengthened individual and institutional capacity in professional administration, strategic and operational planning, financial management and M&E: Decentralization of financial management should be integrated into improved strategic planning and decision-making processes
- Increased demand for and use of high quality, transparently available data to inform decision making and monitoring in the health sector: Re-focus activities to create Data Demand and Information Use
- Increased civil society engagement and feedback for improved health sector accountability: Focus upon enhancing patient/health consumer rights, especially related to improved access and quality, and enhancing gender-responsive service delivery

Some of the original activities overlapped with other non-health USAID activities, such as the USAID Fiscal Reform Project. In other elements, (e.g. Gender Responsive Budgeting) the approach taken was too narrow.

RELEVANT LESSONS

- "Given high levels of turnover in senior staff at the MOH, there must be a focus on systems and on processes strengthened that will have longevity past individuals; and on strengthening the role of mid-level staff who will be MOH leaders of the future".
- PFH needs to work closely with EDE and DRG to avoid duplication on fiscal reform
- Gender-related programming needed to focus on civil society engagement to enhance consumer rights, especially rights of women and vulnerable communities
- The scale of project financial and intellectual resources devoted to [some of] the work was out of proportion to the likelihood of success in some of these areas within the life of the project
- Recommendations in the past, including in the World Bank publication "The Last Mile to Quality Service Delivery in Jordan" (2017), have emphasized the need to integrate a result-driven purchasing mechanism to drive efficiencies and quality improvements into Jordan's health financing system
- Strategic planning of new health facility construction is important because of decentralization of budgets to those who lack experience in handling such substantial budgets (JD 26 million in 2017)

JORDAN FAMILY PLANNING ASSESSMENT (Evaluation of previous USAID FP activities)

Start	2015
End	2016
Value	-
Focus	FP – stagnation of the TFR over the past decade
Implementing Partner	Institute for Reproductive Health, Georgetown University

Between October 2015 and March 2016, the Institute for Reproductive Health (IRH) at Georgetown University conducted an assessment of USAID/Jordan's family planning contributions. The assessment explored reasons for fertility stagnation in Jordan over the last decade. To tell the backstory of USAID programming in family planning, the IRH team conducted an extensive desk review of over 83 documents and 69 key informant interviews with 168 participants both in Jordan and Washington, D.C

ISSUES AND THEMES IDENTIFIED IN THE ASSESSMENT:

Summary

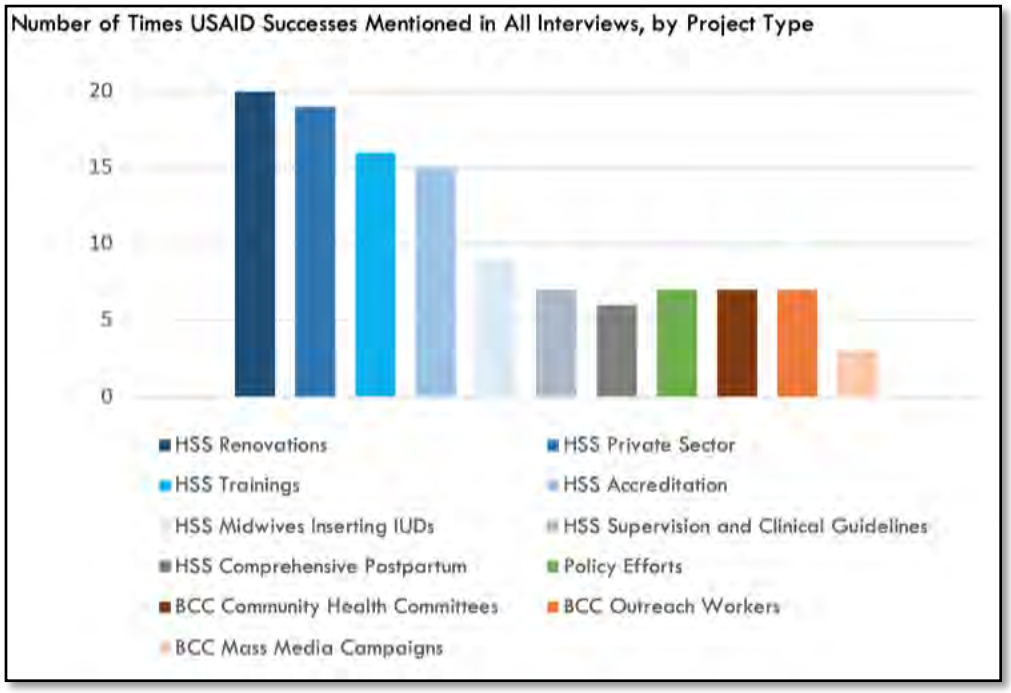
- The IRH team reviewed a number of different theories and evidence exploring TFR stagnation in Jordan. The results from this assessment show that contraceptive effectiveness, rather than contraceptive use, is the key determinant of fertility stagnation in Jordan. Jordan provides a context where family planning access and use are relatively high, but the diversity of methods used by women is low and has shifted towards less effective methods such as withdrawal.
- The increases in use of traditional methods such as withdrawal and decreases in use of more effective methods such as IUDs, suggest that much more needs to be done to change strong social norms and behaviors of all women, men, family members, health service providers, in addition to the political will of policy-makers.
- USAID's investment in health systems strengthening over the last decade has increased access to and use of family planning services. However, this investment has not necessarily translated into improved contraceptive effectiveness, identified above as a key determinant of fertility. As a result, the health systems approach may not be enough as a standalone approach to address contraceptive effectiveness, in addition to clients' and providers' strong social norms around fertility and family size. For instance, while the health systems approach has been successful in increasing family planning use, it has had a weaker effect on reducing method discontinuation and provider bias, both of which are strongly affected by social norms and can ultimately affect the national mCPR.

Additional Details

- Given the strong norms around family size and preference for sons, as well as misperceptions and biases against modern methods (see behavior change below),

increased efforts should be invested toward behavior change and communication and community-based activities addressing social norms

- An important focus of the work should be expanding the method mix in the country and encouraging shifts from traditional methods to more effective modern methods. This will require improving service providers' counseling biases, in addition to increasing community outreach activities involving women, men, mothers-in-law, and other influential opinion leaders.
- Community outreach efforts have been shown to be effective, and should be expanded as they serve a dual role of behavior change and service provision
- Shortages of female clinicians, and among those, not all are willing to fit IUDs
- Most Syrian and Jordanian husbands were against allowing their wives to seek services from male doctors for religious or cultural reasons, except in emergencies or for lack of an alternative female doctor (JCAP 2016).
- Only two-thirds (65%) of women thought that modern methods are more effective than traditional methods, which likely contributes to the relatively high prevalence of traditional method use in Jordan (JCAP 2015c)
- Opposition from husbands only account for about 2% of method choices, and a similar percent for discontinuation
- The role of the mother-in-law appears to be important and "increasing the baseline knowledge acceptance, and access to a range of hormonal methods may produce a generational impact.
- Data should measure the percent of demand met by modern methods. (E.g. 1997-2012: mCPR increased, and unmet need declined, but traditional method use increased proportionally faster than mCPR)
- In interviews with Key Informants, BCC-related issues were low down the list of perceived successes.



- Accreditation was perceived as sustainable, and described as "the shortest and best way to improve [ourselves]"
- Accreditation activities related to FP standards led to 13% increase in CYPs in participating HCs, compared with 5% in non-participating HCs
- The stand-alone evidence-based medicine (EBM) HSS approach was found not improve knowledge or practice scores
- Introduction of postpartum FP in private hospitals (partly because more educated groups use private sector services, and their rates of modern contraceptive use were at 46% three months postpartum compared to a national average of 42%.)
- The health systems approach may not be enough as a standalone approach to address both clients' and providers' strong social norms around fertility and family size. For instance, while the health systems approach was successful in increasing family planning utilization, it had a weaker effect on reducing method discontinuation and provider bias, both of which were strongly affected by social norms
- Initial investment in JAFPP has helped strengthen their services, but they have yet to reach financial sustainability. In addition, despite USAID training investments with private network doctors, their share of family planning services has drastically decreased (from 19.5% in 2002 to 7.4% in 2012)
- A key challenge moving forward entails identifying an appropriate balance in USAID investment and collaboration across public and private sector
- Between 2002 and 2012, the percentage of women accessing modern contraceptive methods from JAFPP virtually halved, while the percentage relying on a private doctor dropped by almost two-thirds (although uptake through private hospitals/clinics doubled)

Behavior Change

- The Together for a Happy Family campaign targeted over 2 million persons and was the first-ever national campaign to specifically target men. From 1996 to 2000 – when the campaign was conducted – the number of men who considered the IUD safe for their wives rose from 34% to 50%, respectively; while the number of men considering the pill safe increased from 25% to 36% (Cobb et al. 2003)
- Other behavior change approaches – such as the Mabrouk initiative – used premarital counseling as an entry to discuss life planning and family spacing among newly married couples. However the initiative had mixed results: although reports touted the Mabrouk initiative as effective, some interviewed stakeholders thought that the materials were not well-contextually adapted and that counselors needed more training. In addition, the initiative was not sustained after project end
- Use of Social Workers: A 2015 randomized study about the outreach program showed 48% and 59% gains in modern method uptake among the women-only counseling and couples counseling intervention groups, respectively, in comparison to the no-counseling control group. The study also showed lower use of traditional methods and fewer concerns about side effects in the intervention groups (SHOPS 2015c). Between October 2014 and September 2015, outreach workers conducted a total of 466,961 family planning counseling visits and generated 29,139 new users of modern "USAID covers around 70% of family planning projects on the ground (JCAP planning 2015a; projects p. 7).
- Provider bias: Research suggests that providers may at times refuse to prescribe hormonal methods until the woman has given birth to at least two children (Maffi 2013). In other instances, providers may be fearful of becoming liable for potential miscarriages. For

instance, some health service providers will not administer tetanus shots to pregnant women for fear of being held liable by the woman's family in the case of a miscarriage (Maffi 2013)

- More recent mass media campaigns (2010-2015) showed more mixed results.

"What should USAID's strategy be going forward?"

Community-centered SBCC and Engaging Men:

- Include the "social" in social and behavior change communication (SBCC) to deconstruct gender and social norms rather than targeting or correcting specific behaviors
- Link and strengthen service delivery components with community-based approaches (for example social worker outreach and HSS II Bridge models)
- At the community level, target men's engagement in family planning

Youth:

- MOH school health and sports programs are excellent channels for youth engagement. Encourage youth to plan for their lives and delay having children after marriage

Community health workers outreach program

- Home visits are one of the most effective methodologies to raise awareness and encourage a woman to identify her needs for family planning and seek appropriate services.
- The outreach program should be continued and expanded to reach areas with underserved and very rural and Bedouin areas

Health Systems Priorities

- Conduct an assessment of the health systems needs in response to the refugee crisis, and as per assessment, prepare strategies to educate and raise awareness among Syrian refugees on reproductive health, family planning, service providers, and services
- Improve Ob/Gyn residency programs
- Focus training on reducing provider bias and misconceptions about modern methods
- Expand post-partum/post-miscarriage FP to all public hospitals, and follow up PPFP with a phone call
- Provide TA and financial support to a wider range of NGOs, such as the Institute for Family Health
- Expand training of pharmacists to improve FP counseling on contraceptive effectiveness and correct use

RELEVANT LESSONS

- One study from 2014 used existing data from birth registries to estimate TFR rather than waiting for the next Demographic Health Survey
- Use of Social Workers (1996-2015): Interviews conducted in Jordan showed that the social worker outreach program may be an effective and targeted way to promote behavior change and communication, in particular among husbands and mothers-in-law

- J2SR: The report described USAID's substantial investment in FP in Jordan, while identifying three specific failures of commitment: expressed, institutional and financial. (Earlier desk reviews identified the "lack of government funding as the key limiting factor in family planning program sustainability" (HPI 2009))

STRENGTHENING HEALTH OUTCOMES THROUGH THE PRIVATE SECTOR (SHOPS) (Final Evaluation)

Start	July 2010
End	September 2015
Value	$38,062,336 (amended from $24,362,336 in 2010 to $33,362,336 in 2011 and an additional $4,700,000 in field support in 2012)
Focus	Family Planning and use of the Private Sector
Implementing Partner	Abt. Associates

SHOPS (also known through its Arabic name as "Ta'ziz") began in 2010 with the primary goal of expanding the access, quality and utilization of Family Planning (FP) services by partnering with the private and non-governmental sectors. SHOPS interventions were designed to overcome the challenge of Jordan's plateauing contraceptive prevalence and total fertility rates.

According to SHOPS 'Cooperative Agreement, family planning challenges were to be addressed by SHOPS as follows:

- Increasing the use of existing methods, particularly underutilized methods such as injectable contraceptives and implants;
- Increasing the range of product options in the injectable/implant category;
- Developing marketing and behavior change strategies to improve the acceptance of hormonal methods;
- Maintaining and expanding current collaborative relationship with pharmaceutical companies while exploring new partnership opportunities, and;
- Removing medical barriers (provider bias)

SHOPS worked closely with six grantee partners, building capacity in 78 service delivery points (clinics) across Jordan, four private hospitals (for post-partum FP), 300 network doctors, and 300 pharmacists, supported by a team of 200 community health workers (CHWs) referring women to SHOPS 'family planning outlets. (CHWs made 1.4 million household outreach visits, reaching 678,595 women of whom 89,600 were new acceptors of FP)

ISSUES AND THEMES IDENTIFIED IN THE EVALUATION:

Effectiveness

- SHOPS increased demand for, access to, and quality of FP services with targeted clients, however, cultural norms and practices that were not addressed through SHOPS are likely to have diluted the results to effect of reducing fertility to slow population growth
- Vouchers provided by CHWs referred women to private doctors and health clinics for cost-covered consultations for family planning decision-making, resulting in a 22 percent uptake in modern methods
- While SHOPS campaigns for oral contraceptives and Intrauterine Device (IUDs) boosted the uptake of IUD insertion services, the effect on demand was transient

- SHOPS' pilot initiative offering post-partum FP counseling through private hospitals demonstrates significant potential for increasing FP access to women at a critical juncture in their reproductive lives
- The lack of data tracked by SHOPS on discontinuation makes it challenging to address the issues of long-term modern FP and impact on Couple Years of Protection (CYP) and total fertility
- SHOPS' inability to contract with UNRWA (due to incompatible contracting protocols) resulted in a missed opportunity for engagement with ten percent of the target population for FP services, dampening project potential reach in UNRWA catchment areas

Gender

- The cultural preference for male children, which often results in families continuing to have children until a sufficient number of male children are produced, was not part of SHOPS' programming or design. Changing deeply-seated social preferences for male children may require considerable social research to identify messaging that is culturally acceptable and not perceived to be based on a foreign agenda
- Although men were recognized as significant influencers in family planning decisions, SHOPS lack of attention to gender differentials in messaging and engagement "may have diluted achieving objectives"

Sustainability

- Interventions such as Public Private Partnerships (PPP) did not have a tangible partnership mechanism for sustainability built into the design
- Based on current financial models and practices, JAFPP is not sustainable without donor funding, nor is the CHW program
- The level of clinic visits and clientele growth rate are unlikely to continue at the same rate as with SHOPS support, due to unsustainability of the uptake in FP services associated with voucher redemption

JAFPP

- SHOPS was tasked with assisting Jordan Association of Family Planning and Protection (JAFPP) to become more sustainable. Despite the recommendation to raise prices three times, JAFPP did so only once, generating a 40% rise in revenue. However increased salaries and overheads meant that cost recovery remained stubbornly at 58%. The evaluation concluded that "JAFPP's leadership is not inclined toward sustainability".

Theory of Change

- SHOPS' M&E plan did not have a documented theory of change to tell the story of how activities will lead to outcomes (at multiple levels), nor did it list assumptions upon which the design was based
- Future programming needs to consider the cultural context – norms and practices that are contrary to or could dilute intended results programming
- Systematic collaboration between the private sector and MOH could improve sustainability of FP gains in the private sector

RELEVANT RECOMMENDATIONS AND LESSONS

Effectiveness

- If USAID wishes to ensure increased access to FP, commodities and services should continue to be subsidized through vouchers for FP consultation products until a critical mass has been built for sustained social change in attitudes and decision-making for long-term, continuous use of FP
- Coupons for FP products should be continued but the process should be streamlined to eliminate the need for women to make multiple trips. A directory of participating pharmacists should be readily available in print or through mobile technology to eliminate uncertainty of travel and locations. Relationships should be facilitated between clinics and pharmacies; coupon expiration dates should be eliminated
- USAID should continue to fund CHWs and leverage them as a key resource to expand community outreach. USAID should strengthen CHW-clinic collaboration and create direct and active CHW linkages to UNRWA and other NGO clinics in the target catchment areas in order to increase FP demand
- Expand services of CHWs to include pre-marital girls, preconception, extended family members living in the same house and male relatives (husbands, fathers, brothers), and Syrian communities
- Health programming should focus heavily on addressing misconceptions about the side effects of contraceptives, targeting medical practitioners, clinic staff, pharmacists, CHWs, and the general public in order to increase the use of long-term methods such as IUDs, and to reduce discontinuation. Given cultural practices and norms in which information is delivered in-person, a cost/benefit analysis should be conducted of mass media versus social means such as CHWs and if possible, the impact of each on CYP
- Post-partum counseling through private hospitals should be expanded, following the model SHOPS supported at Specialty Hospital
- Strengthen PPPs by establishing a PPP grant fund for implementation of joint activities by private/public FP actors
- Performance based grants should have a one-year grace period to allow grantees to build adequate capacity and systems to measure performance and meet targets
- Performance based grants should continue to be used as a contracting mechanism, directly tying key benchmarks to activity/project objectives of increased FP demand, access and cost recovery
- Set long-term FP use as a clear project target and track discontinuation

Gender

- Programming objectives, activities, and indicators need to acknowledge cultural norms and practices relative to family size and preference for male children. Such acknowledgement should include behavior change communication to change these norms and practices; identify other stakeholders who are conducting behavior change communication to change these norms and practices; or lower expectations to account for cultural norms and practices
- If behavior change communications is conducted it should be preceded by research to carefully identify messaging and target markets, and recognize sensitivities relative to the perception of imposing Western agendas

- Programming objectives and activities, and indicators need to acknowledge husbands' role in family planning decisions; gender sensitive interventions and messaging should be designed accordingly

JAFPP

- If JAFPP sustainability is a priority for USAID, a Project Implementation Letter (PIL) or Memorandum of Understanding (MOU) stating this agreement should be signed with JAFPP. Terms of the PIL/MOU should include intent for financial sustainability, agreement to reducing Head Quarter (HQ)/clinic expense ratios, and agreement to set prices and services based on market research for each location.
- Assistance to JAFPP should focus on clinic decentralization and facilitating clinics to operate as individual business units (profit centers).
- Financial assistance to JAFPP should be predicated on meeting performance targets, and funding should be provided in tranches conditional upon meeting benchmarks such as cost recovery targets. Support for HQ costs should be minimal with a phase-out plan.
- USAID should support market research to determine whether JAFPP could increase cost recovery and its client base by offering a wider range of medical services for families as a one-stop shop for all maternal and child health needs

OIG-related finding: In 2013, an audit of SHOPS by the Office of the Inspector General (OIG) found that: "JAFPP did not make progress toward its financial sustainability target." While JAFPP offered services at a steep discount, it lost money on each client. Increasing the number of clients thus accelerated JAFPP's revenue losses, putting the sustainability of project achievements at risk." OIG recommended that USAID/Jordan require JAFPP to formally commit to specific sustainability measures (e.g., price increases) as a condition of receiving additional assistance under the agreement. In response, SHOPS provided JAFPP with a performance-based grant that included performance bonuses based upon JAFPP meeting sustainability benchmarks. In Q1 2015, JAFPP reported that 13 of 23 clinics had received performance bonuses for meeting targets that created competition among clinics to improve. However, the JAFPP performance incentive system criteria did not include cost recovery as an incentive target.

JORDAN HEALTH AND COMMUNICATION PARTNERSHIP (JHCP)
(Final Evaluation)

Start	2004
End	2011
Value	$26 million
Focus	Family Planning/BCC
Implementing Partner	Johns Hopkins University

The evaluation was commissioned approximately 15 months before the project's conclusion. The program had three main aims:

(1) Implementing a national health communication strategy using the life-stages approach
(2) Assisting local communities in adopting healthy behaviors
(3) Supporting child spacing and the small family norm

From May 2008, the project focused more on FP rather than broader healthy lifestyle issues. The evaluation team was directed to focus primarily on JHCP's performance against the program's revised objectives to promote FP behavior change through promotion of a three-year birth spacing interval and promotion of a cultural shift in favor of a smaller desired family size.

ISSUES AND THEMES IDENTIFIED IN THE EVALUATION:

The evaluation found that JHCP's activities had been effective in training selected audiences and communicating behavior change communication (BCC) messages through media and Internet campaigns.

Involvement of Religious Leaders

- Involvement was shown to increase discussion of FP messages, but not all trained leaders integrate FP messages into their sermons.
- JHCP facilitated the issuance of a *fatwa* (an interpretation of Islamic law) that found FP, contraception, and birth spacing to be acceptable practices. The fatwa addressed the widespread misconception that large families are an Islamic value, when they are in fact a traditional or cultural value
- The involvement of religious leaders in addressing FP issues was a powerful intervention that increased the impact of all other JHCP activities and other USAID FP projects, by opening up public dialogue on an otherwise taboo topic
- Monitoring data suggest that the training and follow-up needed to improve to increase religious leader activity and address their remaining biases and discomfort discussing FP. The unique participation of Jordanian women religious leaders in the training facilitated more direct, less structured communication with women in the community

- The strong partnership between the two religious agencies and JHCP is reflected in the stakeholder's stated desire to institutionalize training and expand activities to the national level.
- Participating religious leaders had a high opinion of USAID, despite earlier misgivings

Media Campaigns

The media campaign was well-designed, but the fragmented nature of media in Jordan prevented it from reaching the broadest possible audience.

Hayati Ahla [My life is more beautiful] National FP Multi-Media Campaign

- The media campaigns were described as "well designed", according to many Jordanian officials and media figures. There was 23% un-prompted recall and 30% prompted recall. Follow up actions were taken by 40% of those who recalled the messages
- The evaluation results suggest that media coverage was not as far-reaching as expected, probably due to the fragmented nature of Jordanian media and the dominance of international and regional media

Mabrouk Packets for First Birth Couples and Newly Married Couples

- Mabrouk was identified as a cost-effective, innovative way to reach a primary audience for FP messages through the Civil Status and Passports Department, achieving national scale. Mabrouk I was aimed at newly-married couples and Mabrouk II targeted those who came to register a birth. Training was provided for 200 CSPD staff to aide discussions, and production costs were $0.87 for each packet. There are no dissemination costs beyond materials production. CPSD offices also had video screens which played Mabrouk messages
- JHCP's work with Civil Status and Passports Department (CSPD) was also considered an innovative partnership
- The CSPD took ownership of Mabrouk to the degree that it has allocated an operating budget for the activity, but the budget was inadequate for reproduction of Mabrouk packets

Innovate Internet Activities

JHCP has used innovative Internet activities to provide international-standard health information to a wide audience.

JHCP Internet Activities—Sehetna

- Sehetna was considered innovative and creative as a tool to reach young people, and provided international-standard health information, to help counteract misconceptions held by youth, health services recipients, and health providers. It also effectively disseminates JHCP and Ministry of Health (MOH) materials. This was transferred to GOJ at the end of the activity, and then promptly shut down

Arab Women Speak Out Community Mobilization Activity

- Arab Women Speak Out (AWSO) was identified as a powerful tool for empowering women with positive models and information, by presenting sensitive FP messages in the context of larger health and social issues which helped women accept them

- AWSO reached a secondary audience, with many women reporting that they talked to friends and neighbors about FP and other topics. In addition, AWSO materials and techniques have been adopted by health projects that work at the community level

Health Competent Schools Initiative

- JHCP was successful in institutionalizing Health Competent Schools Initiative (HCSI) in the Ministry of Education. The activity was adopted by the Royal Health Awareness Society and initially received USAID Education funding
- HCSI was described as "cost effective and low maintenance". Once materials were distributed to schools and the teachers trained, there was limited continuing involvement needed with individual schools
- While community outreach was not a major component in the design, during implementation schools used it extensively with parents, then with the larger community, introducing health competency to many more beneficiaries than a school-based program could reach
- Behavior change and expanded awareness of health competency issues among students was "substantial" suggesting a long-term impact on student health

Ambassadors/University Training for Selected Students as Ambassadors

- The training for ambassadors was insufficient to address student shyness about FP. It also failed to give them tools for addressing FP issues (e.g., gender-specific groups, instructional DVDs or protected websites, external expert speakers)
- Irregular follow-up from JHCP and a lack of a longer-term plan of activities reduced longer-term impact and institutionalization
- Student peer approaches to communicating were effective, but considered labor intensive, with a relatively small reach that required audience-specific messages and material. Maintaining motivation was also identified as an issue. The evaluation explicitly concluded "for these reasons the University Ambassador Initiative is not recommended for continuation"

Consult and Choose Counseling Materials

- Consult and Choose (CC) training and materials were intended to raise the quality of FP/RH counseling in GOJ facilities. JHCP developed the material, and HSSP II supported the roll-out. Twelve health centers were equipped with TVs and DVD players to help with the roll-out of messages about birth spacing and modern contraceptive methods
- Most materials focused on the use of FP but not sufficiently on the critical behavior change messages related to smaller families and use of modern FP methods
- In the clinics observed, the clients getting counseling were those already seeking FP services, so there are still missed opportunities for counseling
- Clinic staff rated the training as "good but limited." Suggestions for improvements include more practical/applied training; follow-up training; and a better training module on dealing with problem clients. Staff also recommended improvements to the training implementation, including added incentives and moving off-site
- The presence of a designated midwife counselor increased the quantity and quality of information provided to clients, there are still missed opportunities for disseminating information

- The counseling training did not fully address provider biases, particularly for short-term methods, where discontinuation rates were high.
- Staffing should be an issue of concern for MOH and the Health Systems Strengthening Program. Several people with counseling assignments shifted responsibilities depending on workloads.
- Discussions with women at health centers point to gaps in private sector support for contraceptive methods, with counseling rarely available at pharmacies. The centers should offer counseling to all clients, especially for user-dependent methods like the pill and condoms
- CC exemplifies a collaborative working relationship with other USAID projects focused on FP

GOOD PRACTICE

- The network of local partners that JHCP has built was strong and partners regarded their relationship with JHCP as positive. The partnerships were credited for the institutionalization and going-to-scale of some activities (although "the large number of JHCP partners and activities probably limited the potential contributions of some activities due to human and financial resource constraints.")
- JHCP has established a good model for public-private partnerships, notably with Fine Paper Products through the HCSI. With the precedent now established, the positive experience with Fine Paper Products has opened the door for MOH to undertake future partnerships

RELEVANT LESSONS

- The evaluation noted that "FP service provision was not a constraint to the adoption and use of contraception. Access to public and private health services, contraceptive knowledge, and contraceptive use levels were already high, now was cost considered a barrier. Improved quality of care could affect fertility timing, but would not change fertility levels without a change in desired fertility"
- "Based on the evaluation's findings, BCC priorities should be the following: the involvement of religious leaders, as key influencers of social norms, to champion FP at a national level; and a mass media strategy using a range of available channels to support religious leaders' messages, educate couples and providers, and create demand for modern FP methods"
- Building consensus among partners can be difficult and time consuming; moreover, the products of consensus building often tend to be weak, as they often reflect the position of the weakest partner (e.g., spacing as a lead message rather than family size norms).

HEALTH SYSTEMS STRENGTHENING II (Midterm Evaluation)

Start	2009
End	2014
Value	73,000,000
Focus	HSS - support of reduced fertility rates and improved women's health
Implementing Partner	Abt.. Associates

No end of program evaluation could be identified on any local systems (USAID or on the Jordan Knowledge Management portal) or by the Development Experience Clearing House. The report's authors noted the project was "on track to meet all of its objectives"[4] and that some of the achievements "go beyond what its indicators capture". They also noted the project had "excellent relations with both the Ministry of Health (MOH) and U.S. Agency for International Development (USAID)."

ISSUES AND THEMES IDENTIFIED IN THE FINAL REPORT:

The report addressed the six different result areas that HSS project was tasked with delivering.

Knowledge Management

- Capacity-building and institutionalization of data systems has resulted in MOH ownership of the health management information system (HMIS), and MOH was beginning to use the system for decision making. However better outcome indicators were required
- USAID had supported the development of multiple, parallel information systems, which the evaluation team "struggled to understand"

Primary Health Care

- Supporting accreditation for PHC centers created a "culture of quality"
- The inclusion of accreditation criteria for FP services would likely result in more FP users
- At the time of the evaluation, the project had not managed to meet its annual targets for creation of a satisfactory referral system
- While the use of health outcomes (e.g., management of hypertension and diabetes) as a proxy for supervision was described as "plausible", the evaluators were not confident that clinical outcomes would improve in the short term. In addition, targets set for these

[4] Figures in the main body of the report suggest otherwise: HSS only met 13/23 of its Year 3 Targets. Some figures in the report were themselves contradictory. For example, under the MNCH task, the following was reported in the evaluation: "An indicator of quality is the percent of women monitored during labor using the partograph. The baseline was 80%; the year 3 target was 90%, and the year 5 target is 95%. The year 3 achievement was 86%. Another indicator of quality is the percent of women with pregnancy-induced hypertension managed according to the clinical guidelines. The baseline was 80%; the year 3 target, 90%; the year 5 target, 95%. The year 3 achievement was 88%. These targets were achieved." (p.12)

indicators were essentially unchanged from baseline levels. The evaluation team believed project activities were very likely to have a substantial impact on effective supervision, but poor selection of indicators meant that important gains were not captured and lessons were missed.

Maternal and Neonatal Health: Safe Motherhood

- The introduction of evidence-based medicine, update of clinical guidelines, and creation of centers of excellence were highly valued by the MOH
- The use of other maternal indicators, such as incidence/1000 births of eclampsia seizure and blood transfusions, would track outcomes better
- In the span of one year, turnover of MOH trainers can be between 50 and 60%
- HSS II identified and tackled unrecognized problems—such as neonatal transfer and IV fluid preparation

Improve Quality of and Access to FP/RH Services

- The percentage of 444 MOH HCs offering four or more methods of contraception declined below the baseline in Year 3. The number of CYPs also dropped by almost 12% between 2010 and 2012. This was because midwives largely stopped fitting IUDs because of legal ambiguity. (In 2009 47% of IUDs were fitted by midwives; this dropped to 26% in 2011)
- The MOH conducted a situational analysis on the safety of midwives inserting IUDs. No safety issues emerged from the analysis. A compromise policy emerged (captured in the midwives' newly drafted job description) whereby the MOH decided that a midwife could insert an IUD if a "trained" physician, who would assume medical/legal responsibility, was present at the same facility. In order to meet this requirement, physicians with no prior expertise in IUD insertion received a two-day course in supervision of IUD services
- IUDs are the most popular FP method in Jordan; they have the lowest discontinuation rates and the greatest impact on CYPs[5]
- The legal/administrative barriers placed on midwives performing IUD insertions are the major reasons for the failure to reach targets
- Post-partum FP (after deliveries and miscarriage) rose from a baseline of 0% to 20.4% in three years. (The evaluation outlines the programmatic approach used). Intervention sustainability was affected by a lack of staff; the requirement for existing staff to take on additional work, and for hospitals to supply IEC material

Engage and Empower Communities to Adopt Healthier Lifestyles

- Community Health Committees had been established, although their sustainability was questioned
- Indicators measured activity. Evaluators noted that without outcome measures it was not possible to determine the effectiveness these community interventions

[5] HSD's Discontinuation Study (2018) found this still to be the case, with IUD discontinuation at 14.8% after 12 months, compared with 23.6% for implants; 30.2% for condoms; 37.9% for COCs and 42.8% for injectables

Renovations

- MOH embraced the American Institute of Architects design standards, although it was difficult to assess whether this directly impacted health outcomes

RELEVANT LESSONS

- Pursuing the change in the midwifery law to allow IUD insertions is still relevant
- Log-frames should reflect outcome data to improve project focus
- Indicators should measure outcomes (or at least outputs) and targets should be ambitious rather than based on a slight increase in the baseline position
- Turnover rates of between 50-60% brought into question the sustainability of training clinical staff in some of the main teaching hospitals
- The USAID strategy should focus at HC level, where the bulk of FP interactions take place. Interventions could include HC renovations, supervision, referrals and accreditation
- Pursuing an integrated MCH/FP program is important going forward. This might include allowing projects to tackle previously un-identified issues in order to aide ownership by the health facility and their staff
- Intervention sustainability (e.g. post-partum FP) was affected by a lack of staff; the requirement for existing staff to take on additional work, and for hospitals to supply IEC material
- Supporting accreditation of PHC facilities raises service quality
- USAID should support broad BCC campaigns that focus on the health advantages of birth spacing and enable families to plan their desired family size. This needs to target men as well as women
- While development of HMIS was helpful, USAID has left a legacy of multiple, parallel information systems
- Field visits identified the importance of a functioning referral system among MOH staff, however the same staff indicated that the referral system was not well established and achievements were slow. This reinforces the need for field-level evaluation to assess actual achievements, rather than reported progress.

HEALTH SYSTEMS STRENGTHENING II BRIDGE PROJECT (Final Report)

Start	2014
End	2015
Value	10,848,000
Focus	HSS - Finance (UHC; health insurance); Governance
Implementing Partner	Abt.. Associates

The HSS II Bridge project lasted for just one year. There was no formal evaluation. Instead key points have been derived from the Project's final report.

ISSUES AND THEMES IDENTIFIED IN THE REPORT:

FP

- Service Delivery Improvement approaches can dramatically increase uptake of FP
- Uniting a health facility and their Health Directorate teams in a common goal allowed them to achieve rapid progress
- Engagement with stakeholders at central and health directorate level, and facility level improved ownership
- Data ownership improves with prompt feedback of results

Maternal and Newborn Care

- HSS II Bridge focused on reducing post-partum hemorrhage, and introduced the Active Management of the Third Stage of Labor. (Part of the advice includes "cut and clamp the cord 1-3 minutes after birth". This is contrary to evidence from the Lancet that identified delaying cord clamping to 3 minutes could increase serum ferritin concentration at 6 months of age (used for storing and releasing iron) and reduce the need for blood transfusions and complications after birth by up to 39 percent in healthy term infants. (Studies typically compared clamping at 1 minute and 3 minutes) [6]

Community Health Councils

- 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 objectives. "As a direct result of project support, two CHCs completed

[6] Bhutta ZA, Das JK, Rizvi A, et al. (2013) Evidence based interventions for improvement of maternal and child health nutrition what can be done and at what cost. *The Lancet* 382: 452–77. DOI: dx.doi.org/10.1016/ S0140-6736(13)60996-4.

organizational, structural, and legal transformations into official CBOs, laying the foundation for increased impact and community engagement."

- In June 2015, HSS II Bridge and MOH's HCAD jointly assessed the effectiveness of CHCs. This found that CHCs were a key part of the collaborative process and that for 21 out of 23 of them, they achieved a 30% increase in new FP visits over the course of the SDIC. The report concluded that "CHCs should be considered an intrinsic part of any future scale up of the FP SDIC".

RELEVANT LESSONS

Family Planning

- Use of the Service Delivery Improvement Collaborative (SDIC) worked in 24 of the busiest Health Centers, resulting in uptake of FP more than doubling. This was attributed to "increased efficiency, awareness and quality of services". This required intensive data gathering, data review and regular performance reviews to enable health center staff to solve longstanding service delivery problems
- A similar SDIC approach that worked (i) with hospitals in partnership with local health centers and (ii) only with hospitals (for example to improve post-partum uptake of FP), had minimal impact because levels of autonomy were far lower and changes were therefore far harder to implement. In addition inconsistent supervisory systems led to reduced opportunities for monitoring data
- Without hospital leadership having a clear mandate and autonomy, it will be difficult to deliver significant changes in FP uptake
- The Women and Child Health Directorate at MOH were "resistant" to the introduction of a modern natural method of FP
- The project pilot multiple approaches to encourage users of traditional methods of FP to switch to modern methods. Four approaches were tested: couples counseling by appointment; internal referral within a health center to identify and respond to unmet need; increased health education sessions in health centers, and strengthen information about modern methods by providers in the community. "Internal referral" achieved a 98% success rate in switching, followed by 89% success for improved health education within health centers. Neither of the other two approaches achieved similar gains. Of the four, the two most successful also demonstrated substantial reach, although the percentage of women who were users of traditional methods was relatively low (i.e. although "health education" reached 545 women, only 64 were identified as users of traditional methods; "couples counseling" only reached 49 couples but 38 of these were users of traditional methods).

Maternal and Newborn Care

- Uptake of the ATSL was variable across the six hospitals. The project identified a need for additional "clinical and management capacity" and through work with MOH's Quality Directorate, identified a need for improved consistency for documentation, as well as clinical governance.
- The project helped implement a nasal-bubble continuous positive airway pressure (NB-CPAP) protocol at 30 MOH and RMS hospitals. Several hospitals were outliers for survival rates, notably those receiving Syrian refugee neonates described as "complex cases".

(E.g. Mafraq Hospital's survival rate dropped as low as 59%, while most hospitals were in the 90+% range).

- The Project worked with JCAP to design a pre-conception component for unmarried youth into their plans for later implementation. The target were youth in universities and out-of-school youth. (This appeared to not learn the lessons from JHCP's work in Universities).
- The JMMSR conceptual framework built upon existing structures and procedures. Almost all births are in health facilities, which lends itself to a facility-based follow-up. Requiring all births to be recorded correctly and reported to DOS would aid the tracking of all births.

CHALLENGES IDENTIFIED

Human Resources for Health Issues

- HSS II Bridge identified multiple HRH-related issues, such as the absence of clear criteria for the allocation of staff to health facilities. Some HCs were over-stretched while others had staff that lacked core competencies
- There is a "large gap" between pre-service education for physicians and midwives and the actual skills the MOH needs from these cadres

Budget Issues

- The project identified a large discrepancy between operational planning and actual budgets at hospital level

Equitable Access to FP Services

- While FP SDIC worked in 24 HCs it did not work in hospitals. For example, financial and organizational constraints restrict facilities' ability to adapt and engage with regular performance reviews

Strengthen MOH & RMS – Best Practice for M&NH

- Improvements can be challenging because they do not fall within the mandate of any one Directorate

Capacity Building in MOH

- High staff turnover is a particular problem in IT for MOH, because of recruitment of staff into the private sector. This creates challenges for IT and HMIS system maintenance

PRIVATE SECTOR PROJECT FOR WOMEN'S HEALTH (Final Report)

Start	2005
End	2012
Value	$18.97m
Focus	FP, Improving Women's Health, Breast Cancer Awareness and Detection, and Medical Treatment in the Private Sector for GBV
Implementing Partner	Abt.. Associates

No end of program evaluation could be identified on local systems or by the Development Experience Clearing House.

ISSUES AND THEMES IDENTIFIED IN THE FINAL REPORT:

Community Outreach Program

- CHWs promoted awareness of birth spacing and use of modern contraceptives, self-breast examination and pap smears, antenatal care for pregnant women, postnatal care, and contraceptive options following delivery
- The home visit was the foundation of the community outreach program. Trained CHWs visited women in their homes for a specified number of visits at four- to six-week intervals
- Women who were already satisfied users of a modern family planning method received only two visits (65%). An additional 1-2 visits were justified for non-users of any method, users of traditional methods or the lactational amenorrhea method, women with high maternal risk, and pregnant women
- The program reached around 87% of MWRA, resulting in 12.5% of those reached adopting a modern contraceptive method
- CHWs were trained in EBM through the use of Critically Appraised Topics (CATs), short summaries of evidence to help provide a response to clinical questions
- A mid-term evaluation (2008) found that
    - "Outreach is effective but requires persistence". Women visited by CHWs adopt modern methods following visits three, four, seven, and eight, with the largest number of women adopting following the fourth and eighth visits. once a new user adopts an FP method, she requires continued counseling and support in the first three to six months of use to help reduce the likelihood of discontinuation
    - "The referral system is an important component of the outreach service continuum and is important to the CHWs' credibility among the women in the communities."
    - Messages on different health areas helped introduce FP. However, managing several health topics posed challenges for CHWs. Some CHWs had trouble mastering a host of health topics while others spent less time on challenging topics such as family planning and instead gravitated to other health messages

Enhancing Quality in Private Providers (EQuiPP)

- To improve private sector health services, PSP-Jordan partnered with Jordan's leading medical institutions to deliver clinical and evidence-based medicine (EBM) training programs, quality assurance services, and Continuing Medical Education (CME) credits
- Two new methods—Implanon® and NuvaRing®—entered the market, introduced through outreach and the PSP-Jordan-initiated network of private physicians
- Many private physicians and pharmacists failed to provide medically correct and client-sensitive family planning or breast or cervical cancer screening services. Sometimes providers lacked the appropriate knowledge or skills; others were reluctant to prescribe modern family planning methods to younger married women or to explain the possible side effects of such methods
- Potential clients expressed the desire for female providers, convenient resupply of methods, empathetic counselors, and affordable services

Evidence Based Medicine and Training Approaches

- PSP used three approached: (1) classroom and clinical training, (2) the use of evidence-based medicine and detailing, and (3) a quality assurance certification process
- PSP-Jordan collaborated with Bayer Schering Pharma (BSP), a major supplier and marketer of oral contraceptives, to introduce the EBM approach
- More than 1,790 private sector physicians participated in one or more PSP-Jordan training programs on their day off or even closed their clinics in order to participate
- The curriculum was expanded to include topics of interest to private providers, including cancer and diabetes, and sessions were scheduled in short segments in order to meet providers' competing demands
- A range of incentives motivates private providers to deliver FP under certain conditions. This included opportunities to update clinical skills and knowledge for both personal and professional reasons and to earn CME credits

Pharmacies

- A mystery client study in 2006 showed several barriers to good counseling and correct use, e.g., not providing appropriate advice if a client misses a pill. PSP-Jordan instituted a CME program in family planning for pharmacy staff through the Jordan Pharmacists Association (JPA) and two private pharmacy franchises. The project trained over 1,150 pharmacists
- PSP-Jordan developed a family planning curriculum for preservice training and signed agreements with two of the largest private universities (Al Zaytoonah University and Al Zarqa Private University) in Jordan to include family planning in their curriculum for pharmacy students

Early Breast Cancer Detection

- During the first home visit, a CHW talked about the importance of early detection for the successful treatment of breast cancer

Violence Against Women Domestic Violence

- In conjunction with the Institute for Family Health, the project trained 17 private hospitals in procedures for detection of domestic violence and onward referral
- The Private Hospital Association's hospital accreditation requirement for family protection was a critical incentive in motivating private hospitals' participation in the VAW initiative

EXPANDING HIV PREVENTION IN JORDAN (Final Report)

Start	October 2006
End	September 2008
Value	1,150,000
Focus	HIV Prevention
Implementing Partner	Family Health International (now FHI 360)

No end of program evaluation could be identified on local systems or by the Development Experience Clearing House.

ISSUES AND THEMES IDENTIFIED IN THE FINAL REPORT:

The activity was focused on supporting GOJ with an HIV Prevention Strategy. This included direct program activity with high-risk populations; collecting and analyzing strategic information; providing a forum to help people living with HIV and AIDS, and to create an enabling environment for an effective national response.

Cultural norms and sensitivities were repeatedly cited as challenges. Meanwhile access to condoms was described as widespread, although their use for disease prevention appeared secondary to their use as a contraceptive. Condom usage overall was described as "low".

RELEVANT LESSONS

- SBC approaches made a significant and demonstrable impact on stigma-related issues (such as "willingness to share a meal with a coworker PLHA" for those exposed to the program's interventions)
- The program's own research found that there was "a surprisingly low level of exposure" to SBC program interventions

ANNEX B - Examples of Pilot Projects Discontinued or Not Scaled Up

Examples of Pilot Projects Discontinued or Not Scaled Up (chronological order):
(Source: IRH/Eval)

Initiative	Description
Comprehensive Postpartum Project (CPP) (1995-2000) [not scaled-up and discontinued after project end]	• Mentioned during interviews as one of the most successful projects. • Twenty-one centers were established at public and NGO hospitals to provide comprehensive mother and child health services including family planning. After project end, MOH was unable to maintain the centers and with time, trained staff shifted, well baby clinics closed, electronic information system stopped, and client numbers dropped.
Training centers for laparoscopic tubal ligation (2000-2004) [not scaled-up and discontinued after project end]	• EngenderHealth established two training centers for laparoscopic tubal ligation, one at Al-Bashir hospital for MOH and a second at the Al-Hussein Hospital for RMS. These centers were equipped with needed equipment and furniture, developed a training curricula and standards of care, and a memorandum of understanding was signed with MOH. • After the project end, none of these training centers conducted more trainings
Sehetna web site (2006-2011) [discontinued after project end]	• The web site was established by the JHCP project to be run by MOH after the project. However, it was closed after the project ended.
Mabrouk Initiative (2006- 2011) [discontinued after project end]	• Established by JHCP to target newlywed couples, the Mabrouk kit included information on healthy lifestyles and family planning was distributed through the Department of Civil Status for newly married couples at the time of receiving their family card. • The kit was not re-printed and the initiative stopped
Safe Motherhood Committees (2007-2014) [discontinued after project end]	• The committees were established at all public hospitals to oversee safe motherhood services including family planning. Activities include hospital yearly workplan reviews and indicators review and action planning. • Interviews conducted for this assessment suggest that some of the committees stopped meeting and fulfilling duties after the HSS II project ended
The perinatal information system (2007-2014) [discontinued after project end]	• Initiated by HSS, the web-based electronic system registers antenatal care, delivery, and postnatal care provided at MOH hospitals. The project provided the system and computers, and built staff capacity on its use. • The system was not sustained because it depends on the Internet, which is not functional at many hospitals as suggested by interviews conducted for this assessment. In addition, service providers appeared to be reluctant to enter data as they are busy and data entry take time, and as a result the system was not used completely in many hospitals. In other hospitals it was replaced by the Hakim program for automating public hospitals

Initiative	Description
Follow-up for postpartum women	• HSS II project conducted a study to measure the effectiveness of postpartum family planning counseling and services at Al -Bashir hospital.

receiving family planning counseling at Al- Bashir hospital (2013) [discontinued after project end]	• The follow-up stopped after the study period ended due to funding constraints.