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FINAL REPORT

Jordan Family Planning Assessment

USAID FROM THE AMERICAN PEOPLE

FACT Fertility Awareness for Community Transformation

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LIST OF ACRONYMS AND KEY PHRASES

AWSO	Arab Women Speak Out
BCC	Behavior change and communication
CHWs	Community Health Workers
CPP	Comprehensive Postpartum Project
CSDP	Civil Status and Passports Department
CYP	Couples years of protection
DHS	Demographic Health Survey
EBM	Evidence-based medicine
ESF	Economic Support Fund
FP	Family planning
GBV	Gender-based violence
HCAC	Health Care Accreditation Council
HMIS	Health management information system
HPC	Higher Population Council
HPI	Health Policy Initiative
HPP	Health Policy Project
HSS	Health systems strengthening
IUD	Intrauterine device
IRH	Institute for Reproductive Health
JAFPP	Jordan Association for Family Planning and Protection
JCAP	Jordan Communication, Advocacy and Policy
JCLS	Jordan Contraceptive Logistics System
JHAP	Jordan Health Accreditation Project
JHCP	Jordan Health Communication Partnership
KAP	Knowledge, attitudes and practices
LARCs	Long acting reversible contraceptives
MCH	Maternal and child health
MWRA	Married women of reproductive age
MOH	Ministry of Health
mCPR	Modern contraceptive prevalence rate
NGO	Non-governmental organization
ODA	Official development assistance
PHCI	Primary Health Care Initiative
PHR	Partnership for Health Reform
PSP	Private Sector Project for Women's Health
RAPID	Resources for the Awareness of Population Impacts on Development
RH	Reproductive Health
RHAP	Reproductive Health Action Plan
SHOPS	Strengthening Health Outcomes through the Private Sector
SDGs	Sustainable Development Goals
TFR	Total fertility rate
UNFPA	United Nations Population Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
USAID	United States Agency for International Development
WISN	Workload Indicators for Staffing Needs

EXECUTIVE SUMMARY

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.

The assessment findings show that USAID's contributions in increasing family planning access and use have been extensive, but perhaps not targeted enough toward social norms to significantly decrease Jordan's total fertility rate (TFR). Key findings are presented by assessment question below.

1. **What are the reasons – including supply and demand factors – for TFR and modern contraceptive prevalence rate (mCPR) stagnation?**

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. In Jordan, indirect determinants of fertility, such as strong social norms around family size and son preference, in addition to word of mouth around contraception and side effects, all play a key role in determining contraception use, dis/continuation, and switching. The stagnation of TFR and mCPR pre-dates the influx of Syrian refugees, and the assessment cannot determine whether this has had or will have an effect on Jordan's TFR. Recent research suggests that Syrians and Jordanians may in fact have similar fertility preferences, despite stigma that Syrians may be less educated and therefore want more children.

The assessment findings also show that the stagnation in Jordan was not just limited to fertility and mCPR outcomes. From 2007 to 2012 for instance, other maternal, newborn, and child health (MNCH) outcomes also stagnated in Jordan: maternal mortality stagnated at 59 per 100,000 live births and under-5 mortality at 21 per 1,000 live births between 2007 and 2012 (DHS 2007-2012; World Development Indicators 2012). Moreover, a new TFR calculation using birth registry data shows that TFR may have in fact decreased to 3.1 in 2014 for Jordanian nationals. Beyond the new TFR calculation, however, 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.

2. **How effective have USAID's inputs and programming been on increasing family planning uptake?**

The assessment findings show that 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. Despite USAID/Jordan's sizable contributions in family planning over the last 20 years, political and financial commitment from the Jordanian government remains verbal, at best. The lack of government commitment and financial ownership over Jordan's family planning program is a key barrier in ensuring that effective pilot projects - such as the HSS II Bridge family planning improvement collaborative, outreach worker program and postpartum/post miscarriage family planning projects - are scaled up and sustained after USAID funding ends.

3. **What should guide USAID's strategy going forward?**

The impact of USAID's investments in health systems and service delivery over the last decade are evident. Quality of general maternal, newborn, and child health and reproductive health services has improved, and access to family planning services has increased. However given the strong norms around family size and preference for sons, as well as misperceptions and biases against modern methods, increased efforts should be invested toward behavior change and communication and community-based activities addressing social norms. Although a number of methods have been introduced in the country, several methods are still not routinely or widely available or used, such as injections and implants. 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. Given the ongoing challenges in sustainability of programs, there is also a need for continuing advocacy with the government to assume greater ownership of the work. Finally, key informant interviews in Jordan show that many Jordanians blame the massive influx of Syrian refugees for the deterioration of maternal, newborn, and child health and family planning indicators. The increasing tensions and stigma around Syrian refugees, accompanied with the resurgence of communicable diseases, point to shifting health priority needs which will need to be supported by USAID's investment in Jordan's health system.

OVERVIEW OF THE ASSESSMENT

Despite nearly universal knowledge of contraceptive methods, high rates of female literacy, support for spacing births, and several years of increase in the contraceptive prevalence rate (CPR), family planning uptake in Jordan stagnated from 2002 until 2012. The 2012 Demographic Health Survey (DHS) found changes in the method mix that included decreases in permanent method use and increased use of both condoms and withdrawal, with high rates of method failure and a fertility rate that has not declined in 10 years. Yet a recent measurement of total fertility rate (TFR) – using vital birth registries – showed a decline between 2012 and 2014, which might indicate that this situation is changing. However this new calculation does not include the sizable and growing refugee population. This assessment was conducted between October 2015 and March 2016 by the Institute for Reproductive Health (IRH) to describe reasons for fertility rate stagnation and USAID's family planning contributions in Jordan over the last decade.

ASSESSMENT METHODOLOGY

To determine the reasons for Jordan's TFR outcomes and USAID's contributions in family planning, the assessment aims to answer three research questions:

1. What are the reasons – including supply and demand factors – for TFR and modern contraceptive prevalence rate (mCPR) stagnation?
2. How effective have USAID's inputs and programming been on increasing family planning uptake?
3. What should guide USAID's strategy going forward?

To answer these questions, the assessment included: a desk review of over 83 documents; and 69 interviews with 168 participants, including 23 US-based key informants and 145 respondents in Jordan, including MOH, partners, and local NGOs. The assessment team included several staff members from IRH in the US, a Jordanian-based consultant with extensive experience with family planning programs in Jordan, and a US-based consultant with expertise in evaluating reproductive health programs. The team developed a question guide to structure the key informant interviews, which was reviewed by USAID/Jordan.

Given the large number of interviews, we conducted further coding analysis to quantify salient themes among different groups of Jordanian and US-based stakeholders. Interviews were analyzed in Dedoose software and coded under sub-categories according to the study research questions. The total number of coded excerpts for each topic was divided by the number of interviews conducted by interview group. The frequency of topics in each interview group is indicative of the salience of the topic, or its relative importance to the participant. A higher salience score shows that a participant may have significant experience with a given topic and spent more time discussing it (Bernard 2006). Annex 1 includes a description of the participant groups and summaries of quantitative interview findings. Interview groups were disaggregated according to the following categories:

I. Central MOH Officials: MOH Employees in Amman who work on high-level FP programs. Includes hospital administrators, directors of directorates, and heads of MOH sections.
II. Regional and Other MOH Officials: MOH employees based in different regions of Jordan who generally work "on the ground" at hospitals, health centers, and universities. Includes regional health governate directors and staff, hospital directors and ward heads, Jordanian medical faculty and professors, physicians, nurses, and FP counselors.
III. Private Sector Employees: People working in the private sector. Includes NGO employees, physicians, outreach workers, project and field directors, and researchers.
IV. Other Government Employees: Jordanian government employees not associated with any of the categories above. Includes officials at the Higher Population Council, Royal Medical Services, National Aid Funds, and Jordan University. Also includes policymakers.
V. Donor Employees: Donor organizations employees, such as USAID, UNFPA, JICA, WHO, and UNRWA.
VI. International Experts: Experts who work in family planning and global health but do not fall into one of the categories above.
VII. USAID Project Contractors: Contractors who implement family planning programs in Jordan, specifically those funded by USAID. Includes employees who work for Abt Associates, Palladium Group, and others. Also includes employees who have worked on projects such as SHOPS, JCAP, and HSS II.

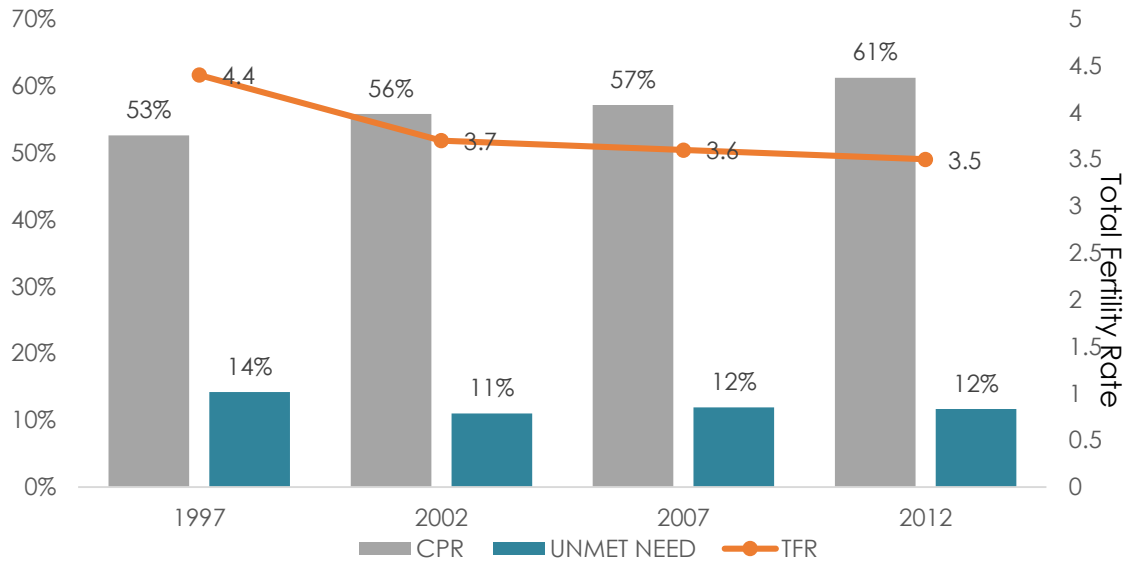
The primary limitation of this assessment is the absence of current DHS data or other national level TFR and CPR data. Jordan is impacted by the immigration of people from neighboring countries, all of which have an impact on the Jordanian health infrastructure. Without current national level assessments, the impact of those movements cannot be described accurately. Since the 2012 DHS is the most recent national level data available, the study team also collected couples years of protection (CYP) from 2010 to October 2015 from Jordan's MOH online database. Biases presented another challenge as interviewees are typically biased toward more recent experiences of USAID projects, rather than older projects. Similarly, USAID end-of-project reports tend to bias positive outputs related to key milestones and successes. Programmatic activities that were less successful are often not reflected. To control for these biases, the study team used multiple data sources, including study briefs and external evaluations whenever available.

RESULTS

R.Q. 1 WHAT ARE THE REASONS – INCLUDING SUPPLY AND DEMAND FACTORS – FOR TFR AND mCPR STAGNATION?

The TFR in Jordan declined rapidly during the period 1983-2001, from 6.6 to 3.7 (Rashad and Zaky 2013). However, from 2002 to 2012 the rate stagnated, declining only to 3.5 over the last decade (DHS; see Figure 1). A 2012 analysis of Jordanian fertility patterns found that the stall was real and not due to data errors, and it was also one of the longest lasting periods of stagnation recently assessed worldwide (Cetorelli and Leone 2012). Stalling in TFR decline is typically accompanied by leveling off in multiple measures, including CPR, unmet need/demand for family planning, and the desired fertility rate (Bongaarts 2005), all of which have occurred in Jordan. The stall in fertility decline could prevent Jordan from reaching its goal of replacement-level fertility, a TFR of 2.1, by 2030, leading to high population growth and increasing pressure on limited resources.

Figure 1. | Trends in TFR, CPR, and Unmet Need for Family Planning, 1997 – 2012



DETERMINANTS OF FERTILITY IN JORDAN

To identify reasons for TFR and mCPR stagnation, this section first uses a theoretical framework to identify key determinants of fertility in Jordan. Second, potential reasons for TFR stagnation are explored, including factors related to: 1) supply, 2) demand, and 3) country context. It is encouraging that a new estimate calculated in 2015 indicated a decline in TFR to 3.1 in 2014 (USAID/Jordan internal presentation 2015). As a result, a brief overview of this new calculation is also included below.

There are both indirect and direct determinants that affect fertility. A classic framework identified eight proximate determinants of fertility (Figure 2) (Bongaarts 1978). This framework is well-known and widely-cited in the family planning literature and is a useful starting point to

explore issues around fertility.

Figure 2. | Classic Framework, Determinants of Fertility

Indirect Determinants	Direct Determinants	Outcome
Socio-economic, cultural, environmental variables ⇨	Intermediate fertility variables ⇨	Fertility
	1. Proportion married 2. Contraception 3. Induced abortion 4. Lactational infecundability 5. Frequency of intercourse 6. Sterility 7. Spontaneous intrauterine mortality 8. Duration of the fertile period	

Among these factors, analysis points to four key factors that may influence fertility: 1) contraceptive use and effectiveness; 2) proportion of women married; 3) lactation/duration of postpartum infecundability; and 4) induced abortion (Bongaarts 1978; Al-Massarweh 2013).

1. Contraception

Evidence suggests that contraception is the most important direct determinant in Jordan's fertility stagnation (Al-Massarweh 2013). 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. To understand how method effectiveness may be related to the stagnation of TFR in Jordan, we applied Bongaarts' (1983, 1984) Index of noncontraception to data from several DHS reports. The index of noncontraception provides a way to gauge the effectiveness of the method mix as it relates to the extent that each method is used. Scores (C_c) for this index are typically reported as proportions between 0 – 1, with scores closer to 0 reflecting more effective contraceptive method use in the focus country. The calculation uses both the proportion of married women currently using contraceptive methods (*u)* (DHS reports) and the average contraceptive effectiveness (e) (Hatcher et al. 2004) using the formula below:

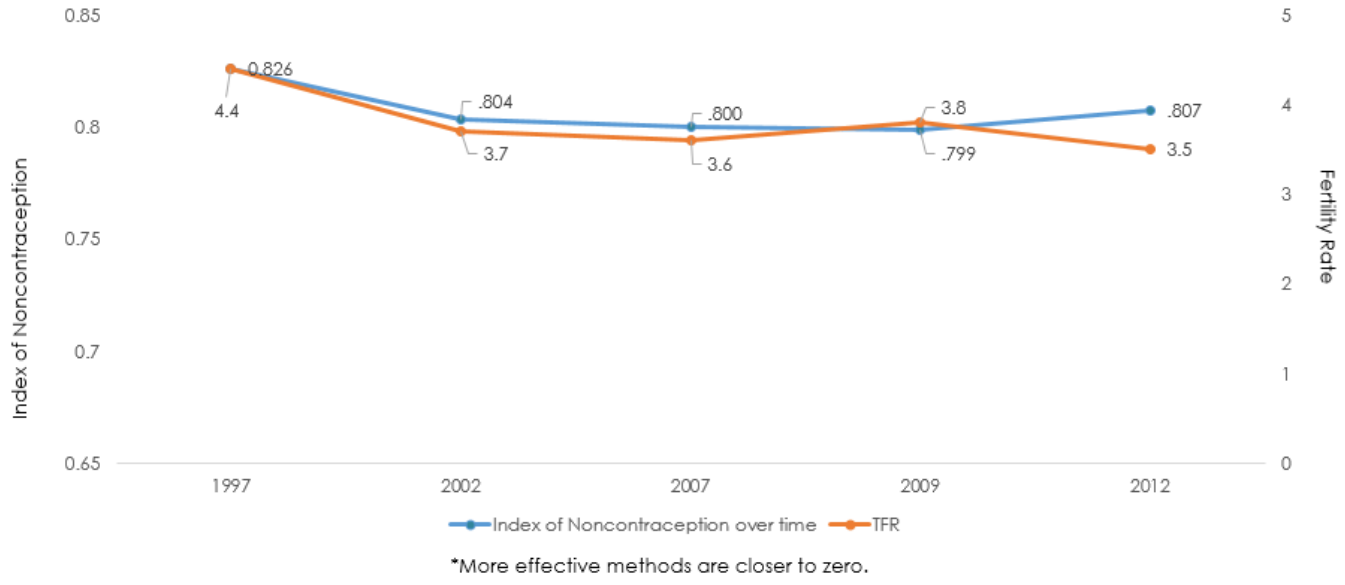
$$C_c = 1.18ue$$

For Jordan, the index was calculated using current family planning use of currently married women from DHS reports (1997, 2002, 2007, 2009, and 2012). In this calculation, we included IUD, implants, pills, injections, and condoms and removed lactational amenorrhea method (LAM) and "other" traditional methods from the calculation as there are not clear effectiveness values for these methods.*

* As described in Bongaarts (1983, 1984), the DHS prevalence rates for each method were multiplied by their typical method use effectiveness value (Hatcher et al. 2004) and summed to arrive at weighted effectiveness sum, which was converted into a proportion. This proportion was subtracted from 1 to arrive at the average contraceptive effectiveness. The average contraceptive effectiveness was then multiplied by the proportion of women using any family planning method (except LAM and traditional methods). This figure was then multiplied by 1.18, as described in the formula to arrive at the index value.

In Figure 3, the index of noncontraception is graphed next to the TFR for the relevant years. As the graphic presents, the average use-effectiveness of contraceptive methods changes minimally as TFR stagnates. In addition, the range of the index score from 1997 to 2012 (0.826 to 0.807) is relatively close to 1, indicating high ineffective method use in Jordan over that time period. To put this into perspective, Bongaarts provides the example of the US improving its contraceptive effectiveness from 0.31 in 1965 to 0.22 in 1973. TFR in the US during this time reduced from 2.72 to 1.67. In Jordan, the 15 years from 1997 to 2012 reflected a slight 0.019 improvement in the index and a 0.9 change in TFR. From 2007 to 2012, ineffective method use actually increased slightly, with the index score increasing from 0.800 to 0.807. During the same time period, DHS data show an increase in withdrawal use from 10.8% in 2007 to 14.3% in 2012, most likely contributing to the weaker noncontraception index score for the same time period, which may be related to TFR stagnation.

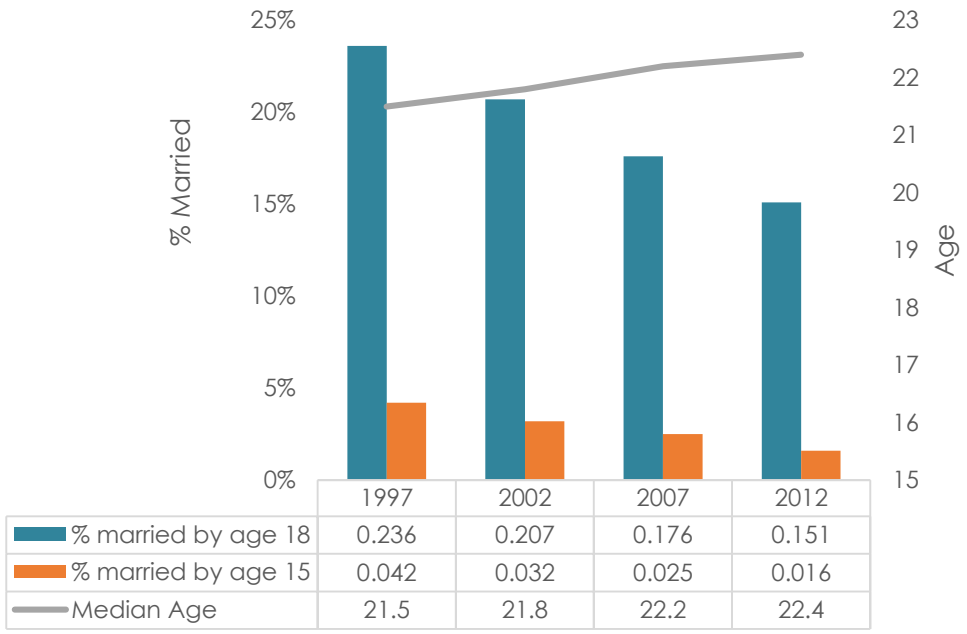
Figure 3. | Average Use-Effectiveness of Contraceptive Methods and TFR in Jordan, 1997 – 2012



2. Marriage

Age of marriage has increased over the last decade, suggesting that marriage may not be a major factor in TFR stagnation. In particular, age at first marriage increased by almost one year over the period of 1997 to 2012. In addition, early marriage decreased with fewer girls married by age 18 (from 23.6% to 15.1%). Al-Massarweh notes that between 2002 and 2009 fertility rates increased and were highest among 25-29 year olds, and as a result, attributes much of the TFR stagnation to this age group (Al-Massarweh 2013). However, the increased fertility rate in this age group might be partly due to the slightly increased age of marriage leading to slightly delayed fertility but not reduced overall fertility rates. As elaborated below, normative pressures around immediate pregnancies after marriage and son preference – albeit defined in this framework as indirect determinants of fertility – may play a more important role in determining contraceptive and fertility outcomes.

Figure 4. | Age at First Marriage, 1997 – 2012



	1997	2002	2007	2012
% married by age 18	0.236	0.207	0.176	0.151
% married by age 15	0.042	0.032	0.025	0.016
Median Age	21.5	21.8	22.2	22.4

3. Lactation

According to DHS data, the proportion of children that are exclusively breastfed between 0–5 months declined from 27% in 2002 to 22% in 2007 and then increased just slightly to 23% in 2012. Al-Massarweh found that breastfeeding patterns did not change between 2002 and 2009, with a very low median of 3.5 months of breastfeeding (Al-Massarweh 2013). Breastfeeding – and its impact on postpartum infecundability – affects fertility. However in Jordan, there has not been a significant change over time; as a result it is unlikely that breastfeeding has played a large role in fertility patterns. However, it may in the future: a number of key informants pointed to the need to improve breastfeeding practices for improving both maternal and child health in the country.

4. Induced abortion

Abortion is generally prohibited under Jordanian law. However the 1971 Public Health Law permits induced abortion to save a woman's life, but with the restriction of the physician's approval and a written consent from her or her spouse if she unable to provide it. There is limited data for abortion in Jordan, and as a result it is difficult to assess its contribution to fertility rates. According to research conducted by Hessini in 2007, the estimated number of abortions in Jordan for the period 1995–2000 is about 196,792 (cited in Ismail 2015). Al-Massarweh noted that according to 2012 DHS, 2.6% of married women of reproductive age had at least one induced abortion during their life (Al-Massarweh 2013).

REASONS FOR TFR STAGNATION IN JORDAN

In Jordan, there are a number of additional reasons for the TFR stagnation, including factors related to supply, demand and country context, which are presented below. Figure 5 shows the average number of times each type of reason – categorized by supply, demand, and refugee factors – were discussed in each interview group. On average, demand and norm reasons were discussed the most among all groups except central MOH officials. Supply reasons were also discussed extensively. To a lesser extent, refugees were also mentioned as a potential reason for TFR stagnation, and in particular among those working in regional MOH directorates and service delivery levels.

Figure 5. | Reasons Cited for TFR Stagnation, per Interview Group

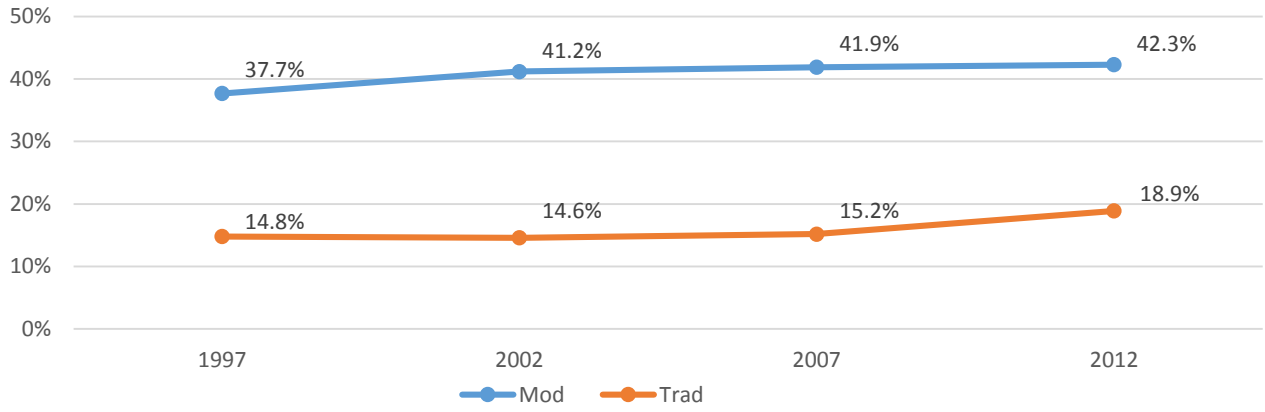
SUPPLY SIDE REASONS

Despite potential improvements in Jordan's recent TFR, evidence points to a number of supply side reasons – including changes in method mix, high rates of discontinuation, provider bias, and limited availability of female providers – which have affected national TFR, primarily through impact on contraceptive use.

Limited method mix with shift toward withdrawal and condoms

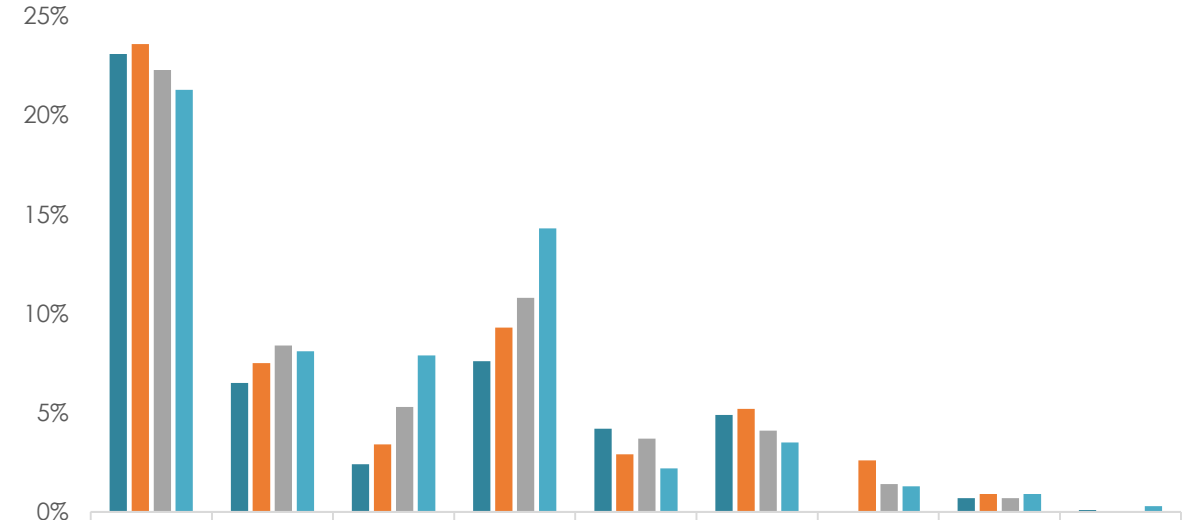
DHS data from 1997 to 2012 show a trend in increasing uptake of traditional methods, and in particular withdrawal, with the steepest increase occurring between 2007 to 2012 (Figure 6). During this time period, traditional methods use increased from 15.2% in 2007 to 18.9% in 2012. In comparison, modern methods showed very little change, increasing only slightly from 41.9% in 2007 to 42.3% in 2012. When disaggregating the method mix from 1997 to 2012, only two methods – condoms and withdrawal – have consistently increased over time (Figure 7). Withdrawal use jumped from 10.8% in 2007 to 14.3% in 2012. At the same time, DHS data in Figure 7 show declines in percentage of women using IUDs and pills from 2007 to 2012 – with small fractions in usage of injections and Implanon over the same time period (< 1%).

Figure 6. | Modern and Traditional Methods, by DHS Year (1997 – 2012)



Interviews with key informants also called attention to the issue of high traditional method use. Some providers stated that they encouraged women insistent on using withdrawal to switch toward condom use. However, the potential for condom failure is high as its effectiveness does not exceed 85% with typical use (Hatcher et al. 2004). Moreover, in Jordan male partners are rarely involved in counseling sessions, and it is not the norm for providers to perform condom demonstrations.

Figure 7. | Modern and Traditional Methods, by DHS Year (1997 – 2012)



	IUD	Pill	Con	With	Ster	Rhythm	LAM	Inj	Imp
1997	0.231	0.065	0.024	0.076	0.042	0.049	0	0.007	0.001
2002	0.236	0.075	0.034	0.093	0.029	0.052	0.026	0.009	0
2007	0.223	0.084	0.053	0.108	0.037	0.041	0.014	0.007	0
2012	0.213	0.081	0.079	0.143	0.022	0.035	0.013	0.009	0.003

Fluctuating rates of discontinuation

The one-year probability of discontinuing the use of family planning decreased from 48.9% in 1997 to 39.7% in 2007, but in 2012 rose to 48%. According to the 2012 DHS, more than half of the women using injectables, male condoms, and oral contraceptives discontinued use of their method within one year. The IUD had the lowest discontinuation rate, with only 15% of women discontinuing its use within a year. The reason given most frequently for discontinuation was the desire to get pregnant (33%), followed by method failure (18%), side effects or health concerns (15%), and desire to have a more effective method (13%).

Jordan's method mix has an impact on continuation rates, given the shift to methods that are easy to discontinue and typically have high rates of method failure. An analysis by John Ross in 2001, looking at 1997 Jordan data, remains relevant today:

> "Whenever the average continuation time is brief, total prevalence of users cannot rise beyond a certain point. Couples constantly move in and out of the pool of users. The pool loses many members each year and the new adoptions merely replace them instead of adding to the pool [...] To address the incessant movement in and out of the pool of users by so many couples, the focus must be upon continuation, not upon the rate of adoptions since that is already high."

Provider and counseling bias

The limited method mix and stalled increase in modern method use is in part due to provider bias. Evidence shows that both public and private sector providers have misconceptions around hormonal methods and side effects despite USAID investment in training initiatives (El-Khoury et al. 2013; Al-Massarweh 2008; Engender Health 2004). Evidence also suggests – and field interviews support this – that provider bias can either be against providing long-term hormonal methods or in favor of one particular "solve-all" method, such as the IUD (HPC 2010). Additionally, providers – like most Jordanians – see the goal of family planning as a way to space children and highly value fertility and children. These beliefs may impact their counseling practices. For instance, a secondary review of literature showed that providers tend to prescribe: 1) oral contraceptives or traditional methods for delaying the first birth; 2) modern methods, and in particular oral contraceptives for spacing; and 3) IUDs for limiting births (SHOPS 2011).

Addressing provider counseling and bias is complex. The methods provided in Jordan may be the "right" methods in achieving the three goals of delaying first pregnancy, spacing pregnancies, and limiting number of children. However, providers may be unable to match client desires to appropriate methods both due to method unavailability and pervasive fears around hormonal side effects. As a result, women are less likely to receive full information and may not be making informed choices about family planning methods during counseling sessions. This contributes to the high rates of discontinuation and/or method switch described above.

Lack of availability of female providers

In addition to provider bias, the lack of available providers can limit access and uptake, particularly in remote and rural areas where there is high turnover. Of particular concern is the limited number of female physicians, with most based in urban areas. According to a 2011 brief, there were approximately 326 female physicians working in the private sector, 106 working in MOH health care centers, and 21 working at the Jordan Association for Family Planning and Protection (JAFPP). The vast majority (88%) of the female physicians were located in Amman, Zarqa, Irbid, Balqa, and Madaba. Many of the female physicians were not trained to insert IUDs, while others were unwilling to insert IUDs. As a result, there are very few female physicians available to meet the needs of the rest of the country (PHCI 2000; HPP 2013).

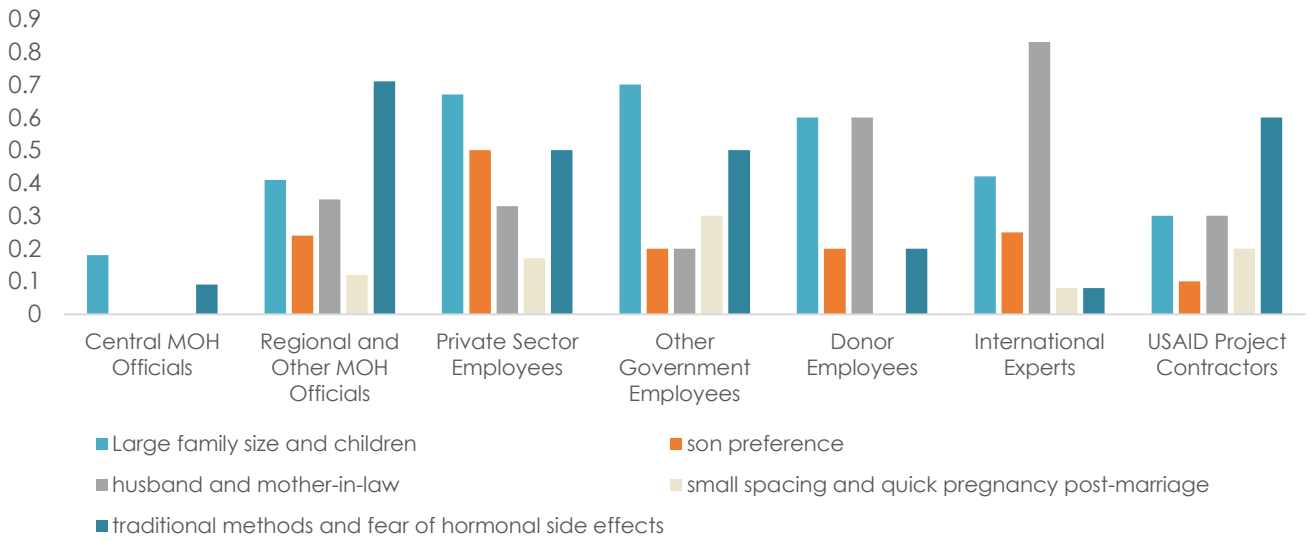
Qualitative research found that both men and women prefer that women receive services from female service providers, in part due to religious reasons (PSP 2012; SHOPS 2015b; JCAP 2015b). Participants from JCAP's 2016 qualitative study, "Exploring Gender Norms and Family Planning in Jordan," noted that it was not permissible in Islam for women to seek the services of male providers if there was a female service provider available, except in emergency situations. Women also felt more open to asking questions to female service providers and believed that female providers would better understand and respond to their needs. 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). These findings highlight the need for greater access to female providers to encourage increased use of modern contraceptive methods.

DEMAND SIDE REASONS

As per the aforementioned Bongaarts framework, a number of *indirect determinants* impact fertility, including the decision to use contraception and choice of method. Method mix is not only affected by supply side issues, as described above, but also by perceptions and beliefs of men, women, and family networks. In Jordan, indirect determinants play a particularly strong role in contraceptive decisions and method choices. These contextual, normative, and cultural factors reinforce each other and have led to high levels of traditional method use and discontinuation rates, subsequently impacting fertility outcomes.

As stated above, the majority of interviewed participants on average pointed to demand and social norms reasons as key contributors to TFR stagnation. Figure 8 shows the number of times demand-side reasons – categorized by family size, influence of husband and mother-in-law, son preference, fear of side effects, and small pregnancy spacing – were cited by interview groups. On average, desire for large families and fear of hormonal side effects were mentioned more frequently than son preference and small spacing between pregnancies. Perceptions of husbands and mothers-in-law affecting TFR stagnation differed among groups, but was higher among non-Jordanians overall.

Figure 8. | Demand-side Reasons Cited for TFR Stagnation, per Interview Group

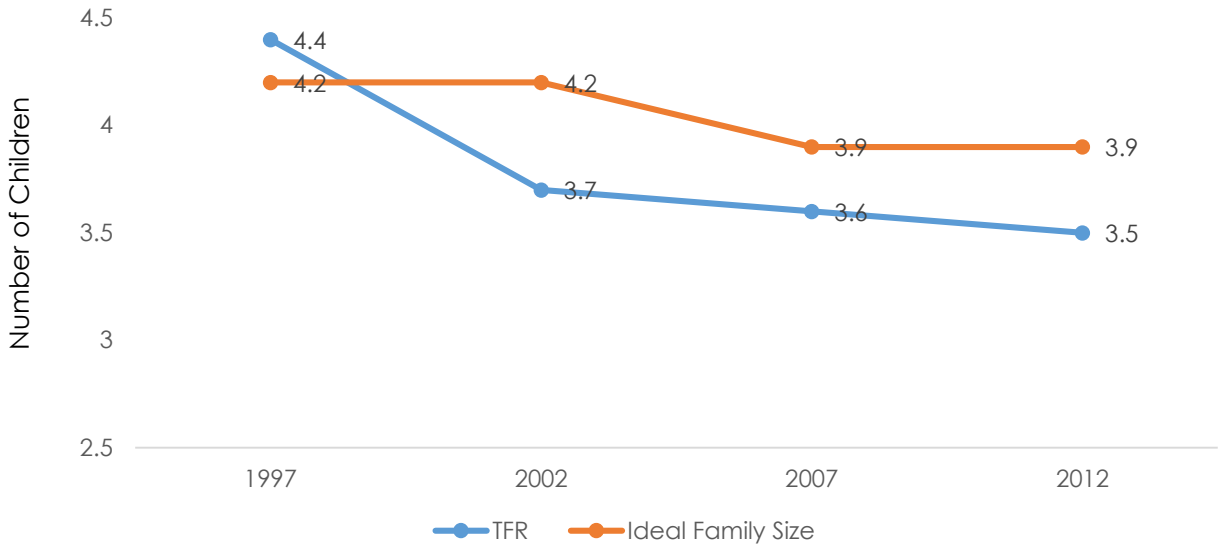


Strong social norms around children and family size

On average, the ideal family size in Jordan is four, which has remained consistent over the last two decades (Figure 9). In fact, the overwhelming majority of interviewed key informants agreed that four is considered an acceptable and quite successful number, relative to larger family sizes and higher fertility rates in the rest of the Middle East. Jordanian couples also navigate strong social norms around desire for pregnancies right after marriage and son preference (JCAP 2015b). The impact of son preference is evident in statistics on family planning use after delivery. With every additional male child, women were 30% more likely to use modern contraceptive methods, compared to only 11% with every additional female child (PHCI 2005). A qualitative study found that couples would continue child-bearing beyond their

ideal number of children to give birth to a boy, and if subsequent children are not boys, anecdotal evidence from certain geographical areas suggests that husbands might resort to marrying another woman to have a son (JCAP 2015b).

Figure 9. | Total Fertility Rate and Ideal Number of Children in Jordan (1997 – 2012)



Misperceptions and fear of side effects

In part due to the provider bias mentioned above, there is inadequate counseling and resulting misinformation and misperceptions around methods. This leads to a lack of understanding about the relative effectiveness of different methods (HSS 2014a). For example, 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).

In addition, there is limited fertility awareness, which can lead to even greater likelihood of failure of traditional methods. One study found that only about one-third (35%) of women correctly identified their fertile period, and among rhythm users, only 41% gave the correct answer (JCAP 2015c). The 2012 DHS also showed limited fertility awareness, with almost two-fifths of ever-married women not knowing the fertile period or giving the wrong answer. The authors note: "since traditional methods are being used by a substantial number of women, family planning workers need to provide more information on the physiology of reproduction, with emphasis on the ovulatory cycle" (DHS 2012).

Fear of side effects is the most commonly reported reason for women to discontinue or not use hormonal methods. In particular, bleeding, spotting, and worries about infertility are mentioned, as well as concerns about hypertension, fetal abnormalities, diabetes, and cancer (JCAP 2015c; DHS 1997; DHS 2002; DHS 2007; DHS 2012). When asked, almost half (47%) of the reasons for discontinuation or method avoidance were related to fear of side effects of

modern methods, making it the main reason (JCAP 2015c). These fears influence method use and lead to adopting less effective methods, such as withdrawal or condoms (Lewis et al. 2011). The overarching fear of side effects – and in particular miscarriages – also permeates into counseling delivery at the health service level. Some evidence suggests that providers may fear becoming liable for potential miscarriages (Maffi 2013), and potentially choosing to offer non-hormonal methods such as condoms.

Word of mouth among family members, friends, and communities also plays a role in limiting long-acting method uptake. Hospital providers in Amman noted little interest in Implanon, either from clients or providers, because women do not hear about it from friends and providers do not know much about it. "In the end it's all about word of mouth," explained one informant. Providers noted a similar situation for injectables as women do not hear about positive experiences from other users. "They trust their friends more than they trust me," stated one provider.

Men's influential role in family planning: who decides?

Men are often cited as a key barrier to use of family planning. The results from the 2016 JCAP qualitative gender study found that respondents viewed the man as the head of the household and the primary provider for the family. Many put this role in a religious context, quoting Islamic scripture: "Men are the protectors and maintainers of women." This points to the fact that men have a greater share in decision-making at the family level (JCAP 2016).

There are mixed findings regarding who ultimately decides about using family planning and whether this limits use of contraception. Focus group study participants said that the final decision to use family planning methods was the man's (JCAP 2016). However, findings from a large KAP survey found that opposition to use a method by husband or other family members was reported to be as low as 2% (JCAP 2015c). Similarly, the 2012 DHS found that only about 2% of discontinuations of contraceptive use were due to husband's disapproval of family planning. The DHS looked at participation in household decision-making as a measure of women's empowerment and found a positive relationship between this empowerment and use of contraception. Current use of a modern method is only 32% for women who participate in none of the household decisions, while this increases to 43% for women who participate in all three household decisions.

There is agreement that men are rarely involved in family planning services. According to JCAP's 2016 qualitative gender study, Jordanian and Syrian married women wanted their husbands to accompany them to family planning centers. However, these women reported that their husbands rejected the idea based on the belief that family planning issues are women's concerns. Lack of participation in family planning counseling impacts men's preference for non-hormonal methods, such as condoms and withdrawal. While men need to be more involved and receive education on family planning methods, facilitation of this education can come from outside of the health setting. A 2015 SHOPS randomized study showed that offering at home family planning counseling visits can increase modern method uptake. The study showed that both women-only and couples-based counseling led to significantly higher uptake in modern methods (28% and 30% respectively), in comparison to the control group (19%). At the same time, a group of interviewed outreach workers emphasized that from their experiences, the most effective counseling is with the woman

alone. Women who attend family planning counseling alone are more open and free to say what they want.

Finally, research suggests that mothers-in-law may also play an influential role in fertility decisions. From her ethnography research on childbirth in Jordan, Maffi argues that women in Jordanian society may use pregnancy and fertility as a way to leverage power and improve their status within their family group (2013). As new brides eventually become future mothers-in-law, they may exert this authority over their daughters-in-law. In the book *Women, Islam, and the State,* Deniz Kandiyoti concludes, "the deprivation and hardship [a woman] can experience as a young bride are eventually superseded by the control of authority she will have over her own daughters-in-law" (1991). As a result, increasing the baseline knowledge, acceptance, and access to a range hormonal family planning methods may produce generational impact.

Limited participation of women in the workforce

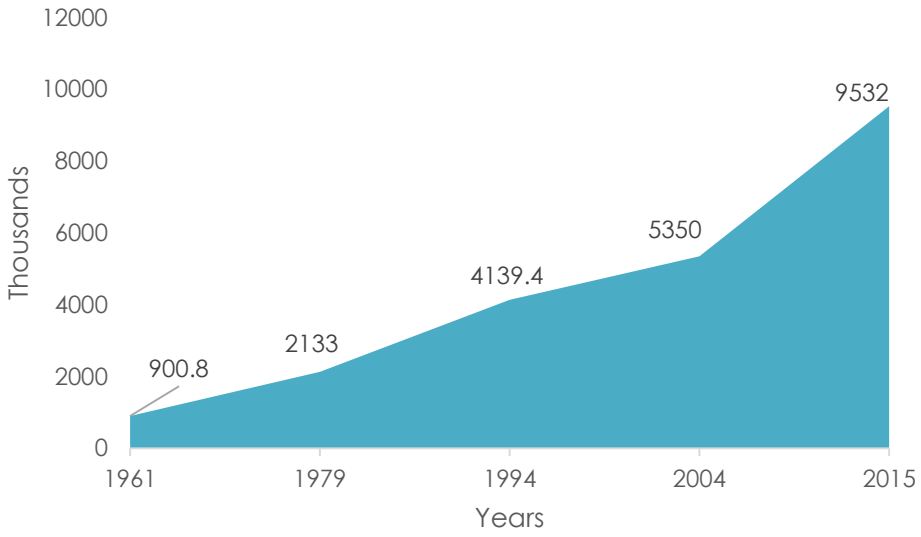
In spite of high levels of education among women in Jordan, this has not translated into significant participation of women in the workforce. The annual Employment and Unemployment Survey in Jordan shows only a small increase in the participation of women in the labor market, from 12.4% in 1993 to 14.7% in 2011 (HPC 2013; p. 8). The National Reproductive Health/Family Planning Strategy notes the strong relationship between TFR and women's participation in the labor market, citing studies that have demonstrated that a one percent increase in women's participation in the labor market decreases the TFR by 0.5 percent (HPC 2013; p. 8). Women's limited participation in the work force indicates that "the reproductive role is far more dominant than productive roles for women in Jordan" (Bryan and Naffa 2012). These authors note various limitations that discourage women from working, such as restrictions on where they can work, what type of work they can do, and the number of hours they can work. They conclude, "by limiting women's employment options, the society effectively encourages reproduction, an area where women receive positive social and familial reinforcement," a theme that was also heard repeatedly in key informant interviews. The social pressures that discourage women from holding jobs outside of the home and reward women for their reproductive roles are a form of institutional sexism that limits women's agency (Doyle and Paludi 1997; Unger and Unger 1993). Economic empowerment increases women's agency because it can lead to increased bargaining power within the home, including decisions around family planning.

Participants in JCAP's qualitative gender study unanimously agreed that there were predefined gender roles within the family. These roles derived from religious teachings and aligned with the prevailing customs and social traditions. They considered the woman's main roles to be raising children, serving her husband and children, and performing household chores (JCAP 2016).

Country context and population segments

The context in Jordan has changed dramatically in recent years due to a significant influx of refugees. Results from Jordan's 2015 census show that 30% of 9.5 million residents are non-Jordanians. There are 1.3 million Syrian refugees, 636,000 Egyptians, and 634,000 Palestinians with no national identification number. Much of the rapid population growth in recent years is due to migration: the average growth rate for Jordanians is 3.1% annually, compared to 18% for non-Jordanians (Ghazal 2016).

Figure 10. | Growth in Jordan's Population, 1961 – 2015 (Census Data)

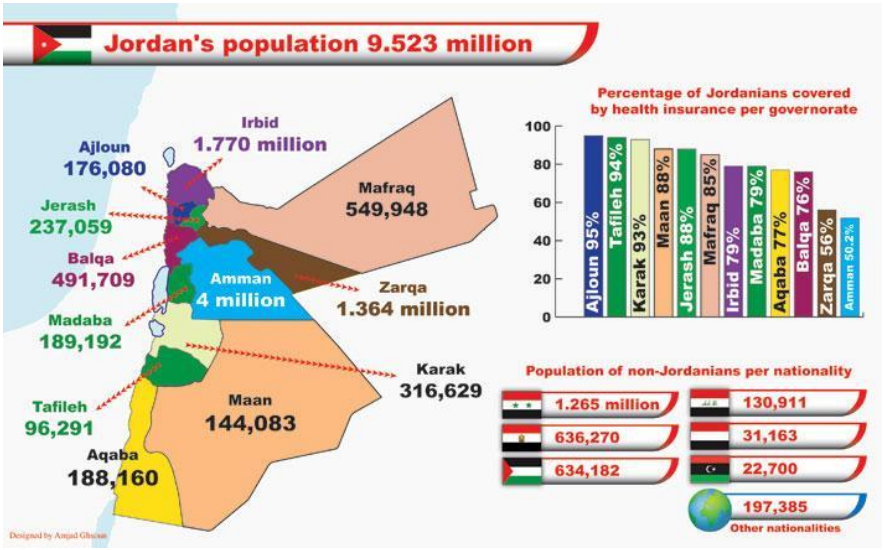


(Source: Department of Statistics (DOS). 2016. Jordan Population and Housing Census: 2015.)

Impact of refugee population on TFR

The recent census quantified the refugee situation. Syrians constitute 46% of non-Jordanians living in the Kingdom and 13.2% of the overall population. This is putting a strain on public services and resources and could potentially threaten achievements in the health sector (Jordan Country Development Cooperation Strategy 2013-17). Key informants mentioned that with the influx of refugees, Jordan was seeing an increase in previously controlled communicable diseases. Available data validate this perception. For example, at the beginning of the crisis in 2012, the Pulmonary Tuberculosis (TB) annual case notification rate per 100,000 population among Jordanians was only 5, compared to 13 for Syrian refugees (Slaih 2013).

Figure 11. | Jordan's Refugee Population (2016 Census Data)



(Source: Department of Statistics (DOS). 2016. Jordan Population and Housing Census: 2015.)

It is unknown what the exact impact the Syrian refugee population will have on national CPR and TFR. Common beliefs among key informants included that the new Syrian refugees have lower education, bear more children, do not believe in family planning methods, and are polygamous. Yet, findings of JCAP's qualitative gender study (2016) showed that Syrian and Jordanian women have similar preferences for family size and desired number of children.

A number of key informants cited the influx of Syrian refugees as a reason for TFR stagnation. However, this is more a reflection of perceptions and tensions around the refugee situation than actual causality as the stagnation predated the influx of refugees. For instance, with recent stock-outs of Implanons, one MOH provider felt that it was wrong that a Syrian receive the implant rather than a Jordanian. The statements below show the sentiments expressed by MOH providers and staff during interviews, highlighting the tension of the situation:

> "Now many times I cannot find a bed for a Jordanian."
>
> "We are stagnating from refugees, not from our people."

While the impact of the Syrian refugees may be unclear, the needs and demands of this population have become a significant priority for the country. As a result, diminishing attention has been given toward other issues, such as population growth: "the multi-dimensional Syrian refugee issue has overshadowed the population issues, and the essence of the Higher Population Council's agenda, as well as the local population challenges" (JCAP 2015d).

The impact of the Syrian refugees in host communities and health centers has been felt throughout the country, with the heaviest burden in the governorates of Mafraq, Irbid and Amman. A 2016 HPC study shows that of 572 surveyed Syrians living in host communities (14% Male, 86% Female), only about half (50.3%) received reproductive health services from nongovernmental agencies. The survey results also show that of the currently married women 12-49 years old in the sample (68.2% of total sample), about half of them (49.7%) indicated that they used a form of family planning, and 26.2% reported that they are using the IUD, followed by oral contraceptives (10.5%). Most of the healthcare services agencies/organization interviewed in the HPC study, including public facilities, expressed increased operational costs and high financial burden as a result of Syrian refugee influx. This sense of burden was confirmed by field interviews conducted for this assessment, and in particular among MOH governorates and health service providers in Mafraq, Irbid and Amman.

Increase of traditional methods and TFR in rural areas

DHS data show that traditional method use increased at a higher rate in rural areas, jumping from 15.6% in 2007 to 21.6% in 2012, compared to 15.1% to 18.3% in urban areas. At the same time, there has been an increase in rural TFR and also in the differences between fertility rates in rural and urban areas: in 2012, the rural rate was 3.9 compared with 3.4 in urban areas, while there was less of a disparity in 2007 – 3.7 vs. 3.6 in rural and urban areas, respectively. These numbers indicate high need in rural areas. In addition, Bedouin communities, which make up

anywhere between 6% to 10% of Jordan's total population (Lowi 1995; key informant interviews), continue to have high fertility desires and are underserved in general health services. For instance, a 2014 qualitative study revealed that misconceptions around side effects and modern methods are very common among Bedouin communities and that Bedouin women are at times disrespected by and receive less attention from health care providers (HSS II 2014a).

Given Jordan's high urbanization rate, some researchers and interviewed key informants have suggested focusing family planning efforts in dense urban areas – such as Amman, Irbid, and Zarqa – and overcrowded refugee camps to have an impact on TFR (Al-Massarweh 2013). However, DHS data show that TFR decreases in Amman, Irbid, and Zarqa may not have been enough to offset the TFR stall. For instance, both Irbid and Zarqa's TFR decreased from 3.8 to 3.6 from 2007 to 2012, while Amman's TFR decreased from 3.4 to 3.2 during the same time period. Despite the decrease in TFR in all three of these densely populated areas, Jordan's national TFR only decreased from 3.6 to 3.5 during the same time period. Figure 12 and Table 1 show the percent change in TFR across all 12 governorates from 2007 to 2012. The data show that only five governorates decreased their TFR during the time period (Aqaba, Amman, Irbid, Zarqa, and Madaba). Figure 13 shows percentage changes in contraceptive use for each governorate during the same time period. The evidence is mixed. Two of the seven governorates (Karak and Ma'an) with TFR increases from 2007 to 2012 had very drastic percentage increase in withdrawal: Karak had a withdrawal increase from 6.3% in 2007 to 15.6% in 2012, while withdrawal in Ma'an increased from 10.1% to 23.4% during the same time period. However, both Aqaba and Madaba, which experienced a drop in TFR, had increases in withdrawal during the same time period. This would suggest that other factors may be affecting TFR, including indirect and socio-cultural determinants that may be affecting discontinuation and switching rates.

Figure 12. | Percent Change in TFR across Jordanian Governorates, 2007 – 2012

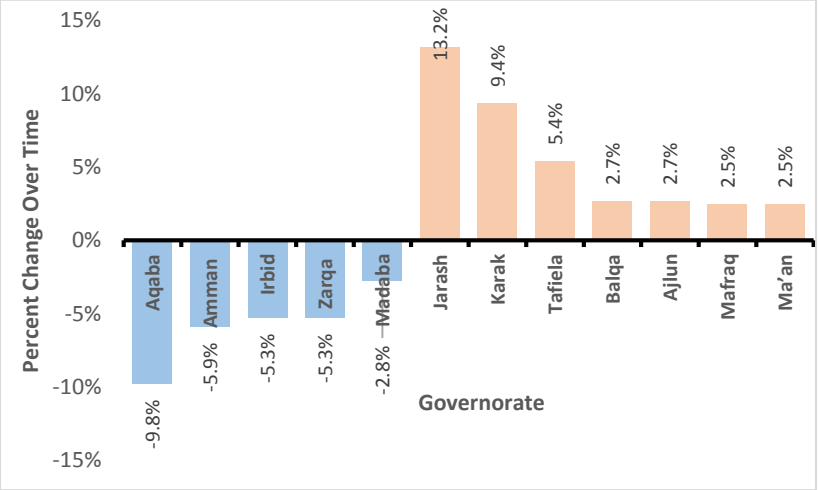
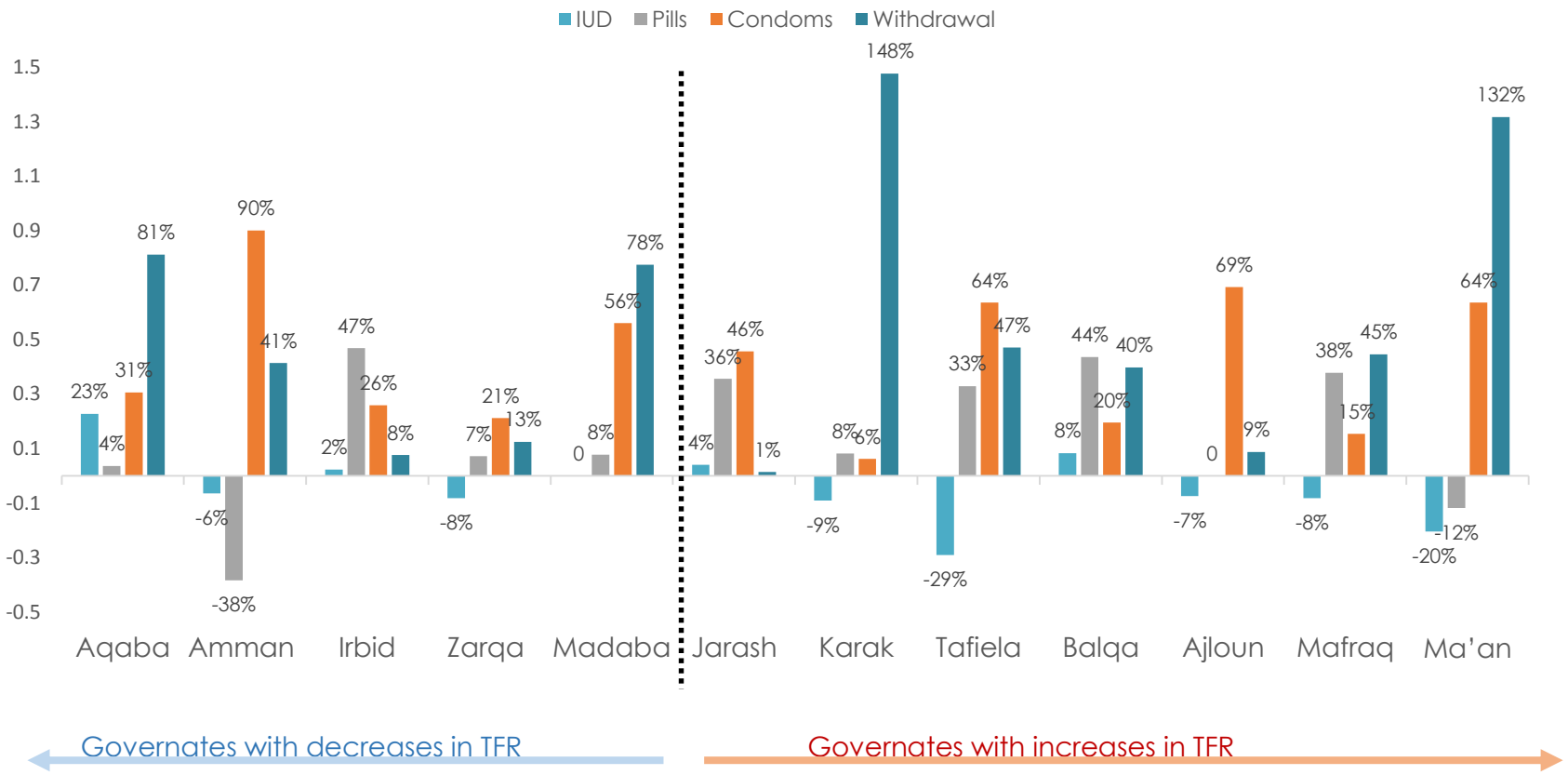


Table 1. | Percent Change in TFR per Jordanian Governorate, 2007 - 2012

Governorate	2007	2012	% CHANGE TFR
Aqaba	4.1	3.7	-9.76%
Amman	3.4	3.2	-5.88%
Irbid	3.8	3.6	-5.26%
Zarqa	3.8	3.6	-5.26%
Madaba	3.6	3.5	-2.78%
Jarash	3.8	4.3	13.16%
Karak	3.2	3.5	9.38%
Tafiela	3.7	3.9	5.41%
Balqa	3.7	3.8	2.70%
Ajlun	3.7	3.8	2.70%
Mafraq	4	4.1	2.50%
Ma'an	4	4.1	2.50%

Figure 13. | Percent Change in Method Use across Jordanian Governorates, 2007 - 2012



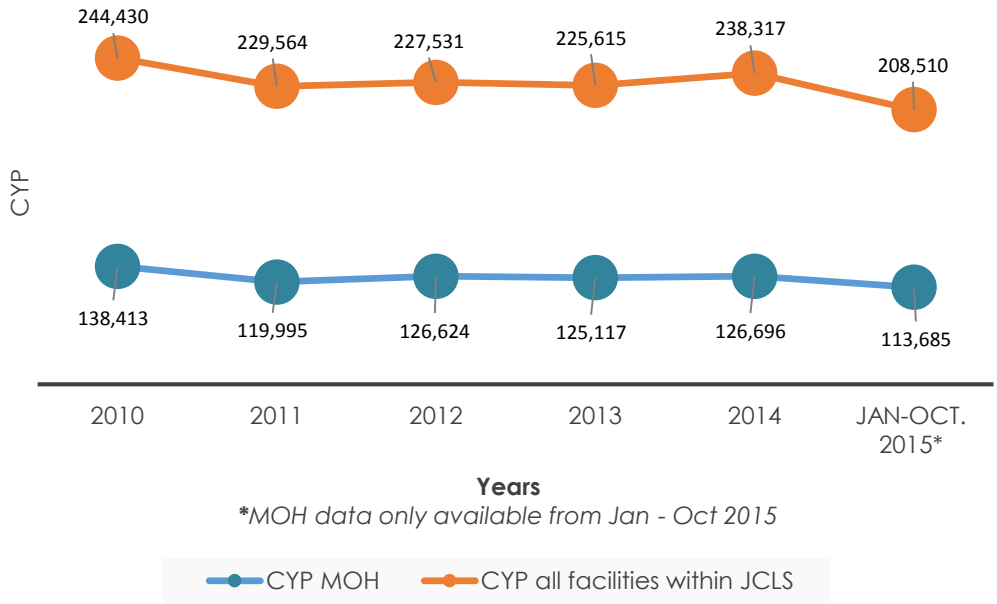
EXPLORING NEW MEASURES FOR FAMILY PLANNING AND FERTILITY

A new measure shows improvement

As noted earlier, a new calculation indicates that there might have been a reduction in TFR in the last few years, estimated as 3.1 for 2014. This new calculation used data from birth registries, which was considered a strong data source given that the majority of women give birth in health facilities. The other strength of this measure is that it can be calculated more regularly rather than waiting five years for each DHS study. USAID and the MOH have accepted the new TFR measure as accurate, but at the time of the field interviews in January 2016, it was unclear how accepted it would become in the wider body of stakeholders in Jordan. One key issue with this new calculation is that it only includes women who have Jordan nationality or are living in Jordan as registered, and as the recent census data highlights, this leaves out a significant and growing refugee proportion of the population. As such, the calculation will not be replacing the DHS survey, rather it will be used as a national TFR measure for Jordanian nationals and residents, only.

The next DHS will not be conducted until 2017. As a result, the IRH team collected CYP data from the MOH database to determine whether there was indication of changes in contraceptive acceptance in recent years. These data show limited change from 2010 to October 2015, both in MOH facilities and in all the facilities that receive supplies from the Jordan Contraceptive Logistics System (JCLS). This does not necessarily mean that TFR has not declined, but it does indicate that there has been limited change in modern CPR.

Figure 14. | CYP for MOH and JCLS Facilities, 2010 – October 2015



Many interviewed MOH respondents noted that while there have not been significant TFR decreases in recent years, holding TFR steady should be perceived as a success given the refugee-related challenges facing the country (many interviewees shared this sentiment despite the fact that DHS data were collected before the start of the refugee crisis).

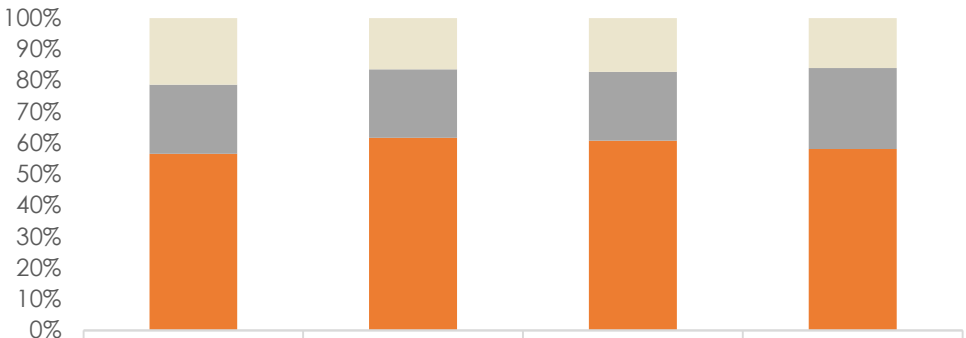
How well is Jordan meeting family planning needs?

All the factors described above limited the impact of improvements in the family planning program on reducing TFR. Most importantly, the limited method mix with high use of traditional methods, the lack of change in desired family size, and the limited involvement of women in the workforce have led to stagnation in TFR. Improving the method mix by making a wider range of methods more routinely and widely available, adding other methods such as the combined injection and emergency contraception can have a significant impact on CPR. Following on SHOPS' feasibility study introducing emergency contraception in Jordan, multiple interviewee sources in Jordan expressed the need to introduce emergency contraception despite existing stigma and barriers to its integration into the market. Finally, a review of 27 years of international data found that the addition of one method available to at least half the population correlates with an increase of 4–8 percentage points in total use of the six modern methods (Ross and Stover 2013).

At the global level, USAID and others have suggested a new indicator be adopted for family planning and be included in the framework for the Sustainable Development Goals (SDGs) (Fabic et al. 2015; Starbird 2016). They argue that unmet need or mCPR on its own does not tell the full story of how well a program is working. Rather than either of these single measures, they recommend the percent of demand met by modern contraception as a better measure, with its emphasis on modern methods due to their greater effectiveness as compared with traditional methods. They have also suggested a global target of 75% met demand with modern contraception by 2030, which has been adopted by FP2020 and others.

The 2012 Jordan DHS notes that percentage of demand satisfied is defined as total contraceptive use divided by the sum of unmet need plus total contraceptive use. Figure 15 shows total demand (adding contraceptive use and unmet need) and the percentage made up by each component. If traditional method use is included, then met demand is over 80%. However, if we only look at met demand with modern contraception and consider those using traditional methods as having an unmet need, then this percentage drops to 60% or below. **Considering the global target of 75%, this shows an important gap to meet**. This indicator helps call attention to one of the key reasons in the stall in fertility decline as well as ways that the family planning efforts can work to address it. The National Reproductive Health/Family Planning Strategy points out the impact of high use of traditional methods: among the 17.4% of pregnancies that are unintended, 80% of these pregnancies are the result of traditional method use (HPC 2013). In 2010, HPC, through the support of USAID's Health Policy Initiative (HPI), conducted a simulation to assess how changing the method mix would affect TFR. The results showed that reducing traditional method use such as withdrawal by half could contribute to reducing TFR by 0.35 points, from 3.80 to 3.45 children per woman (HPC 2010).

Figure 15. | Percent of Demand Met by Modern Contraception



	1997	2002	2007	2012
unmet need	14.2	11	11.9	11.7
trad CPR	14.8	14.6	15.2	18.9
mCPR	37.7	41.2	41.9	42.3

The Health Policy Initiative brief on method mix highlighted this issue of high use of traditional methods and noted three high priority issues to address in order to improve the method mix: 1) fear of side effects/health concerns; 2) provider bias; 3) female provider availability (HPI 2011). The analysis of research question two looks at how well some of these issues have been addressed and research question three identifies potential effective approaches moving forward.

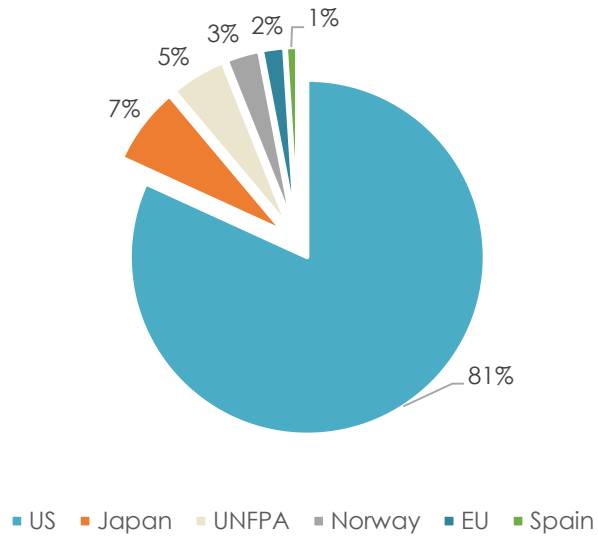
R.Q. 2 HOW EFFECTIVE HAVE USAID'S INPUTS AND PROGRAMMING BEEN ON INCREASING FAMILY PLANNING UPTAKE?

This section highlights key findings from USAID/Jordan's overall contribution toward family planning. Assessment of the overall donor landscape shows that USAID's contributions in the reproductive health and family planning sector cover over 80% of the total reproductive health and family planning donor funding in Jordan. Overall, health systems investments have led to improved quality of services in both public and private sectors, family planning, and maternal, newborn, and child health indicators, primarily through renovations and development of clinical guidelines, capacity-building, and supervision. However, USAID programs have had weaker investment and efforts across behavior change and communication and policy components. Given Jordan's strong social norms around family size and fertility desires, refocusing objectives toward behavior change and communication and community outreach initiatives may be necessary to affect TFR and mCPR.

DONOR LANDSCAPE IN REPRODUCTIVE HEALTH AND FAMILY PLANNING

Among the 11 donor countries and multilateral organizations in Jordan, USAID contributes the vast majority of all funding in reproductive health and family planning. A 2014 report on "Mapping the Donor Landscape in Global Health: Family Planning and Reproductive Health," showed that between 2009 and 2011 USAID/Jordan contributed to approximately 81% of all official development assistance (ODA) in reproductive health and family planning (Kates et al. 2014). During the same time period, the second and third major donors were Japan (7%) and the United Nations Population Fund (UNFPA; 5%). Notably, USAID contributions toward overall family planning and reproductive health may in fact be underestimated, since the majority of aid has come through Economic Support Funds (ESF), which appear to not be accounted for in the report.

Figure 16.| Percentage of RH/FP ODA Funding Provided to Jordan, 2009 – 2011



(Source: Kates et al. 2014)

Jordan is heavily dependent on USAID funding for reproductive health and family planning programming. In fact, the majority of all interviewees in Jordan identified USAID as the sole major donor in family planning. Findings from these interviews confirm that USAID support in family planning has been vital in both setting and sustaining the family planning agenda in Jordan:

> "USAID covers around 70% of family planning projects on the ground. Without USAID funds and other donors there is no family planning."
> *– Higher Population Council (HPC) Staff*

> "USAID has been the major donor in reproductive health. It's because of USAID's work that the whole topic of reproductive health and population growth was put on the radar screen." *– USAID/Jordan Staff*

Findings from key informant interviews also showed that MOH central staff and service providers have very positive perceptions and experiences with USAID, relative to other donors. Some MOH staff described their relationship with USAID as "close," "collaborative," and having "many, many positives." On very few occasions interviewees expressed concerns of USAID involvement being perceived as Western interventionism among the general population. However, this perception was not common among the majority of interviewed stakeholders.

As the largest donor in Jordan's overall health sector, USAID contributes to both public and private sectors and coordinates programming with other international donor organizations. However, findings from key informant interviews point to challenges in international donor coordination. A number of interviewees expressed the need for better donor coordination and communication among USAID, UNFPA, and other donors. Other interviewees expressed frustration at project duplication. Some Jordanian interviewees cited the national registry for maternal and neonatal mortality surveillance as an example, which according to multiple interviewee sources, was duplicated by both USAID and UNFPA. In general, MOH interviewees preferred that USAID stay as the lead family planning and reproductive health donor, but supported USAID shift toward other thematic areas – such as gender-based violence (GBV) – under the condition that USAID coordinate with other key expert donors in that area.

USAID INVESTMENT IN MATERNAL, NEWBORN AND CHILD HEALTH, AND FAMILY PLANNING

From 1997 until 2015, USAID invested close to $476 million toward the overall health sector in Jordan (USAID/Jordan Obligations by Sector, 1997 - 2014). USAID health funding in Jordan is split between maternal, newborn, and child health (MNCH) and family planning programming, with an estimated 40% and 60% of total heath funding allocated toward

maternal, newborn, and child health, and family planning, respectively (correspondence with USAID/Jordan, February 2016).[2] As seen in Figure 17, USAID invested approximately $285.5 million from 1997 to 2015 toward family planning-specific programming. Figure 18 highlights funding trends from 1997 to 2015 across both family planning and maternal, newborn, and child health sectors per fiscal year. Funding data show a peak funding period between 2008 and 2010 totaling approximately $126.6 million for family planning during that time period. This peak funding period from 2008 to 2010 also corresponds with HSS II investments in public hospital renovations, including obstetric wards and neonatal intensive care units (ICUs). The projected 2015 funding estimates show a second wave of peak funding toward family planning programming, almost doubling from $14.4 million in 2012 to the projected $27 million in 2015 (USAID 2016). In the context of the recent funding increase, this assessment provides an opportunity to evaluate which past strategies should be dis/continued and identify gaps to address with future programming.

Figure 17. | Total USAID Funding toward Maternal, Newborn, and Child Health and Family Planning Sectors, from 1997 to 2015 (in US$ Millions)

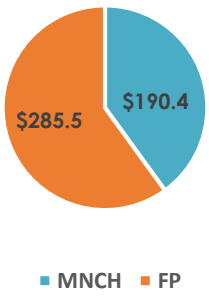
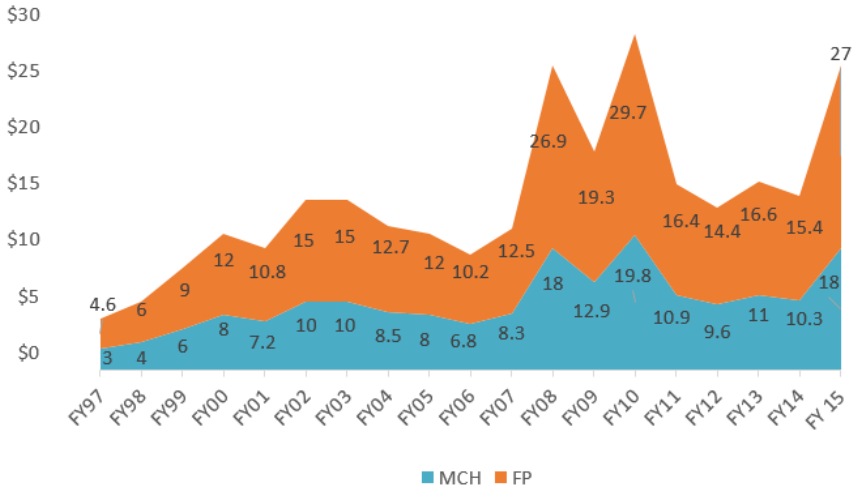


Figure 18. | USAID Funding toward Maternal, Newborn, and Child Health and Family Planning Sectors, by Fiscal Year 1997 to 2015 (in US$ Millions)



[2] The 40/60 MNCH to FP ratio is based on correspondence with USAID/J, and should be interpreted as an estimate rather than a precise investment breakdown. Due to the primarily health systems approach and the overlap of MNCH and FP components within projects, this assessment was unable to disaggregate specifically how much funding has gone toward MNCH or FP for every project assessed.

IMPROVEMENTS AND STAGNATION OF MATERNAL, NEWBORN, AND CHILD HEALTH INDICATORS

Over the last two decades, maternal, newborn and child health indicators have also drastically improved. According to interviewed stakeholders in Jordan, USAID investment were key in improving these indicators. From 1997 to 2012 for instance, maternal mortality dropped from 79 to 59 per 100,000 live births, respectively, accounting for a 25.3% percent decrease over time (DHS 1997; World Bank Development Indicators 2012). Key informant interviews in Jordan confirmed the importance of maternal, newborn, and child health improvements. Many MOH staff and service providers were quick to cite improvements in maternal, newborn, and child health, rather than family planning, as a key outcome of USAID investment as one interviewee plainly stated:

> "Without USAID, maternal and child health indicators would have fallen down [or deteriorated]." – *MOH Central Staff*

Yet similar to TFR and mCPR, data suggest that since 2007, both maternal and under-5 mortality have also plateaued. This suggests that health indicator stagnation in Jordan was not just limited to fertility and mCPR outcomes. The timeline in Figure 19 shows a cross-comparison of USAID-funded projects since 1995, relative to family planning and MNCH outcomes during the same time period.

EFFECT OF USAID PROGRAMS

As seen in the timeline in Figure 19, USAID has supported approximately 20 projects since 1995 across health systems, behavior change and communication (BCC), and policy/advocacy areas.[3] The timeline suggests that some of the earlier USAID investments were exclusively focused on family planning programs (Linkages and Engender Health). However since the mid to late 2000s, investment shifted toward health systems improvements that go beyond family planning service delivery. As seen in Figure 20, the majority of USAID investment has since been allocated toward health systems-focused projects (both public and private), or approximately 75% (US $281.9 million) out of the $375.8 million invested across all projects since 1995. Investments in behavior change and communication and policy projects have been less extensive, totaling 18.0% ($67.6 million) and 7.0% ($26.2 million) of total funds, respectively.[4]

[3] See Annex for a list of USAID-funded projects and descriptions. Funds were estimated from end of project reports and primary documents from USAID/Jordan. These funds are only estimates, and do not include other investments toward RH/FP such as demographic health surveys (DHS) and smaller technical assistance grants.

[4] Funding estimates were collected from end of project reports (see Annex 3 for project funding breakdown). When project funding data were not available, the IRH team retrieved funding estimates through email correspondence with USAID/Jordan. These calculations are estimation of project funding according to primary project component (either HSS, BCC or policy). For instance, secondary behavior change and policy-specific activities tucked under health systems projects were not included in the calculation. One example includes mass media campaigns under SHOPS, which we classified as a private health systems not as a BCC initiative.

Figure 19. | USAID-funded Projects in Jordan from 1995 – 2016

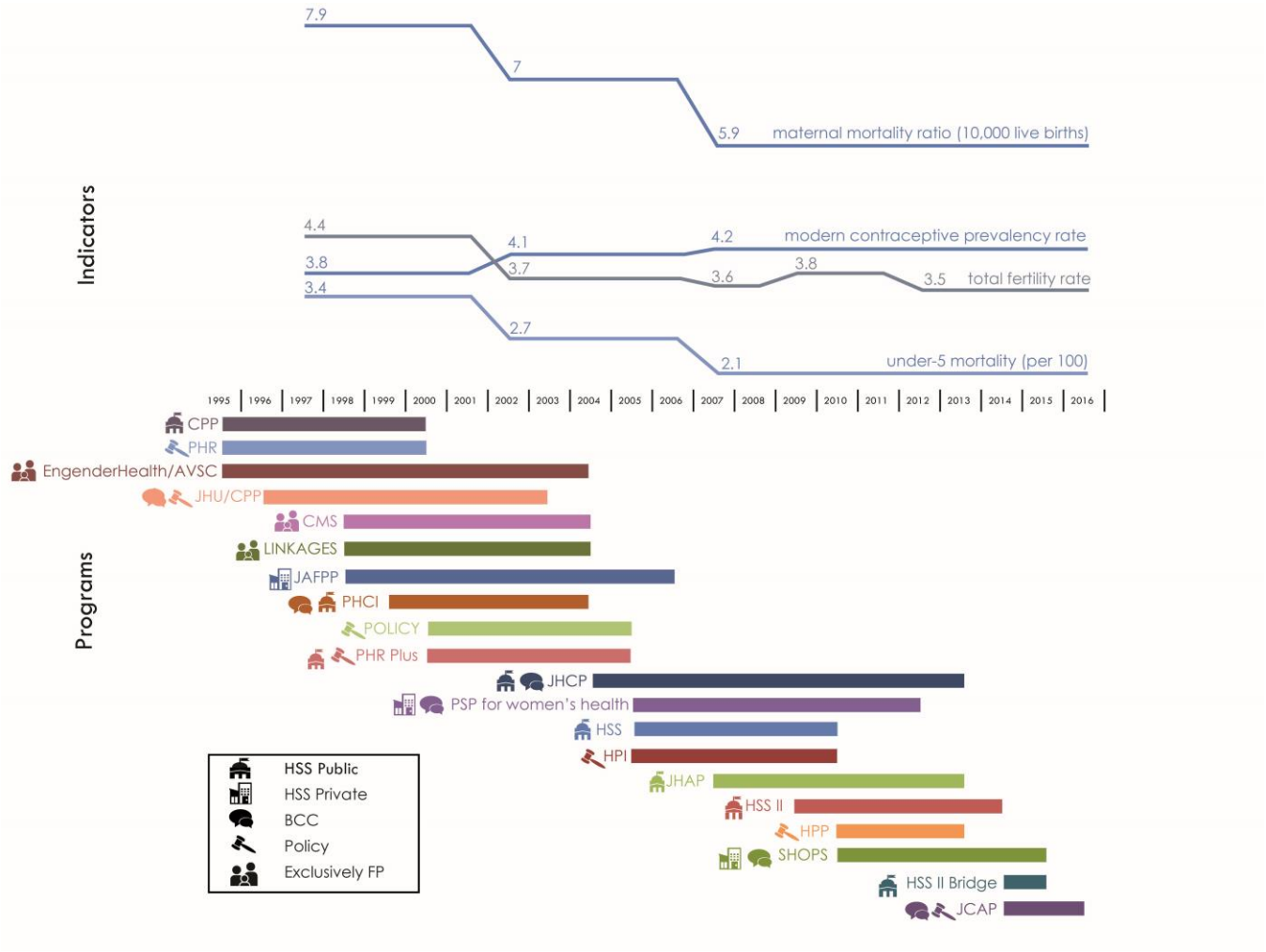
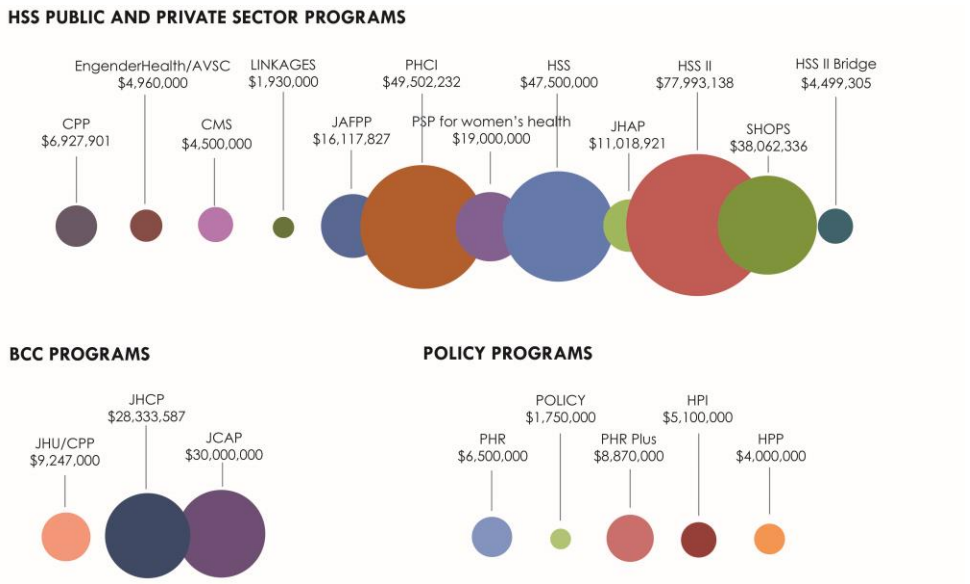


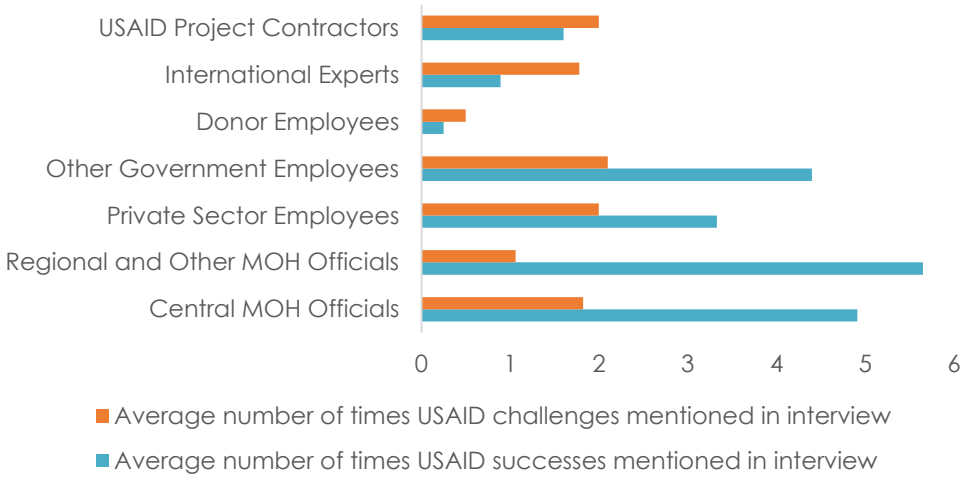
Figure 20. | USAID Investment in HSS, BCC, and Policy Projects, in chronological order (1995 – 2015; US$ Millions)



Perceptions of USAID successes

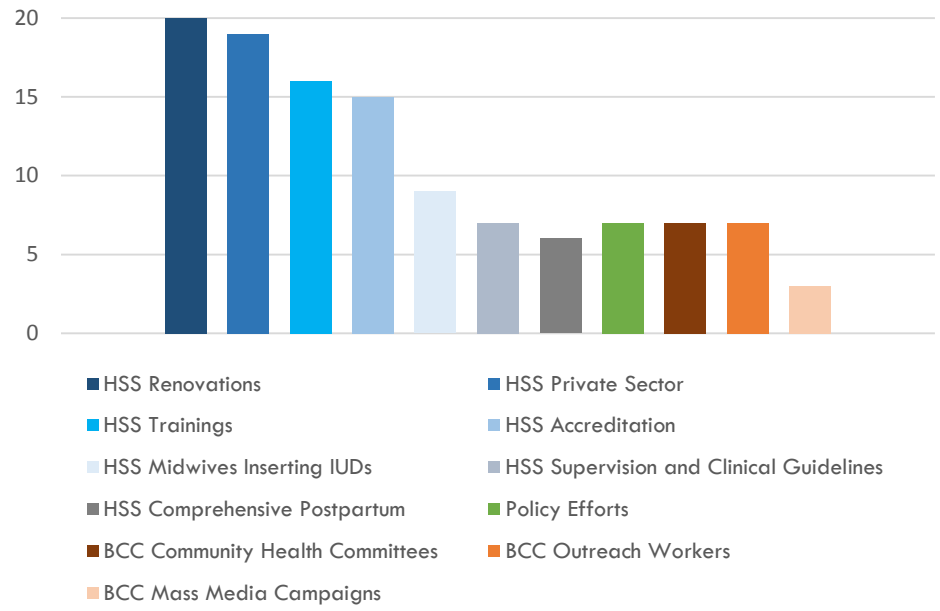
Coding analysis from the interviews indicate that overall, participants found USAID programs to be very successful. For instance, USAID successes were coded 240 times among all interviews, while challenges were coded only 111 times. Figure 21 shows the average number of times successes and challenges were coded per interview. Note that MOH officials, private sector employees, and government officials tended to talk about USAID successes more often than challenges, while USAID project contractors, international experts, and donor employees focused on challenges. It appears that, overall, Jordanians may perceive USAID programs as more successful than non-Jordanians. This may reflect a difference in the level of knowledge of programs and their strengths, as well as differences in perceived overall success.

Figure 21. | USAID Successes and Challenges, Mentioned by Interview Group



Not surprisingly, the vast majority of interviewees in Jordan commonly cited health systems projects – such as HSS I, II, and Bridge projects, Strengthening Health Outcomes through Private Sector Partnerships (SHOPS), and the Jordan Health Accreditation Project (JHAP) – as the most successful projects. Interestingly, the Comprehensive Post-Partum project (CPP) was also cited as one of the first and most successful projects to work on family planning. Participants discussed successful USAID health systems strengthening programs the most, supporting the data indicating that HSS programs have had the biggest impact. Behavior change and communication, and policy efforts were also mentioned, however, to a lesser extent. Key policy efforts mentioned during interviews include task-shifting IUD insertion toward midwives and HPC's use of the RAPID model to engage policy makers.

Figure 22. | Number of Times USAID Successes Mentioned in All Interviews, by Project Type



To assess USAID overall impact on family planning uptake, the following three sections present key findings and contributions according to: 1) Health systems strengthening; 2) Behavior change and communication; and 3) Policy project areas.

1. USAID CONTRIBUTIONS IN HEALTH SYSTEMS STRENGTHENING

Since the mid to late 2000s, the largest proportion of USAID support was allocated toward health systems strengthening, defined in this assessment as improvements toward maternal, newborn and child health and family planning service delivery and quality at public and private health centers and hospitals. Accordingly, a large bulk of USAID funding has been invested toward renovating public primary health care centers, and later shifting to hospital obstetric care wards, neonatal intensive-care units, and emergency departments. In addition, sizable investments have been distributed toward improving service delivery through building the capacity of both public and private sector providers. Although family planning was not the primary focus, family planning specific activities included: working on public-private partnerships, demand generation, counseling, supporting local network of NGOs (e.g., JAFPP), provider attitudes, and behavior change and communication activities. Key USAID contributions toward renovations and health systems strengthening include:

- Upgrading 21 Comprehensive Post-Partum (CPP) centers
- Renovating and equipping 25 public hospital departments
- Renovating and equipping 318 primary health care centers, including computerization of 200 clinics
- Training of 6,000 health service providers and establishment of quality assurance teams at 200 centers
- Training of 1,500 pharmacists and 900 physicians in the private sector on family planning services and counseling

- Conducting 1.4 million family planning counseling visits, reaching over 677,000 low-income women, and generating 90,000 new clients of modern family planning methods (USAID/Jordan, https://www.usaid.gov/jordan/family-planning-reproductive-health)
- Establishing 106 community health committees linked to primary healthcare centers [5]
- Securing an improved logistics systems for contraceptives, which was assumed by Jordan's MOH in 1999 to manage contraceptive distribution (John Snow, Inc. 2013)
- Establishing the Health Care Accreditation Council (HCAC)
- Introducing standards of care for health centers, improving supervision, clinical guidelines, and information systems

EFFECTIVE HSS STRATEGIES

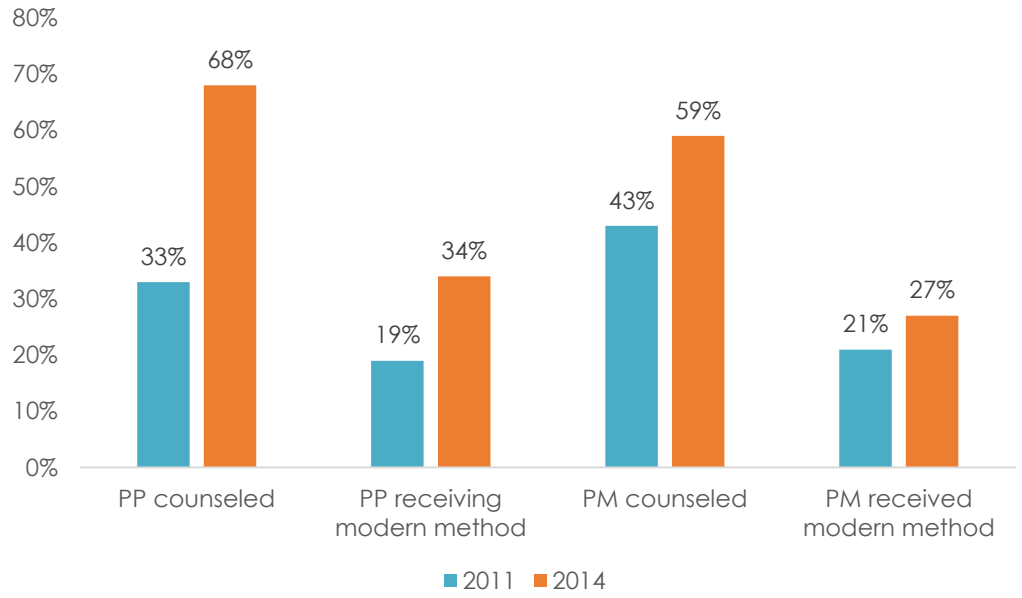
Health systems and renovations (PHCI, HSS I, HSS II and Bridge; 1999 – 2015)

The health systems approach under PHCI and HSS I, II, and Bridge were effective in boosting overall family planning access and use. In 2011, 439,439 counseling visits for family planning and reproductive health services were conducted in the public sector, which increased to 550,470 counseling visits by 2014 (USAID 2016). The increase in family planning utilization may be attributed to USAID efforts. For instance, an evaluation of PHCI (1999 – 2004) showed increases in contraception use and a reduction of traditional methods over time, a trend that was not sustained in the last decade. During the pre-test (1999), 73.4% of participants had used some type of contraceptive, compared to 82.8% of participants at the post-test (2004). In addition, renovations of comprehensive health centers helped facilitate access to family planning services. According to field interviews, the upgrading of facilities to include separate private family planning counseling rooms in comprehensive health centers – in addition to supplying equipment such as beds and ultrasounds – helped generate use of family planning services at the local level. The strategic shift from renovations to service delivery during the second phase of HSS II (2011 – 2014) also led to reported gains. From 2011 to 2014, the number of MOH primary comprehensive health centers offering four or more family planning methods increased from 106 to 145 health centers, respectively.

Finally, HSS II investment in public hospitals included a key initiative on immediate postpartum/post-miscarriage family planning counseling and use. The program started in 2011 and expanded over the last four years to cover 25 public hospitals. Data show that from 2011 to 2014 the percentage of postpartum (PP) and post-miscarriage (PM) women receiving family planning counseling at the 25 public hospitals increased from 33% to 68% (PP), and from 43% to 59% (PM), respectively (see Figure 23) (HSS II 2014a).

[5] Numbers obtained from email correspondence with USAID/Jordan Office of Program Management and USAID/Jordan Population and Family Health home page https://www.usaid.gov/jordan/family-planning-reproductive-health

Figure 23. | Postpartum and Post-miscarriage Counseling and Modern Method Uptake Increase from 2011 to 2014



Lastly, the health-systems approach under PHCI, HSS (I, II, and Bridge) improved overall quality standards and services in all maternal, newborn, and child health, reproductive health, and family planning services. As mentioned earlier, interviewees and in particular MOH participants attributed key USAID achievements to general activities such as training, supervision, and clinical guidelines.

Accreditation (JHAP; HCAC; HSS II; 2007 – 2014)

Despite not having any of the health centers accredited during the project span, JHAP was one of the few USAID-funded projects sustained after project end, with the establishment of the Health Care Accreditation Council (HCAC). Since then over 100 local health centers and 14 hospitals have been accredited, and in some cases re-accredited (JHAP 2013). As one public hospital administrator noted:

> "Accreditation is the shortest and best way to improve ourselves."
> – *Public Hospital Administrator*

Adding some activities related to family planning standards into the accreditation standards also led to increases in CYP among participating primary healthcare centers by 13%, in comparison to a smaller increase of 5% in non-participating sites (HSS II 2014b). Field interviews also confirm that the improved quality of services may have increased use of family planning services in participating health centers.

Insertion of IUDs by midwives (PHCI, PSP, HPP, HSS I, HSS II, BRIDGE; 1995 – 2015)

Given the limited numbers of female service providers, task shifting the insertion of IUDs toward midwives increased uptake of IUDs and improved MOH CYP indicators. First, the number of MOH health centers providing IUDs each year increased from 88 in 2011 to 160 health centers in 2014 (HSS II 2014a). In 2011, CYP dropped when MOH temporarily banned midwives from inserting IUDs (see Figure 14, p. 26). During this time, HSS II helped to reverse the ban. After midwives once again began inserting IUDs, MOH CYP increased, albeit slightly, from 119,995 in 2011 to 126,696 in 2014 (MOH Jordan online database).

Family planning service delivery improvement collaborative (HSS II Bridge; 2014 – 2015)

The reactivation of community health committees and community awareness activities – initially developed by PHCI, HSS I, HSS II – under the family planning improvement collaborative generated immediate demand for family planning services. Unlike its predecessors, the collaborative approach exclusively focused on increasing family planning demand at the primary healthcare level. The exclusive focus on family planning in HSS II Bridge led to reported gains: within six months, CYP increased by 50% in the targeted health facilities (HSS II Bridge 2015). However according to MOH staff and service providers interviewed, not all community health committees are still active since the project ended in late 2015.

Expanding network of private doctors

Both PSP and SHOPS created and expanded a network of private doctors with the goal of increasing family planning access and reducing unmet need for family planning. From 2010 to 2015, SHOPS increased the number of network physicians from 120 to 300, respectively, of which 78% were female (SHOPS 2015a). In addition, network doctors contributed to an increase in national CYP from 20,336 in year one to 45,593 in year five (SHOPS 2015a).

Less effective health systems strategies include the **evidence-based medicine (EBM)** approach**,** conducted by SHOPS. For instance, a 2014 randomized study showed that EBM training provided to private sector physicians improved attitudes and confidence in providing injectables, but did not improve knowledge or practice scores. This suggests that a stand-alone training EBM intervention may not be enough to change provider biases. Another strategy with mixed results included **postpartum family planning introduction in private hospitals**, also introduced by SHOPS. In the private sector, postpartum counseling can be effective in increasing short-term uptake of modern family planning methods. However, it may be more challenging to determine impact on family planning use in the private sector because private sector clients may be more educated and wealthier, making them more likely to use family planning methods anyway (46% of those in the control group were already using modern family planning methods three months postpartum, compared to the national average of 42%) (SHOPS 2015a).

HSS CHALLENGES

USAID investment in HSS has been key in improving standards of care and increasing family planning access and use. However, evidence outlined under research question 1 suggests that these efforts were not enough to significantly affect national TFR and mCPR. One key

takeaway is that **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 has been successful in increasing family planning utilization, 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 key challenges are highlighted below.

Public versus private share of family planning

The majority of USAID funding has been invested in the public health sector, increasing the public sector's share for providing modern methods from 33.9% in 2002 to 44.1% in 2012 (DHS). Figure 24 shows that primary health centers in particular increased their share of modern methods, consistent with USAID investment at the primary healthcare level under the HSS projects. However, public facilities under Royal Medical Services (RMS) and Jordan University Hospital (JUH) continue to have a very small share of the market: from 2002 to 2007, RMS' share decreased from 3.5% to 2.7%, while university hospitals such as JUH decreased from .6% to .5% (DHS).

Figure 25 shows that although the private sector share has been decreasing (from 65.9% in 2002 to 55.6% in 2012), the private sector continues to play an important role in family planning, providing modern methods to over 50% of Jordanian women (DHS 2002 – 2012). DHS data show that investment in JAFPP has had mixed results and their share of family planning services has been declining (from 20.4% in 2002 to 10.6% in 2012). 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). One potential reason for this shift could be the large USAID investments in public health service delivery, which increased access to public family planning services, while reducing demand for family planning services in the private sector. On the other hand, other sectors such as pharmacies and private hospitals have been increasing their share of family planning provision. A number of both public and private sector interviewees expressed the lack of cross-collaboration between public and private sectors as a gap in USAID investment. As a result, a key challenge moving forward entails identifying an appropriate balance in USAID investment and collaboration across public and private sector

Figure 24. | Public Sector as a Source of Supply for Modern Methods, DHS 2002 – 2012

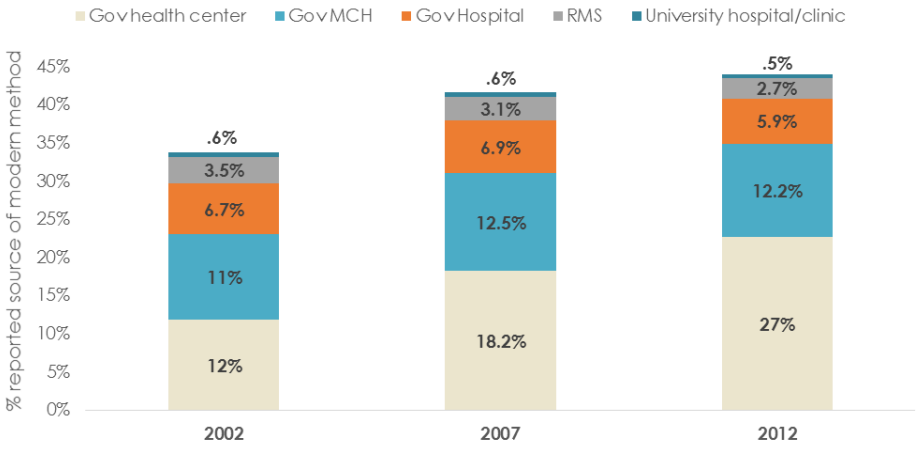
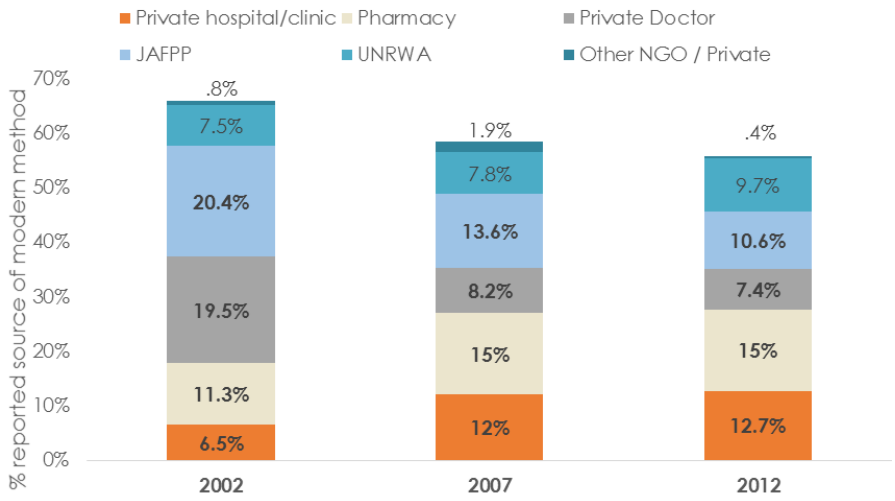


Figure 25. | Private Sector as a Source of Supply for Modern Methods, DHS 2002 – 2012



Gap between projects

MOH interviewees most commonly cited funding discontinuation and project gaps as the biggest barriers in sustaining family planning programs. For instance, a number of interviewees cited that since the recent end of the HSS II Bridge project, some comprehensive health centers had stopped coordination with local health committees. This would suggest a lack of local service delivery ownership over USAID-funded family planning projects.

Weak referral systems

Despite efforts during HSS II to address family planning referrals between health facilities (hospitals to local health centers and in between local health centers), family planning client follow-up from hospitals to health centers is weak. As mentioned above, project reports show that USAID investment in hospital service delivery increased postpartum family planning counseling and use. However, field interviews showed that hospital-based family planning counselors are unable to confirm whether postpartum clients follow through with referrals given to them for family planning methods at other facilities. In addition, some interviewed family planning counselors expressed the need to have an electronic system in order track a client's family planning history, including use of past family planning methods. Given the high method switching and discontinuation rates in Jordan, a longitudinal study should be conducted with women receiving postpartum family planning methods in hospitals to investigate the relationship between referrals for family planning services, client satisfaction and utilization of family planning services, and client follow-up procedures. Another option is establishing a phone call follow-up system for all family planning services including postpartum clients.

MOH internal and structural challenges

A number of internal MOH challenges were cited by MOH participants, including high staff turnover, weak follow-up and support from central MOH and Jordan Government, and insufficient transport and training incentives. In particular, health service providers in primary

health centers and hospitals expressed frustration at staff turnover and departure of midwives to other health facilities previously trained by USAID in IUD insertion or family planning counseling. MOH interviewees also cited high transport costs – currently not subsidized by either MOH or USAID - as the main barrier to attending trainings. Another common challenge cited during interviews included weak supervision and support for family planning activities by the central MOH and health directorates staff. While the vast majority of MOH interviewees spoke highly of the support they received from USAID-contracted staff, they stated that little to no follow-up was done after the project was over by MOH.

2. USAID CONTRIBUTIONS IN BEHAVIOR CHANGE AND COMMUNICATION

Communication and behavior change activities were initiated in Jordan in 1996 with technical assistance of the Johns Hopkins Center for Communication Programs (JHCCP), followed by the Jordan Health Communication Partnership (JHCP 2004 – 2011), and the Jordan Communication, Advocacy and Policy (JCAP) project. Early behavior change and communication strategies under JHCCP and JHCP were instrumental in enabling a supportive family planning environment among women, men, and families. More recent behavior change and communication mass media campaigns under SHOPS have reported success in intermittently increasing awareness of methods such as IUD and oral contraceptives. However, the more recent mass media campaigns have had mixed results in not only sustaining family planning demand, but addressing social norms around fertility desires, family size, and son preference.

EFFECTIVE BEHAVIOR CHANGE AND COMMUNICATION STRATEGIES

Together for a Happy Family and Let Arab Women Speak (JHU/CCP and JHCP; 1996 – 2011)

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). The Let Arab Women Speak initiative, implemented by JHCP, trained 65 facilitators in reproductive health using the Arab Women Speak Out (AWSO) empowerment training program, reaching over 6,000 women at the community level (Cobb et al. 2003). Project reports show that such behavior change and communication campaigns were key in garnering social support for family planning as a spacing mechanism, including mobilizing support from religious leaders. Notably, behavior change and communication initiatives were least cited by interview participants (see Figure 22, p. 36). This could be due to both recall and selection bias, since the projects ended over a decade ago and the majority of interviewed participants in the sample are MOH staff and more likely to report HSS activities.

Social worker outreach (CMS, PSP, SHOPS, and JCAP; 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.

> "We don't cover only the woman – we also talk about the impact of spacing on the children and even the economic situation of the family." – *Social Worker*

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 contraceptive methods (JCAP 2015a; p. 7).

More recent mass media campaigns show mixed results on sustaining family planning demand (SHOPS, JCAP; 2010 - 2015). Between October 2014 and September 2015, approximately 354,144 married women of reproductive age (MWRA) saw or heard at least one placement of JCAP's Oral Contraceptive Pills (OCP) campaign. Evaluation results of SHOP's social marketing (OCP) campaign from 2011 to 2013 showed that 91% of respondents remembered the campaign slogan when prompted. The evaluation results also showed that the likelihood of being an OCP user increased with increased exposure to the campaign. However, evidence suggests that campaigns for IUDs boosted the uptake of IUD services, but demand dropped and was not sustained after the campaign (SHOPS 2013).

BEHAVIOR CHANGE AND COMMUNICATION CHALLENGES

Overall, USAID's contributions to behavior change and communication have been rather limited in comparison to overall investments in health systems strengthening. A 2011 evaluation of JHCP noted the need to change cultural norms in order to reduce fertility rates. The authors conclude that access, cost, and quality of care are not the main constraints to adoption and use of contraception, stating that "improved quality of care can affect fertility timing, but will not change fertility levels without a change in desired fertility" (Lewis et al. 2011).

The early **mass media campaigns** were effective in increasing acceptance of family spacing among the general population. Previous mass media campaigns attempted to tackle norms around son preferences and targeted husbands and mothers-in-law, both of whom play an influential role in preference for boys and pressuring for quick pregnancies after marriage. However, assessment findings suggest that mass media campaigns alone cannot singlehandedly address the strong social norms among close-knit families and communities concerning family size and son preference. 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.

As explored under research question 1, gender and social norms reinforce unabated fears around hormonal side effects and have contributed to the recent uptick in traditional methods. As a result, targeted community-based approaches like the social worker outreach model (albeit more costly), may be more effective in promoting behavior change and boosting national mCPR levels. Lastly, a combination of both mass/social media and community-based approaches may be more effective in tackling such strong social norms.

Like the rest of society, many health service providers subscribe to social norms around family size and fertility. As mentioned above, the health systems approach has not been effective as a standalone approach in reducing **provider biases** around informed choice and hormonal method provision. Some 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). These perceptions suggest that additional behavior change and communication strategies – beyond evidence-based medicine – may be needed to deconstruct providers' conceptions of gender norms within their personal and professional spaces.

3. USAID CONTRIBUTIONS IN POLICY AND ADVOCACY

A key component of USAID/Jordan's strategy for family planning includes increasing political commitment and resources to address Jordan's growing population. The objectives of the Health Policy Initiative (HPI) and Health Policy Project (HPP) include strengthening: 1) Jordan's policy environment and support for the implementation of the reproductive health/family planning strategy; 2) the capacity of local partners to advocate and conduct awareness-raising and policy reform activities; and 3) support to the Higher Population Council (HPC) and Ministry of Health in advocacy and policy planning (HPP 2013).

Key policy successes and contributions include:

- Addition of a budget line item for family planning, which was assumed by Jordan's MOH in 2008 (HPI).
- Development of the national health accounts (NHAs), which tracks and estimates healthcare expenditures in Jordan (PHRplus)
- Capacity-building of HPC since 2002 (formerly the National Population Council (NPC) established under the POLICY Project) to implement policy and advocacy-related activities; using the Resources for the Awareness of Population Impacts on Development (RAPID) model and integrating reproductive health and population growth topics in school curricula (HPI and HPP)
- Support HPC in the adaptation of the national Population Strategy into Jordan's Reproductive Health Action Plans I and II (RHAP I and RHAP II) under POLICY and HPI. The first RHAP (2003-2007) was endorsed by the Ministerial Council in 2004. The Ministry of

Planning allocated $300,000 to the Reproductive Health Action Plan and MOPIC also allocated funds to implement the plan in its first year

- Support and develop a contraceptive security strategy to support the national Population Strategy ensuring that, by year 2020, all married men and women of reproductive age will have high quality contraceptives in response to their expressed needs. From 2005 to 2010, MOF had committed $2.89 million for contraceptives (USAID communication 2016)
- Creation of Jordan's first national reproductive health/family planning strategy (HPP)
- Creation of the MOH Strategy 2008 - 2012 (HSS) and MOH Strategy 2013 – 2017 (HSS II)
- Creation of MOH Family Planning Strategy 2013 – 2017 (HSS II)
- Including IUD insertion within the MOH midwives job description (HSS II and HPP)
- Integrating RH concepts at school level curricula and adding a course on the impact of population growth to the mandatory graduation requirement at the public university (POLICY project)
- Increasing the age of marriage from 15 to 18 for females and 16 to18 for males, (POLICY project)

POLICY CHALLENGES

Despite USAID/Jordan's sizable contributions in family planning over the last 20 years, political and financial commitment from the Jordanian government remains verbal, at best. Evidence suggests three types of needed commitment – expressed, institutional, and financial – to enable a supportive environment for family planning programs (HIPS 2015). Field interviews repeatedly confirmed the existence of expressed "verbal" commitment by senior government and central MOH staff for family planning programs, but limited commitment in terms of financial resources. This is consistent with desk review findings which repeatedly suggested that lack of government funding is *the* key limiting factor in family planning program sustainability (HPI 2009). Yet the existence and continued strengthening of the HPC also suggest that institutional commitment may also be in place in Jordan. However, HPC faces its own staffing shortages, and has limited capacity and authority in holding policy-makers accountable to family planning programs.

Aside from MOH's 500,000 JD ($705,218 USD) yearly line item for contraceptives, financial commitment toward family planning appears to be non-existent in Jordan. There are two key consequences. First, project activities are not led by government or local institutions and therefore, not sustained over time. These include successful initiatives such as family planning awareness-raising activities conducted by community health committees under the HSS projects to generate family planning demand to local health centers. One interesting exception is the accreditation model, which is now being implemented through the Health Care Accreditation Council (HCAC), and is being expanded. A key factor contributing to the sustainability of the accreditation model may have been a "win-win" opportunity for Jordan's MOH to both improve general healthcare standards, while at the same time improving family planning services. Second, many successful pilots are unable to be scaled-up without USAID support. Lack of budget was the key reason cited during field interviews for project discontinuation. Other key reasons included lack of commitment, monitoring, and follow-up from MOH central management; and little to no managerial support at either central or facility levels. Finally, the desk review, and in particular project reports gathered for this assessment,

had little information on intentions to scale-up. However, findings from the field interviews in Jordan suggest that for a large number of projects, activities were either discontinued or interventions never scaled up, including those described in Table 2.

Table 2. | Examples of Pilot Projects Discontinued or Not Scaled Up, by chronological order

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 clients 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.

Follow-up for postpartum women receiving family planning counseling at Al-Bashir hospital (2013) *[discontinued after project end]*	• HSS II project conducted a study to measure the effectiveness of postpartum family planning counseling and services at Al-Bashir hospital. • The follow-up stopped after the study period ended due to funding constraints.

The lack of government financial commitment – despite the presence of both verbal and expressed commitment – has detrimental consequences on family planning activities and outcomes in the long-term. At the time of the field interviews, participants cited a number of other projects currently awaiting more USAID funding to either start or resume activities. Some cited examples include a maternal mortality registration and a workload indicators for staffing needs (WISN) tool piloted under HSS II. Given the recent surge of USAID funding in the last year, USAID's strategy may need to be re-shifted toward ensuring financial commitment and institutional scale-up of proposed activities. The next section provides recommendations to guide such future strategies going forward.

R.Q.3 WHAT SHOULD GUIDE USAID'S STRATEGY GOING FORWARD?

The impact of USAID's investment in health systems and service delivery over the last decade is evident. The quality of general maternal, newborn, and child health and reproductive health services has improved, and access to family planning services increased. These investments provide a strong foundation upon which to continue building family planning programming. Moving forward, improving family planning outcomes may entail a shift in focus toward community health outreach at the comprehensive, primary and village health center level. Given the strong norms around family size and preference for sons, as well as misperceptions and biases against modern methods, increased efforts should be invested in 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 counseling skills of providers and addressing their biases as well as increasing the availability of female physicians at the primary healthcare level. Outreach efforts have been shown to be effective, and should be expanded as they serve a dual role of behavior change and service provision. Given the ongoing challenges in program sustainability, there is also a need for continuing advocacy with the government to assume greater ownership of the work. In addition, the massive influx of Syrian refugees since 2012, accompanied with the resurgence of communicable diseases, including TB as mentioned earlier, points to shifting health priority needs which will need to be addressed.

Specific behavior change, policy, and health system priorities to guide USAID's strategy forward are described below (Tables 3-5).

Table 3. | Social and Behavior Change Communication Priorities

Priority Component/Theme	Recommendation
Community-centered SBCC and engaging men	• Include the "social" in social and behavior change communication (SBCC). Community-centered SCBB is one of the high-impact practices in family planning (HIPS 2016). A community-centered approach works with and through community groups 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. Evidence-based campaigns include Instituto Promundo's Programs H and P, which have effectively engaged men and youth in reproductive health and family planning at the community and primary health service delivery level (Barker, Ricardo and Nascimento 2007).
Youth	• MOH school health and sports programs are excellent channels for youth engagement. Evidence suggests that involving teachers is key in sustaining school-based interventions. Evidence-based resources include Population Council's "It's All One Curriculum;" and Rutgers' "The World Starts with Me (WSWM)" a computer-based sexuality education program for in- and out of school youth (Kato-Wallace et al. 2016) • Encourage youth to plan for their lives and delay having children after marriage. Provide premarital couples with family planning counseling through implementing the newly developed premarital guidelines. Train counselors and ensure guidelines are relevant and contextually appropriate.
Community champions engagement	• Involve religious leaders, especially women preachers, and family planning champions as active participants in *designing* and implementing campaigns. • Special orientation sessions on family planning and modern contraceptives should be provided to those religious leaders to assure full understanding.
MOH promotional materials	• Involve communities in developing educational materials such as brochures and posters with contextually-relevant images and clear messages.
Community health workers outreach program	• Home visits are one of the most effective methodologies to raise awareness and encourage woman to identify her needs for family planning and seek services. • The outreach program should be continued and expanded to reach areas with underserved and very rural and Bedouin areas.

Table 4. | Policy Priorities

Priority Component/Theme	Recommendation
Increase government financial ownership	• Continue advocacy efforts with government to improve sustainability of programs through greater government ownership and commitment, including verbal, institutional and most importantly financial commitment (HIPS 2015). • Use the new census data as an advocacy tool to highlight the impact of the growing population on country resources and infrastructure.
Share assessment results	• Share the results of this assessment among local stakeholders, including policy makers, public and private health sector staff and providers, and donors.
Task-shifting IUD insertion	• Ensure task-shifting and implementation of IUDs by midwives to provide IUDs and removing the condition of needing supervision of trained physicians.
Encourage women in workforce participation	• Encourage increased participation of women in the work force, both through policy support and behavior change and communication activities to address social norms that discourage this participation. • For example, the evidence-based RAPID model could be used with the Ministry of Labor to show the positive impact of increased participation of women in the work force on all sectors of Jordanian society.
Improve donor coordination	• Conduct advocacy with other donors to support family planning activities and improve collaboration among donors to share experiences and lessons. • Avoid duplication and assure proper use of resources.

Table 5. | Health Systems Priorities

Priority Component/Theme	Recommendation
Expand method mix	• Reintroduce methods that have experienced minimal uptake, such as Implanon and injectables. Introduce new methods such as combined one-month injection and emergency contraception. In particular, the combined injection is highly effective with no bleeding side effects. • Introduce fertility awareness-based methods (FAM) such as Standard Days Method (SDM). Fertility awareness messaging and methods can be offered as a way to increase overall knowledge about fertility and a gateway to other methods. Counseling sessions for women who decide to use FAM should include clear information on fertility periods and how to use the method.

Conduct assessment of health systems' response to refugees	• Conduct an assessment of the health systems needs in response to the refugee crisis, and where possible integrate family planning into the identified priorities. • As per assessment, prepare strategies to educate and raise awareness among Syrian refugees on reproductive health, family planning, service providers, and services.
Continue training and supervision	• Expand training on IUD insertion to other midwives, Ob/Gyn and family medicine residents/specialists, and female general practitioners. • Improve residency programs of Ob/Gyn and family medicine to assure that family planning is included within their syllabus and scheme of competencies. • Strengthen supportive supervision at the MOH central and health directorates-level, RMS, and NGOs, increase number of supervisors in governorates with high number of health facilities such as Amman, Irbid, and Zarqa. • Decentralize location of trainings to local health directorates. • Focus trainings on reducing service providers' bias and misconceptions toward modern family planning methods. • The evidence-based medicine approach showed little impact. Alternative evidence-based counseling guidelines include the WHO Medical Eligibility Criteria for Contraceptive Use and Selected Practice Recommendations for Contraception Use.
Integrate client-centered and psycho-social approach to counseling	• Due to the refugee crisis, both Jordanians and non-Jordanians may need increased psycho-social support as a result of the economic downturn and social disruption, both of which affect fertility decisions. • Explore alternative spaces to counsel men on family planning (i.e., workplace, group awareness sessions), while ensuring women's privacy to interact with providers.
Improve postpartum family planning and linkages	• Expand postpartum/post-miscarriage family planning to all public hospitals. • Link postpartum family planning with follow-up phone call system or care line for family planning; in addition to establishing a care line at all health facilities level). • Promote post-partum breastfeeding and LAM during both antenatal and post-partum consultations.
Increase support and collaboration for private sector	• Provide technical and financial support to more NGOs and community organizations working in family planning, such as the Institute of Family Health. • Expand training of pharmacists to provide improved family planning counseling to clients on contraceptive effectiveness and correct use.
Exclusively focus on family planning in health care centers	• Expand the improvement collaborative approach to other health centers, making family planning the focus of health centers' work through antenatal counseling, internal referrals for MWRA from other clinics to family planning clinics, and assigning specific indicators and activities.

DISCUSSION

Despite the 2002 to 2012 TFR stagnation, many successes have been achieved in improving maternal, newborn, and child health and family planning outcomes. Stagnation is not uncommon: for example in 2005, USAID studied family planning plateaus in Senegal (Wickstrom et al. 2006) and Tanzania (Pile and Simbakali 2006), and both countries have now seen CPR increases. Moreover, a new TFR calculation using birth registry data shows that TFR may have in fact decreased to 3.1 in 2014 for Jordanian nationals. Beyond TFR calculations, the increases in traditional methods and decreases in long acting reversible contraceptives (LARCs) such as IUDs, suggest that much more needs to be done to promote behavior change among all women, men, health service providers, and policy-makers.

At the same time, the complexity of the refugee crisis is now overshadowing family planning priorities and population issues. The majority of interviewed local health service providers, MOH staff, government officials, and implementing partners fear that the influx of Syrian refugees now threatens to reverse the decades of improved maternal, newborn, and child health and reproductive health outcomes. The impact of the Syrian refugee crisis is unknown and has had a somewhat paralyzing effect on Jordan's ability to move forward with family planning. At the same time, preliminary results from JCAP's qualitative gender study show that Jordanians and Syrians may be more alike in their reproductive intentions than anticipated. As one interviewee stated, "*Refugees are not a Jordanian problem – it is a world problem. Why should we face it alone?*" Many respondents felt that given the challenges facing Jordan, even stagnation of indicators was, on some level, a success. However, there is recognition of the need for improvement. Part of USAID's strategy moving forward will clearly need to include support to address the refugee crisis, while both maintaining and improving the family planning gains achieved in the last two decades.

Previous USAID investments in family planning and related health systems provide a strong foundation upon which to pivot future investments. The suggested pivot emphasizes client-centered delivery models, localized family planning services and community-based social and behavior change campaigns. Programmatic activities that address community and familial fertility norms, increase the options available to couples, and support providers will evolve the landscape of reproductive health service delivery in Jordan.

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ANNEX

I. List of Key Informant Interviews

Interviews conducted in Jordan during November 2015 – February 2016

1. Dr. Sawsan Al-Majaly, Higher Population Council Secretary General
2. Mr. Bassam Danial, Executive Director & Dr. Salma Madany, Medical Director - Jordan Association for Family Planning & Protection (JAFPP)
3. Dr. Faezeh Abo Al-Jalo, Reproductive Health Technical Advisor, UNFPA
4. Dr. Ali Arbaji, Infenet consultant, Ex. Project Management Specialist, Population and Family Health office/USAID – Jordan
5. Dr. Sabry Hamza, Health Systems Strengthening II Bridge Project Chief of Party (COP) and Ms. Susan Wright HSSII Bridge Deputy COP
6. Dr. Ayman Abdelmohsen, Jordan Communication, Advocacy and Policy Project COP
7. Dr. Auday Nsierat, Health Technical Officer – WHO
8. Dr. Maha Al-Saheb, Quality Assurance Task Manager, Strengthening Health Outcomes through the Private Sector (SHOPS) Project
9. Dr. Muntaha Gharaebeh, Jordanian Nursing Council Director
10. Dr. Sawsan Al-Daejeh, Programs & Project Manager - Higher Population Council
11. Dr. Adla Hamlan, Lecturer at Princess Muna College for Nursing & Ex. Family Planning Coordinator/ RMS
12. Dr. Ishtaiwi Abu Zayed, Chief Field Health Program & Ms. Mai Al-Shahtout, Field Nursing Services Officer – United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA)
13. Dr. Mohamed Hiasat, Director of Medical Committees & Insurance Directorate, Ex. Director of Ob/Gyn department / RMS, and family planning Trainer
14. Dr. Manal Tahtamuni, Director & Ms. Buthaina, Quality coordinator - Institute of Family Health (IFH), Noor Al-Hussein Foundation
15. Ms. Manal Ghazawi, Coordinator/National Reproductive Health/Family Planning Strategy - Higher Population Council (HPC)
16. Mr. Bassem Aziz, Reproductive Health Project Director & Dr. Sahar Izat, Field Director - Circassian Charity Association
17. Ms. Rania Al-Abbadi, Asst. Secretary General for Technical Affairs and Strategic Planning Coordinator - Higher Population Council
18. Dr. Raeda Al-Qutob, Senate Government Member, Former Higher Population Council Secretary General
19. Mrs. Tahani Shahrouri, Senior Gender & Youth Specialist - JCAP
20. Pro. Iman Badran, Head of NICU; Pro. Shawqi Saleh; Ob/Gyn specialist, RN Kareemah Al-Ra'ey, head of Ob/Gyn nurses; Dr. Ruba Jaber, Family Medicine specialist, Family Medicine clinic, RN Intesar Al-Jaloudy; Postpartum family planning counselor @ Ob/Gyn ward; RN Nadia Nusair, family planning counselor @ family planning out-patient clinic - Jordan University Hospital (JUH)
21. Dr. Mahmood Ka'abneh, Director Assistant for Technical Affairs, Dr. Yasin Al-Tawarah, Director of Planning Directorate & Dr. Abd-Al-Naby Al-Bdour, Ob/Gyn Department, Mrs. Abla Al-Shieba, Director of Nursing Directorate, Mrs. Suzan Al-Amer, Family Planning coordinator – Royal Medical Services

22. Maysa Al-Khateeb, Project Management Specialist, Population and Family Health Office – USAID; Dr. Nagham Abu Shaqra, Service Delivery Team Lead, Population and Family Health Office – USAID and Ex-HPP Country Director
23. Dr. Malak Al-Ouri, Director, Dr. Khawla Kawwa, Head of Family Planning Section, Dr. Abeer Mwaswass, Head of Information and logistics Section / Women and Child Health Directorate - MOH
24. Dr. Ali Al-Saed, Director of Hospitals Administration, Ex. Director of Ajloun & Jerash Health Directorates – MOH
25. Dr. Ayoub Al-Sayaedeh, Director of Non Communicable Diseases Directorate, Ex. Director of Women and Child Health Directorate – MOH
26. Dr. Nimer Al-Kateeb, Private physician from SHOPS Network doctors & Implanon trainer
27. Dr. Shible Sahbany, UNFPA Humanitarian coordinator, Ms. Suzan Kasht, GBV/RH Analyst, Ms. Ibtisam Dababneh, procurement officer – UNFPA
28. Dr. Dief Alla Al-Louzy, Secretary General – MOH
29. Dr. Bassam Hijawi, Minister's consultant, Ex. Primary Health Care Administration Director – MOH
30. Mr. Omar Al-Zaben - Project Manager, Rasmieh and Omaimah, Supervisors, Aiayat and Eman, Field Social Workers, Maha, Computer programs - Out-reach Project, General Union of Voluntary Societies
31. Ms. Ritsuko Arisawa, Project Formulation Advisor, Shereen Abu Hweij, Program Officer, JICA
32. Ms. Kenana Amin, Monitoring and Evaluation, Project design team, Mr. Mohammad Yassien, Deputy Director for Budget Program Management, USAID Program Office
33. Dr. Layl Al-Faiez, Director, Dr. Maher Al-Sharief, Director assistant for PHC, Dr. Iman Sbieh, Head of Women and Child Health Section, Ms. Basima Makahleh Health Promoter - Capital Health Directorate - MOH
34. Dr. Mervat Samour, Director, Midwife Su'ad Al-Batma, head of nurses and health promoter, Midwife Nahed Mustafa and Midwife Maha Al-Sarhan – Princess Basma Health center Capital HD – MOH
35. Dr. Issa Massarweh, Demographer & Professor at Jordan University
36. Dr. Zakaria Al-Nawaiseh, Director, Dr. Abdullah Al-Jbour, Director assistant for PHC, Dr. Hiam Hamieh, Women and Child Health Unit Head, Midwife Samah Mdanat, MCH supervisor, Dr. Manar, Health Promotion and School Health Unit Head, Ms. Rabab Al-Rawashdeh and Ms. Fadia Al-Shawawreh, Social workers at the HP unit - Karak Health Directorate – MOH
37. Dr. Yazan Bqaeen, director, Dr. Mohamed Al-Adaileh, Dentist, ex Health Center director, Midwife Khitam Katatbeh, Midwife Amineh Al-Qatawneh, Nurse Jumanah Qazaz - Al-Manshieh Health Center - Karak - MOH
38. Dr. Ali Al-Hamaideh, Director, Dr. Nather Hawa, Dean of Medical faculty, Mou'ta University and Ex. Ob/Gyn ward head, Dr. Omar Al-Zaben, Ob/Gyn ward head, Nurse Maysoon Rabady, Head of nurses, Midwife Fadia Zriekat, and Midwife Marifeh, Family Planning counselors @ out-patient mother and child health unit, Midwife Subhieh Ma'aita and Midwife Samar Ja'afreh - Family Planning counselors Ob/Gyn ward – Karak Governmental Hospital – Karak – MOH
39. Dr. Haidar Al-Atoum, Director, Dr. Amal Al-Zouby, Director assistant for PHC, Dr. Lutfieh Al-Shalaby, Women and Child Health Unit Head, Midwife Mariam Al-Omary, MCH supervisor, Dr. Nidal Haddad, Quality Unit Head, Dr. Bilal , Health Promotion and School Health Unit Head, Ms. Fatima , Training coordinator - Irbid Health Directorate

40. Dr. Salam Hafouth, female physician, Midwife Amineh Al-Qaraky, Midwife Ala' Al-Rjoub, Nurse Wafa Abu Al-Haeja, Midwife Jumanah Qazaz – Ibn Cina Health Center – Irbid
41. Dr. Abdallah Al-Shurman, Hospital Director, Dr. Abd-AlNaser Jaradat, Ob/Gyn ward head, Dr. Mohamed Al-Rafaie, Ob/Gyn, Dr. Dania Abu-Shieka, Ob/Gyn, Ms. Feda Amura, Head of Nurses, Family Planning trainer, Ms. Abeer Hassan, Safe Motherhood Committee Coordinator, Ms. Rania Mraian, FP counseling trainer, Nurse Dana Obiedat, Hakeem project coordinator, Dr. Fathia Qutaishat and Midwife Manal Smady, Family Planning counselors @ out-patient family planning clinic, Midwife Hana' Al-Balass, Family Planning counselor @ Ob/Gyn ward – Princess Badia Hospital – Irbid – MOH
42. Ms. Basma Ishakat, Director of National Aid Funds, Ex. Policy Project COP
43. Dr. Malek Habashneh, Director, Dr. Randa Bqaeen, head of Media Section, Dr. Basema Estatieh, Head of Health promotion Section, Dr. Hamdeh Abu-Saleh, head of Geriatric Programs Section, Ex. Family Planning trainer and supervisor, Mr. Haitham Sha'ban - Health Communication & Awareness Directorate – MOH
44. Dr. Khalid Al-Edwan, Director of Health Directorates Administration, Dr. Bashir Al-Qassier, Director of Primary Health Care Administration – MOH
45. Engineer Muna Herzallah, Director of Program Section, Directorate of Planning Directorate – MOH
46. Dr. Issa Al-Jaber, Head of Ob/Gyn Specialty - MOH
47. Dr. Abdelmane Sulimat, Head of Ob/Gyn ward at Al-Bashir Hospital / Amman – MOH
48. Midwife Nisreen Walid, Midwife Sahar Qassas, Midwife Thawra Yasin, Family Planning Counselors @ Ob/Gyn ward, Nurse Fadia Qassas, Family Planning counselor at Family Planning out-patient center – Al-Bashir Hospital / Amman – MOH
49. Dr. Ahmed Qutaitat, Al-Bashir Hospital Director, Ex. Hospitals Administration Director – MOH
50. Dr. Dief Alla-Alhusban , Director, Dr. Hzoum Al-Bqoum, Director Assistant for PHC, Ms. Shariefeh Al-Sarhan, Director Assistant for Nursing and training, Dr. Hmoud Al-Sarhan, Health promotion and School health Unit Head, Dr. Ahmed Al-Nawafleh, Quality Unit Head, Midwife Sua'd Shdiefat, MCH supervisor - Mafraq Health Directorate – MOH
51. Dr. Ali Al-Nawafleh, Ob/Gyn specialist, health center Manager, Midwife Hiba Hussein, Midwife Muna Ziod, Nurse Amneh Al-Farahat – Maternal and Child Health Center – Mafraq – MOH
52. Dr. Hani Abu-Alim, Director, RN. Ghada Al-Bzour, Head of nurses, Midwife Rudaina Shdeifat, head of Ob/Gyn nurses, Midwife Rima Al-Zoubi Family Planning counselor @ Ob/Gyn ward and Midwife Basma Falahat, Family Planning counselor @ out-patients Family Planning clinic – MOH
53. Dr. Ghassan Fakoury, Minister's consultant, Ex. Quality Directorate Director – MOH
54. Dr. Ghaleb Qawasmeh, Director of Personal Affairs Directorate – MOH
55. Ms. Andira Awies, Director of Finance Affairs Administration – MOH
56. Ms. Samar Samouh, Director of Information Technology Directorate – MOH
57. Dr. Abdelrahman Al-Maany, Director of Administrative Affairs Administration, and ex-Director of Maan Health Directorate – MOH

Interviews in Washington D.C., October-December, 2015

1. Anne Arnaes, Ex. USAID Mission Director 2003-2007/Jordan
2. Jennifer Mason, USAID/Washington
3. Chris Sargeant, Doctoral Student at University of Michigan
4. Fida Adely, Assistant Professor and Clovis and Hala Maksoud Chair in Arab Studies at Georgetown University
5. Carla White, Jordan Communication, Advocacy and Policy (JCAP) Project (part of Abt Associates)
6. Stephen Rahaim, director for private sector and behavior change at Palladium (Formerly Futures)
7. Jay Gribble, Ex. Work in Jordan for Furtures/Policy project and Abt Associates/
8. Maureen Norton, Senior Technical Advisor, Office of Population and Reproductive Health, Bureau for Global Health USAID; Rushna Ravji , Health Team Lead, Asia and the Middle East USAID; Mark Austin, Asia Health Specialist; Amy Kay, Senior Technical Advisor at USAI, Health Policy Initiative
9. Bob Emrey, Chief, Health Systems Division, Office of Health, Infectious Diseases, and Nutrition; Bureau for Global Health USAID
10. Margarita Fernandez, Vice President, International Health, Gael O'Sullivan, Principal Associate, International Health Division, Mary Scott, Portfolio Manager, Francoise Armand, Principal Associate, International Health, Marriane Khowry, Senior Researcher, Abby Donner, Gender specialist and support Abt projects in Jordan, Abt Associates/Washington
11. Salwa Bitar, Chief of Party, Palestinian Health Capacity Project, IntraHealth, Ex. Project Management Specialist, Population and Family Health office/USAID - Jordan
12. Reed Ramlow, Country Director, Vietnam, FHI 360, Ex. SHOPS COP
13. Scott Radloff, Director and Amy Tsui, Senior Technical Advisor, PMA2020

II. Interview Coding Analysis Results

METHODOLOGY AND GENERAL ANALYSIS INFORMATION

Interviews were analyzed by dividing the number of coded excerpts by the total number of interviews for each interview group (central MOH officials, private sector employees, donor employees, etc.) because different numbers of participants were interviewed for each category. This normalized the responses and created a scale that shows the average number of times (frequency) an excerpt was coded per interview. Because structured questionnaires were used to interview participants, all participants were asked about the same general topics. The frequency indicates the salience of each response. Salience is indicative of knowledge level and importance to the participant. A higher salience score indicates that a participant may have known a lot about a topic and spent more time discussing it (Bernard 2006). Topics (codes used for analysis) included:

Research Question 1:

- Perceptions of the current TFR rate as a success, failure, or mixed
- Potential supply and service reasons for TFR stagnation
- Potential demand and cultural norm reasons for TFR stagnation
- Perceived impact (current or potential) of refugees on TFR

Research Question 2:

- USAID program successes
- USAID program challenges

Research Question 3:

- Types of recommendations given

When multiple participants from different groups were interviewed at the same time, the interview was coded as being from the interview group that the most interviewees fell into. Note that the number of interviews does not indicate the number of participants, as some interviews were conducted with multiple participants at once. The table below shows total number of interviews conducted by interview group.

Table 1. Interview Group by Total Number of Interviews

Interview Group	Number of Interviews
Central MOH Officials	11
Regional and Other MOH Officials	17
Private Sector Employees	6
Other Government Employees	10
Donor Employees	6
International Experts	9
USAID Project Contractors	10
Total	**69**

Interview groups are defined as:

VIII. Central MOH Officials: MOH Employees in Amman who work on high-level FP programs. Includes hospital administrators, directors of directorates, and heads of MOH sections.

IX. Regional and Other MOH Officials: MOH employees based in different regions of Jordan who generally work "on the ground" at hospitals, health centers, and universities. Includes regional health governate directors and staff, hospital directors and ward heads, Jordanian medical faculty and professors, physicians, nurses, and FP counselors.

X. Private Sector Employees: People working in the private sector. Includes NGO employees, physicians, outreach workers, project and field directors, and researchers.

XI. Other Government Employees: Jordanian government employees not associated with any of the categories above. Includes officials at the Higher Population Council, Royal Medical Services, National Aid Funds, and Jordan University. Also includes policymakers.

XII. Donor Employees: Donor organizations employees, such as USAID, UNFPA, JICA, WHO, and UNRWA.

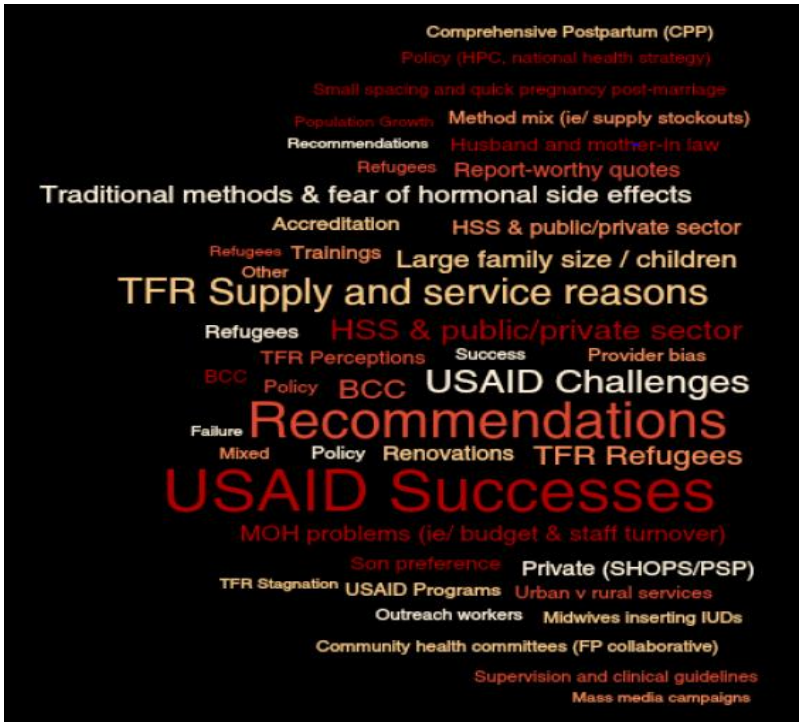
XIII. International Experts: Experts who work in family planning and global health but do not fall into one of the categories above.

XIV. USAID Project Contractors: Contractors who implement family planning programs in Jordan, specifically those funded by USAID. Includes employees who work for Abt Associates, Palladium Group, and others. Also includes employees who have worked on projects such as SHOPS, JCAP, and HSS II.

WORD CLOUD OF CODES AND SUB-CODES

The following word cloud shows the codes and sub-codes used for interview analysis. The size of the word or phrase indicates the number of times it was used to code text from interviews.

Figure 1. Word Cloud of Codes and Sub-codes Used for Analysis



RESEARCH QUESTION 1: WHAT ARE THE REASONS, INCLUDING SUPPLY AND DEMAND FACTORS, FOR TFR AND mCPR STAGNATION?

Discussion of Topics from Research Question 1

Below is a table showing the average number of times each topic from research question 1 was talked about in each interview. Notice that demand and norm reasons were talked about the most among all groups except central MOH officials. Supply reasons were also discussed extensively. TFR perceptions and refugees didn't come up in as many interviews.

Figure 2. Average Number of Times Research Question 1 Topics Mentioned Per Interview, by Interview Group

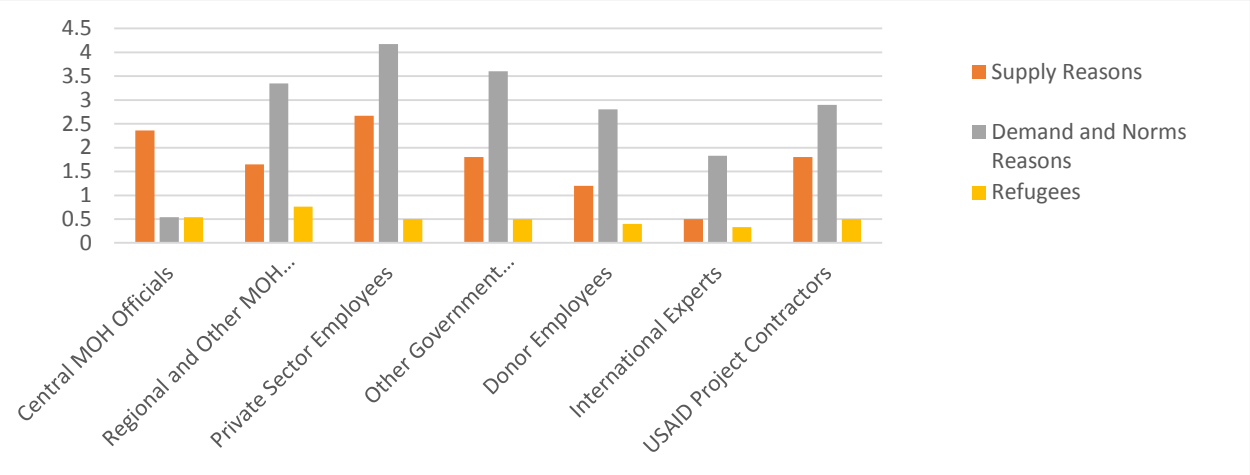


Table 2. Total Number of Excerpts for Research Question 1 Topics, by Interview Group

	TFR Perceptions	Supply Reasons	Demand and Norms Reasons	Refugees
Central MOH Officials	15	26	6	6
Regional and Other MOH Officials	15	28	57	12
Private Sector Employees	2	16	25	3
Other Government Employees	4	18	36	5
Donor Employees	0	6	14	2
International Experts	2	6	22	4
USAID Project Contractors	0	18	29	5

TFR Stagnation—Supply and Service Reasons

Supply and service reasons for TFR stagnation were coded 118 times. MOH problems were mentioned the most, followed by provider bias, method mix, and rural vs. urban issues. All interview groups talked about MOH problems.

Figure 3. Average Number of Times Supply Reasons for TFR Stagnation Mentioned per Interview, by Interview Group

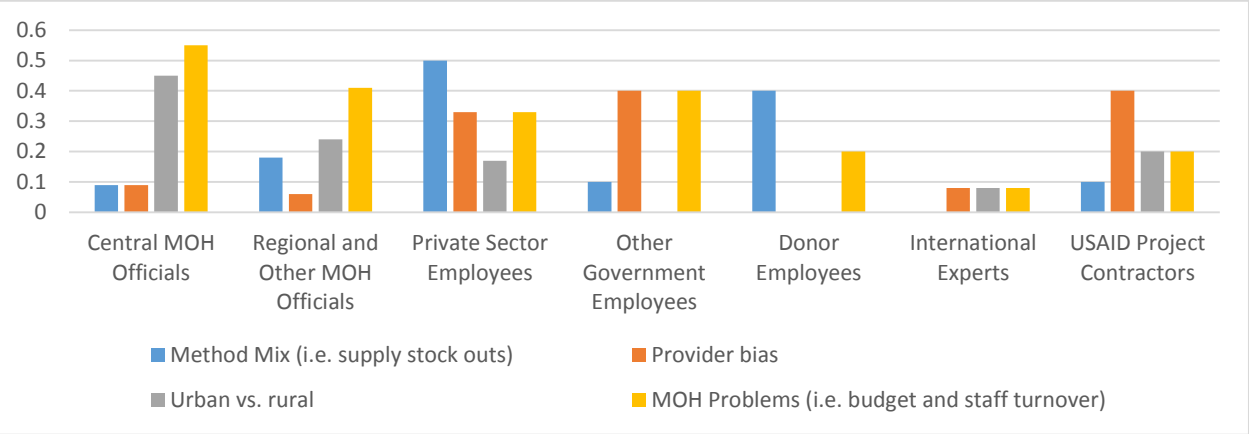


Table 3. Total Number of Excerpts for Supply Reasons for TFR Stagnation, by Interview Group

	Method Mix (i.e. supply stock outs)	Provider bias	Urban vs. rural	MOH Problems (i.e. budget and staff turnover)
Central MOH Officials	1	1	5	6
Regional and Other MOH Officials	3	1	4	7
Private Sector Employees	3	2	1	2
Other Government Employees	1	4	0	4
Donor Employees	2	0	0	1
International Experts	0	1	1	1
USAID Project Contractors	1	4	2	2

TFR Stagnation—Demand and Norms Reasons

The table below shows the average number of times demands and norms reasons were given by interview group. Notice that large family size and desired children, and traditional methods and fear of hormonal side effects were mentioned much more than son preference and small spacing and quick pregnancy post marriage. Perceptions of husbands and mothers-in-law affecting TFR stagnation differed among groups, but was higher among non-Jordanians overall. Son preference was mentioned much more by private sector employees than anyone else.

Figure 4. Average Number of Times Demand Reasons for TFR Stagnation Mentioned per Interview, by Interview Group

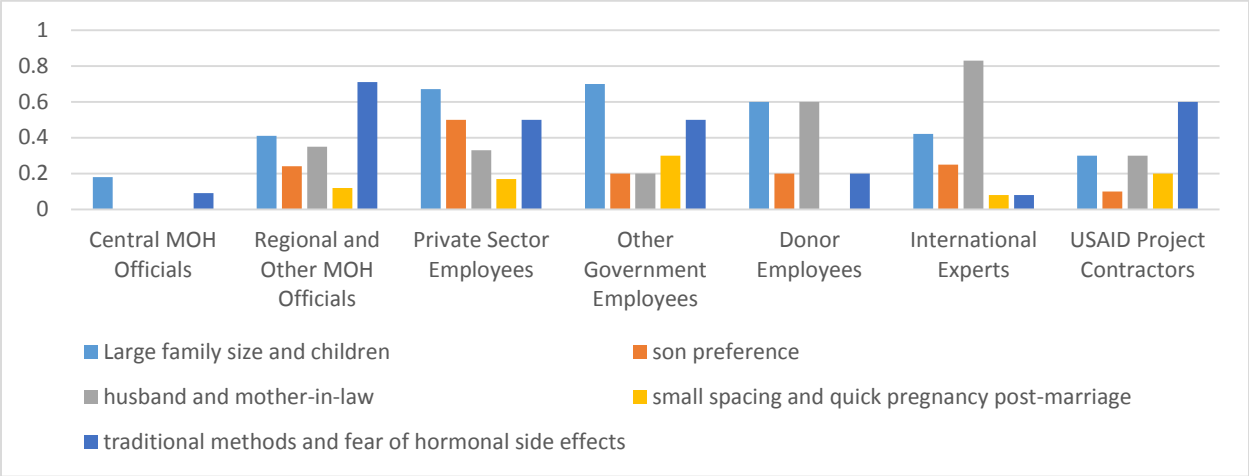


Table 4. Total Number of Excerpts for Demand Reasons for TFR Stagnation, by Interview Group

	Large family size and children	son preference	husband and mother-in-law	small spacing and quick pregnancy post-marriage	traditional methods and fear of hormonal side effects
Central MOH Officials	2	0	0	0	1
Regional and Other MOH Officials	7	4	6	2	12
Private Sector Employees	4	3	2	1	3
Other Government Employees	7	2	2	3	5
Donor Employees	3	1	3	0	1
International Experts	5	3	1	1	1
USAID Project Contractors	3	1	3	2	6

Perceptions of TFR Stagnation and Refugees

Refugees as effecting TFR stagnation was mentioned less than once per interview among all groups. It was mentioned in 50% of interviews on average.

Figure 5. Average Number of Times Participants Discussed Refugees' Impact on TFR per Interview, by Interview Group

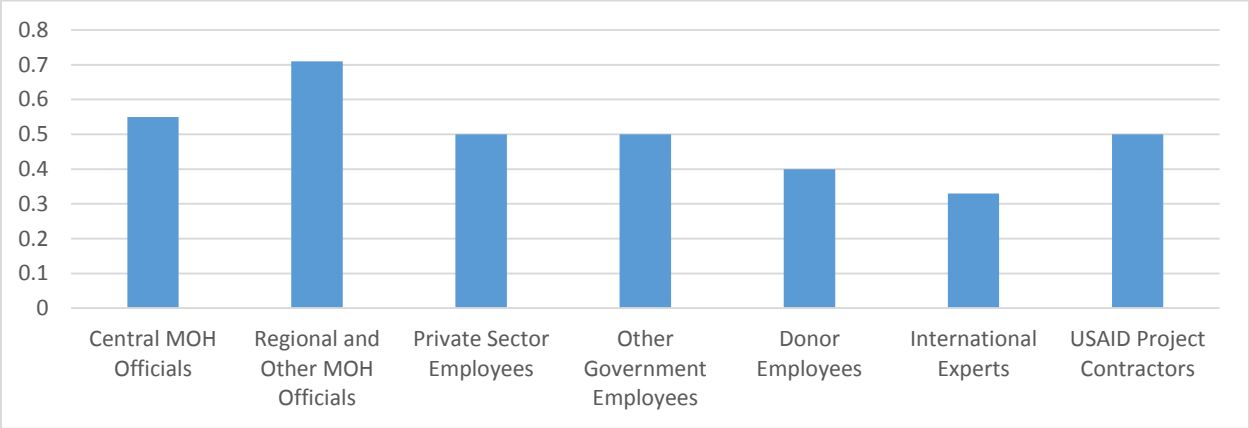
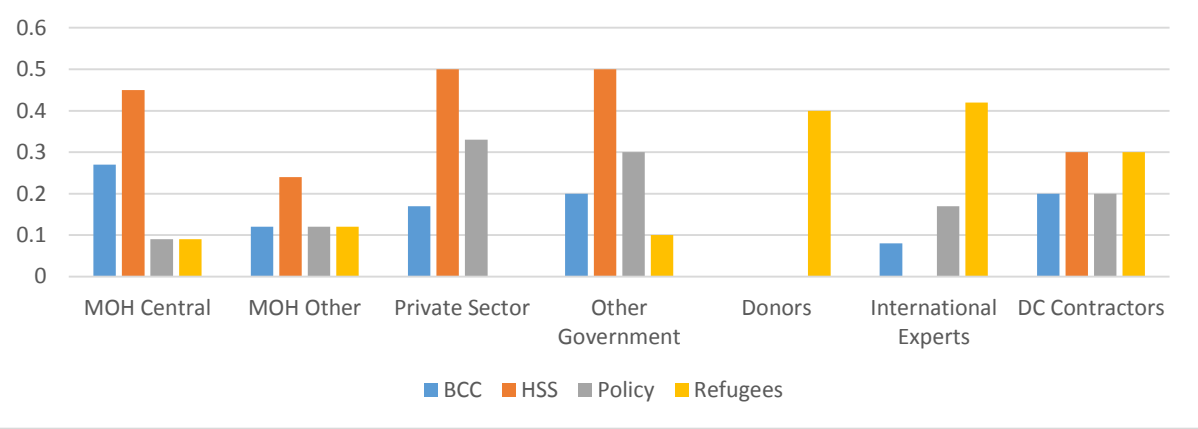


Table 5. Total Number of Excerpts for Refugees' Impact on TFR, by Interview Group

	Discussed refugees' impact on TFR
Central MOH Officials	6
Regional and Other MOH Officials	12
Private Sector Employees	3
Other Government Employees	5
Donor Employees	2
International Experts	4
USAID Project Contractors	5

Refugees were spoken about in terms of challenges. The table below shows challenges by participant type. Note that non-Jordanians (donors, international experts, project contractors) mentioned refugees as a problem much more often that Jordanians (MOH officials and employees, private sector employees, government officials). Notice that donor employees only talked about refugees as a challenge—HSS, BCC, and policy were not mentioned.

Figure 6. Average Number of Times Challenges Mentioned per Interview, by Interview Group



RESEARCH QUESTION 2: HOW EFFECTIVE HAVE USAID'S INPUTS AND PROGRAMS BEEN ON INCREASING FAMILY PLANNING UPTAKE?

Perceptions of USAID Programs' Successes and Challenges

Interviews indicate that overall, participants found USAID programs to be very successful. USAID successes were coded 240 times among all interviews, while challenges were coded only 111 times. The chart below shows the average number of times successes and challenges were coded for per interview. Note that Ministry of Health officials, private sector employees, and government officials tended to talk about USAID successes more often than challenges, while USAID project contractors, international experts, and donor employees focused on challenges. It appears that, overall, Jordanians may perceive USAID programs as more successful than non-Jordanians. This may reflect a difference in the level of knowledge of programs and their strengths, as well as differences in perceived overall success.

Figure 7. Average Number of Times USAID Successes and Challenges Mentioned per Interview, by Interview Group

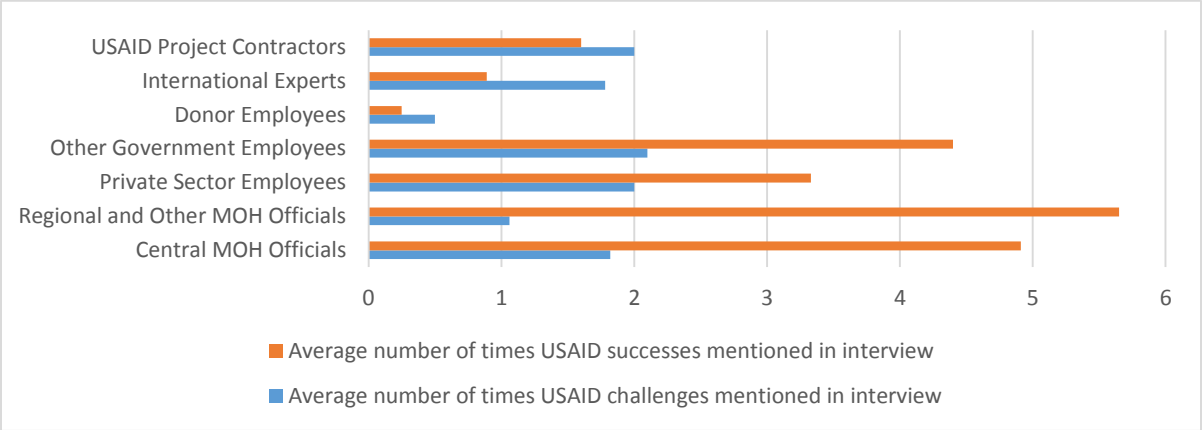


Table 6. Total Number of Excerpts for USAID Successes and Challenges, by Interview Group

	USAID Successes	USAID Challenges
Central MOH Officials	54	20
Regional and Other MOH Officials	96	18
Private Sector Employees	20	12
Other Government Employees	44	21
Donor Employees	2	4
International Experts	8	16
USAID Project Contractors	16	20

Perceptions of USAID Program Successes

Participants talked about successful USAID health systems strengthening programs the most, supporting the data indicating that HSS programs have had the biggest impact. BCC and policy successes were mentioned to a lesser extent.

Figure 8. Total Number of Excerpts for USAID Successes, by Type of Intervention

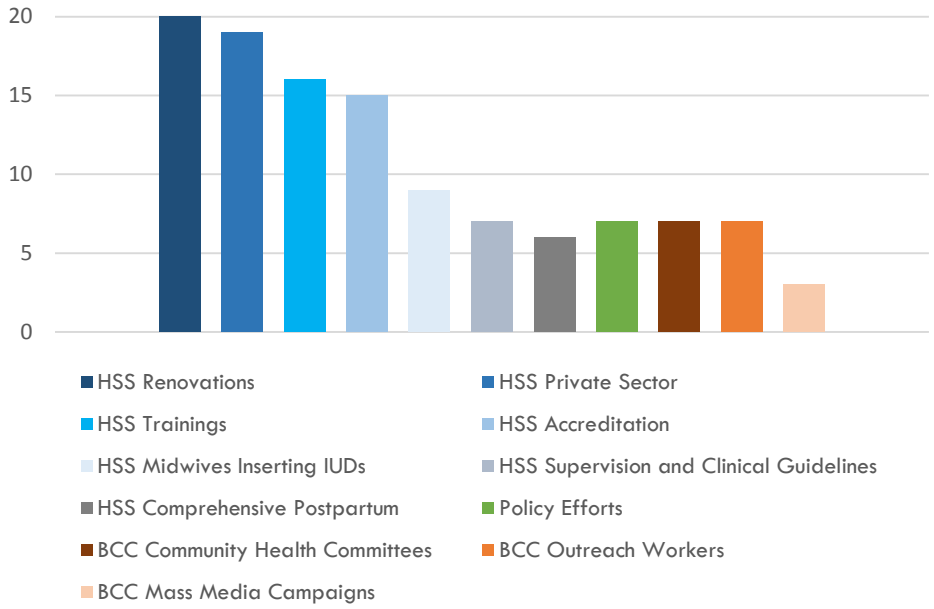


Table 7. Total Number of Excerpts for USAID Successes, by Type of Intervention

	Number of Excerpts	Type of Intervention
Accreditation	15	HSS
Comprehensive Postpartum	6	HSS
Midwives Inserting IUDs	9	HSS
Private	19	HSS
Renovations	20	HSS
Supervision and Clinical	7	HSS
Trainings	16	HSS
Community Health committees	7	BCC
Mass Media Campaigns	3	BCC
Outreach Workers	7	BCC
Policy	7	Policy

Perceptions of USAID Program Challenges

Challenges mentioned from highest to smallest ratio include HSS, refugees, policy, and BCC. In total, USAID challenges were mentioned 111 times throughout the interviews.

Figure 9. Types of Challenges Mentioned, by Intervention Type

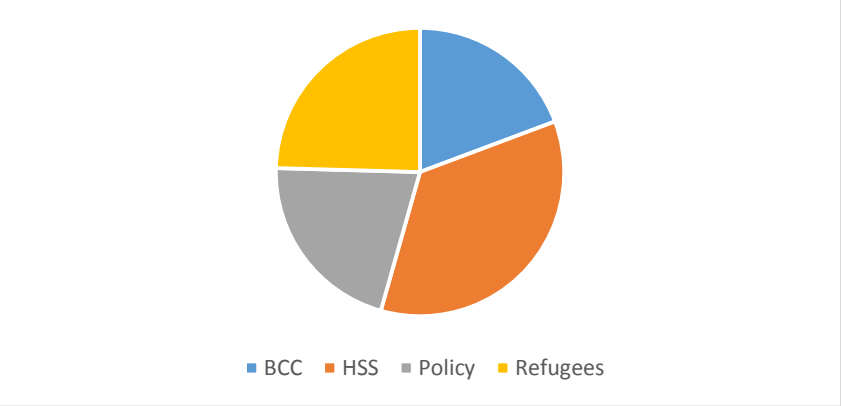


Table 8. Total Number of Excerpts for Challenges, by Intervention Type

Total Challenges	Number of Excerpts
USAID challenges (including sub-codes)	111
BCC	11
HSS	20
Policy	12
Refugees	14

The following two charts show the average number of specific types of challenges mentioned by interview groups after controlling for total number of interviews by participant category. Notice that MOH central, MOH other, private sector, other government, and DC contractors are the only ones who talked about HSS issues, and in each of these groups HSS issues were brought up the most (DC contractors brought up refugees the same number of times). Once again there are differences in perceptions of challenges by Jordanians and non-Jordanians.

Figure 10. Average Number of Times Challenges Mentioned per Interview, by Interview Group

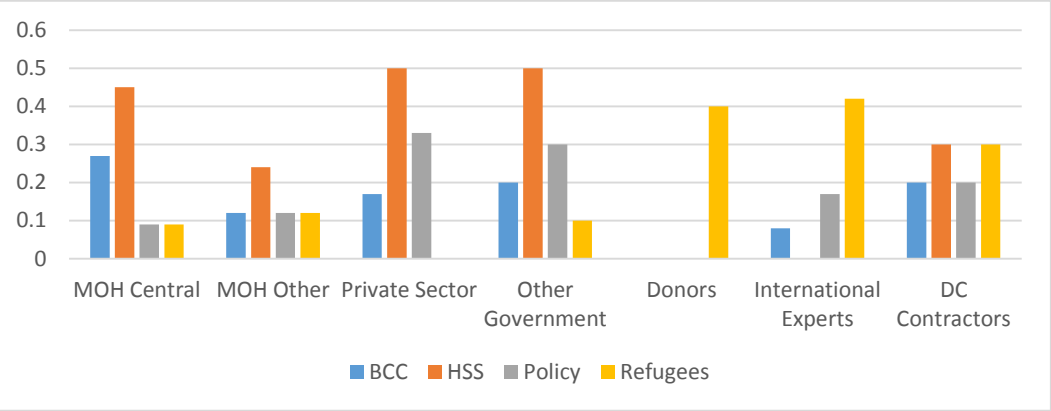


Table 9. Total Number of Excerpts for Challenges, by Interview Group

	BCC	HSS	Policy	Refugees
Central MOH Officials	3	5	1	1
Regional and Other MOH Officials	2	4	2	2
Private Sector Employees	1	3	2	0
Other Government Employees	2	5	3	1
Donor Employees	0	0	0	2
International Experts	1	0	2	5
USAID Project Contractors	2	3	2	3

RESEARCH QUESTION 3: WHAT SHOULD GUIDE USAID'S STRATEGY GOING FORWARD?

Recommendations

Recommendations discussed by participants were most often about HSS improvements. In descending order the next are BCC, policy, and refugees. HSS and BCC were talked about the most. Notice that the frequencies for recommendations are pretty high overall.

Figure 11. Average Number of Times Recommendation Topics Mentioned per Interview, by Interview Group

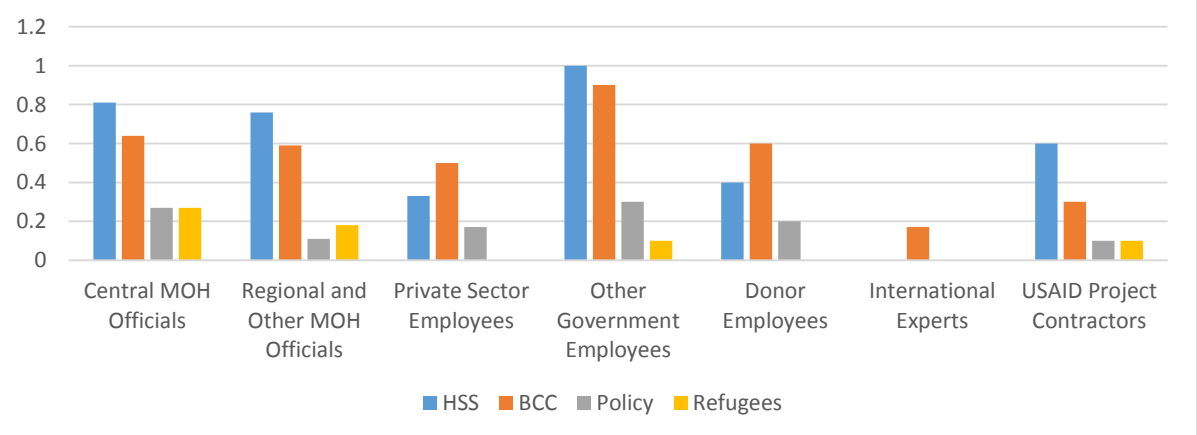


Table 10. Total Number of Excerpts for Recommendation Topics, by Interview Group

	HSS	BCC	Policy	Refugees
Central MOH Officials	9	7	3	3
Regional and Other MOH Officials	13	10	2	3
Private Sector Employees	2	3	1	0
Other Government Employees	10	9	3	1
Donor Employees	2	3	1	0
International Experts	0	2	0	0
USAID Project Contractors	6	3	1	1

III. USAID Project Funding, by Type of Project

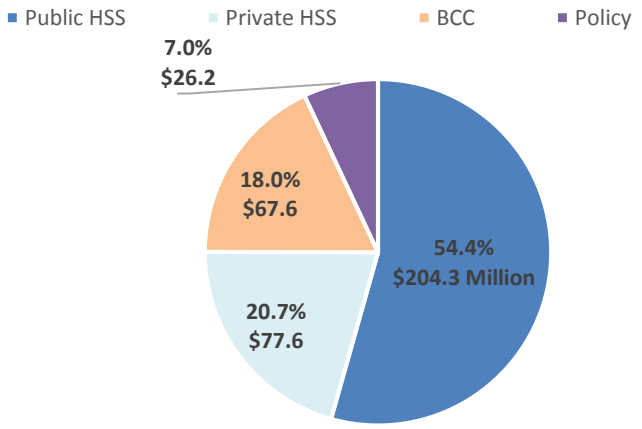
Funding Source and Classification Description

Funding estimates were collected from end of project reports. When project funding data were not available, the IRH team retrieved funding estimates through email correspondence with USAID/Jordan. These calculations are estimation of project funding according to primary project component (either HSS, BCC or policy). We noted where health systems projects were "exclusively FP" focused, these include Engender Health, Linkages and CMS (below in green).

Figure 12. USAID Project Name, Funding and Type

Project Name	Funding in US$ Millions	Type of Project			
		HSS		BCC	Policy
		Public	Private		
HSS	47,500,000.00	X			
HSS II	77,993,138.00	X			
JHAP	11,018,921.00	X			
PSP for Women's Health	19,000,000.00		X	X	
SHOPS	38,062,336.00		X	X	
HPP	4,000,000.00				X
JHCP	28,333,587.00			X	X
JHU/CCP	9,247,000.00			X	X
AVSC International	300,000.00	X Exclusively FP			
EngenderHealth	4,660,000.00	X Exclusively FP			
LINKAGES	1,930,000.00	X Exclusively FP			
CMS	4,500,000.00		X Exclusively FP	X	
CPP	6,927,901.00	X			
HSS II Bridge	4,499,305.00	X			
PHCI	49,502,232.00	X		X	
PHR	6,500,000.00				X
PHR Plus	8,870,000.00	X			X
POLICY project	1,750,000.00				X
JCAP	30,000,000.00			X	X
JAFPP Cost Recovery	16,117,827.00		X		
HPI	5,100,000.00				X
TOTAL USAID projects	**375,812,247.00**	% of total USAID funds			
Public HSS	**204,331,497.00**	54.37			
Private HSS	**77,680,163.00**	20.67			
BCC	**67,580,587.00**	17.98			
Policy	**26,220,000.00**	6.98			

Figure 13. Percentage of USAID investment by project type, 1995 – 2015 (total US $375.8 Million)



IV. USAID Project Objectives and Domains

Project	Domain	Objectives
CPP **1995 - 2000**	-Public sector systems and services	Reduce fertility rate in Jordan by providing access to high quality services. Renovate and equip 21 CPP centers throughout Jordan; train staff; develop and implement National Standards & Service Delivery guidelines for maternal and child health/family planning; and develop information, education and communication (IEC) material to educate women and their families on reproductive health care.
PHR and PHR+ **1995 - 2005**	-Policy -Public sector systems and services	Improve health status and access to quality care throughout Jordan through waste and inefficiency reduction, cost escalation containment, cost effectiveness and efficiency improvement, and health policy reform. Provide technical assistance, training, in the areas of: health policy, management, health care financing, health services delivery, hospital accreditation, hospital systems improvement, and rational use of drugs.
Association for Voluntary Sterilization (AVSC) **1995 - 1997**	-Public sector systems and services -Exclusively FP	Introduce 2 Hormonal Long acting contraceptive methods (Norplant and DMPA) through an acceptability study in 3 hospitals in Jordan
JHU/CCP **1996 - 2003**	-Population through BCC activities -Policy	Provide technical assistance to assist in achieving Jordan's contraceptive prevalence goals for modern methods and USAID's IR 1 and IR 2. The goal of JHU/CCP in Jordan has been to assist the Jordanian government in achieving its family planning/reproductive health (FP/RH) indicators. JHU/CCP, working in collaboration with the National Population Commission (NPC), MOH, JAFPP, Ministries of Youth, Islamic Affairs, and institutes of higher education, has used three approaches: demand generation, advocacy, and capacity building.
Linkages **1998 - 2004**	-Public sector systems and services -Population through BCC activities -Exclusively FP	Provide technical assistance and training to MOH to expand the integration of Lactational Amenorrhea (LAM) in Jordan as a modern family planning method and improve breastfeeding practices through development of information material and counseling, and inclusion of the breastfeeding method in the national information, education and communication strategy.
EngenderHealth **1998 - 2004**	-Public sector systems and services -Exclusively FP	Improve supply, quality, and availability of long acting and permanent methods of contraception within the public sector. Create a supportive environment for long acting hormonal and permanent methods.
Commercial Market Strategies (CMS) **1998 - 2004**	-Systems and services in the private sector -Population (through BCC activities)	Expand the role of the private sector in the delivery of FP products and services, deliver promotion campaigns to increase the role of the private sector in FP service delivery, improve the quality of FP services delivered by the private sector, and increase the demand for FP through NGO outreach activities.

JAFPP Cost Recovery **1998 - 2006**	-Private sector systems and services	**1998-2000**: Provide technical assistance to JAFPP to develop and implement three-year plan for cost recovery and sustainability, through achieving 85 percent of cost recovery for the five clinics established through USAID funding. **2001-2006:** Provide technical assistance to JAFPP to develop and implement five-year plan for institutional, programmatic and financial sustainability, through achieving 75 percent of cost recovery, maintaining 25 percent of FP services market share, enhancing services and public awareness, increasing FP users and providing FP training. At the same time, a five-year endowment of $4.2 million will be provided from the Local Currency, the interest of which will be retained by JAFPP to further build its reserve funds.
PHCI **1999 - 2004**	-Public sector systems and services -Population through BCC activities	Improve the performance and quality of primary and reproductive services of the MOH's Primary Health Care (PHC) system throughout Jordan through training, research, IEC, MIS, and renovation.
POLICY Project **2000 - 2005**	-Policy	Enable policies and plans that promote and sustain access to quality FP/RH services in Jordan, advocacy and education to improve the FP/RH policy environment in Jordan, work to reduce barriers to access to family planning; and promote contraceptive security.
JHCP **2004 - 2013**	-Population through BCC activities -Policy	Promote three year birth spacing intervals and smaller family size. Provide technical assistance to develop and implement a comprehensive national health communication strategy, applying behavior change communication interventions using the life-stages approach.
HPI **2005 - 2010**	-Policy	Provide technical assistance to reduce population growth through improving the policy environment for family planning and reproductive health. Assist the GOJ to develop and implement the Reproductive Health Action Plan in support of the National Population Strategy to ensure achieving population goals of replacement fertility by 2020.
HSS **2005 - 2010**	-Public sector systems and services	Assist the government of Jordan in improving the health status of all Jordanians by strengthening health care delivery systems, improving the delivery of primary and reproductive health services, and promoting active community participation.
PSP for Women's Health **2005 - 2012**	-Private sector systems and services -Population through BCC activities	Improve the health of Jordanian women by increasing demand for contraceptives and other services among women; improving quality of women's health services; raising awareness of, and increase detection of breast cancer in women; and providing private-sector resources to women experiencing domestic violence. Implement behavior change communication activities for physicians and community members.
JHAP **2007-2013**	-Public sector systems and services	Provide technical assistance to strengthen the Jordan Healthcare System through accreditation to improve the quality and safety of health care facilities and services along the continuum from primary to tertiary care.
HSS II **2009 - 2014**	-Policy -Public sector systems and services	Bolster FP in the areas of policy (creating a supportive environment through development and implementation of FP policies and strategies), systems (improve quality and access to FP counseling and services at public health centers and hospitals), and services (expand and improve performance of the systems that support family planning services)
HPP **2010 - 2013**	-Policy	Strengthen the government of Jordan policy environment, as well as support policy analysis and implementation of RH/FP; strengthen the advocacy capacity of local partners and utilize awareness-raising and policy reform initiatives; and support the Higher Population Council (HPC) and Ministry of Health in the development and use of data and tools for advocacy and policy planning. Provide technical assistance and capacity development to HPC and MOH.

SHOPS **2010 - 2015**	-Private sector systems and services -Population through BCC activities	Expand the demand, access, quality, and utilization of family planning services by partnering with the private and non-governmental sectors to increasing the use of existing methods, particularly underutilized methods such as injectable contraceptives and implants; increase the range of product options in the injectable/implant category; develop marketing and behavior change strategies to improve the acceptance of hormonal methods; maintain and expand current collaborative relationships with pharmaceutical companies while exploring new partnership opportunities; and remove medical barriers (provider bias).
HSS II Bridge **2014 - 2015**	-Public sector systems and services	Strengthen health systems and improve quality of health care delivery in Jordan's public sector by using continuous quality improvement principles to strengthen the delivery of family planning, obstetric, and neonatal care services; supporting the information technology infrastructure at the Ministry of Health; engaging community groups; and developing a pre-conception care model.
JCAP **2014 - 2019**	-Policy -Population through BCC activities	Bolster use and continuation of FP/RH services as safe, effective, and acceptable at both the policy and community level by increasing demand for FP services and creating a policy environment that enables reduced population growth.

V. USAID PROJECT COMPONENTS OVER TIME, 1995 – 2015

	PROJECT COMPONENTS			
PROJECT	**Infrastructure and health systems**	**Family planning specific**	**Behavior change**	**Policy and advocacy**
LATE 1990s				
Post-Partum Comprehensive Project 1995 - 2000	Renovated 21 postpartum centers in public and NGO hospitals; improve standards of care, training, supervision, electronic information system.	Centers provided comprehensive family planning, antenatal, postnatal, well baby health services		
The Partnerships for Health Reform (PHR) & (PHR +) 1995 - 2005	PHR plus: Health Insurance Technical Assistance (Health Insurance Pilot Project, HIPP), Hospital Decentralization Technical Assistance, and National Health Accounts (NHA) Technical Assistance.			PHR study on performance assessment, employee development activities, job satisfaction among physicians, perceptions of leadership characteristics
Association for Voluntary Sterilization (AVSC) International 1995 – 1997	Acceptability study to introduce long acting hormonal contraceptives	Introduced long acting hormonal contraceptives, Depo-provera injection and Norplant at 3 public hospitals		Depo-provera injection and Norplant implant introduced to Jordan public sector
JHU/CCP (John Hopkins University Center for Communication Programs) 1996 - 2003			Conducted two multimedia campaigns: "Together for a Happy Family" targeting male involvement in FP; and "We Plan for our Future", targeting youth	Assisted the Jordanian government in achieving FP / RH indicators, working in collaboration with the National Population Commission (NPC), MOH, JAFPP, Ministries of Youth, Islamic Affairs
Engender Health 1998 - 2004	Service delivery, standards of care, training, quality of care, supervision, equipment, IEC	Improved access and quality of long acting and permanent family planning methods		
Linkages LAM Project 1998 - 2004	Service delivery, standards of care, training, IEC	Integrated LAM into national healthcare service delivery		
Commercial Market Strategies 1998 - 2004	Service delivery, standards of care, training, quality of care, out-reach, IEC	Expanded the role of the private sector in the delivery of FP products and services		
2000s				
Primary Health Care Initiative (PHCI)	PHC renovations, PHC clinical guidelines and quality of services in general, IEC	Improvement of family planning and RH services	Conducted Sehy campaign, national health education mass	

1999 – 2004			media campaign training health educators	
JAFPP Cost Recovery & Sustainability 1998 - 2006	JAFPP clinics renovation, management systems, quality of services, improving policy, training, supervision	Improvement of family planning services provided at JAFPP		
Jordan Health Communication Partnership (JHCP) 2004 - 2013		Promoted community adoption of healthy behaviors, After 2008, promoted more intensively family planning behavior change, three year birth spacing intervals and smaller family size.	Assisted local community to adopt healthy behaviors, "Arab Women Speak Out" and "Hayati Ahla" campaigns, IEC materials, Sehetna web site, establish Jordan Health Center for Health Communication	National health communication strategy, Training, advocacy and supporting environment, work with religious leaders, journalists and parliamentarians, women groups, schools, institutional capacity building,
Private sector project for women's health (PSP) 2005 - 2012		Improved quality of family planning services at private sector to increase demand; outreach program, VAW, breast cancer early detection, EBM and pharmaceutical training		
Health Policy Initiative (HPI) 2005 - 2010				Built capacity of HPC, develop RH Action Plan, contraceptive security strategy, undergo population projections, implement RHAP activities
Health Systems Strengthening (HSS) 2005 - 2010	Renovation and equipment for maternity and NICU at public hospitals. Standards of care and clinical guidelines for safe motherhood, neonatal care, FP, RH, PHC and services. Training, management, management information systems, referral and appointment system, supervision system,			Supported creation of MOH Strategy 2008 - 2012, develop health directorates yearly action plans, conducted MOH performance assessment report
Jordan Health Care Accreditation Project (JHAP) 2007 - 2013	Established the Health Care Accreditation Council (HCAC), develop health care standards, assess institutions for accreditation, and build a core of surveyors, award accreditation through HCAC.			
2010s				

Health Systems Strengthening II (HSSII) 2009 - 2014	Expanded renovations for MOH/RMS / JU Hospitals obstetric and neonatal wards and establish out-patient clinics in some hospitals. Capacity building on FP counseling, emergency obstetric care, IUD and Implanon insertion, implement best practices in perinatal and child health, accreditation for PHC health centers, establish community health committees, HMIS, MOH web site, continue referral system, supportive supervision strengthening	Developed Family Planning evidence base clinical guidelines, Postpartum/post-miscarriage family planning clinical guidelines		Supported creation of MOH Strategy 2008 - 2012, Supported task shifting of IUD insertions to midwives
Health Policy Project (2010 – 2013)				Repositioned and strengthened the role of HPC as a policy entity. Use of RAPID. Shift from RHAP to national RH strategy plans. Curriculum integration of population growth
Strengthening the Health Outcomes through the Private Sector (SHOPS) 2010 - 2015		Expanded method mix, private sector demand generation, building capacity of private physicians and pharmacists, outreach program, EBM, Work with JAFPP to assure sustainability	IUD and OCP social marketing campaigns to increase family planning uptake	
Health Systems Strengthening II (HSSII) Bridge 2014 - 2015		Continuation of HSS II, specific to family planning, improvement collaborative model and activate family planning role of community health committees		
Jordan Communication, Advocacy & Policy 2014 - 2019		Community outreach workers and voucher program; Increased demand for family planning services	Oral Contraceptive Pills Campaign	Continued support for HPC, RAPID and national strategy; Expanded Jordan Coalition for Family Planning; Established Governorate Health and Population Policy; established national Champion program

VI. Desk Review Summary: USAID End of Project Reports

Document Name	Summary	Outcomes
The Road to Stronger Health Systems--End of Project Report, 2010 - 2014	The main objectives of this program was to bolster FP in the areas of: **Policy** (creating a supportive environment through development and implementation of FP policies and strategies), **Systems** (improvement of quality and access to FP counseling and services at public health centers and hospitals), **Services** (expanding and improving performance of the systems that support FP services)	• Created a Family Planning strategic plan with MOH; • Regularly monitored performance of directorate and health center action plans; • Helped reverse ban on midwives inserting IUDs; • 68% of postpartum patients received counseling before discharge at 25 public hospitals offering postpartum FP services; • Percentage of MOH primary and comprehensive health centers offering four or more FP methods increased from 19% in 2011 to 33% by 2014.
Jordan Healthcare Accreditation Project (JHAP) Final Report, 2007 - 2013	The goal of this project was to use accreditation as a means to enhance the quality and safety of healthcare services for Jordanians. Jordan's health sector was weakly regulated, so JHAP worked with the Government of Jordan to establish accreditation standards.	• Created reproductive health standards (primary health care, family planning, and reproductive health) • Certified surveyors in the area of primary health care, family planning, and reproductive health • Researchers wanted quality of services in FP/RH centers to improve, as indicated by being awarded Center of Excellence status. None of the FP/RH centers achieved this goal.
Private Sector Project for Women's Health: A Legacy of Partnership for Innovation and Change, 2005 - 2012	Jordan collaborated with the private sector to improve the health of Jordanian women. Implemented an outreach strategy to change attitudes and behavior among women with the highest unmet need for FP.	• CHWs provided home visits as the main part of the community outreach program. • CHW credentials and beliefs in FP and gender equality strongly contributed to the program's success. • Reached nearly 1.5 million women between the ages of 15-60 with messages about FP methods and early detection of breast cancer. • More than 59% of the women reached took some sort of action.
Jordan Communication, Advocacy, and Policy Activity--Annual Report, 2014 - 2019	Strategic objective: bolster use and continuation of FP/RH services as safe, effective, and acceptable. Expected outcomes: increase the demand for FP services, as well as create a policy environment that enables reduced population growth over time. Working at both a community and policy level.	• Have reached 232,194 women, including 179,785 MWRA. • Community level--resumed the Oral Contraceptive Pills Campaign • Policy level--revived the Jordan Coalition for Family Planning; Established Governorate Health and Population Policy committees and worked with them to identify and prioritize FP issues relevant to their constituents.

Strengthening Health Outcomes Through the Private Sector (SHOPS) Final Performance Evaluation, 2010 - 2015	This evaluation analyzes how effective the SHOPS program was in meeting its objectives to increase demand for, access to, and quality of family planning services; assess sustainability of outcomes and practices; identify factors contributing to outcomes and sustainability; and provide future recommendations.	• Effectiveness: CHW outreach and referrals were effective in increasing temporary demand for modern FP services and commodities. • Demand: CHWs provided vouchers for cost-covered consultations for FP, resulting in a 22% uptake in modern methods. Over 89,000 outreach clients accepted new methods. Private sector FP consultations with vouchers totaled 33,260 (of the 89,000). • JAFPP: have built JAFPP systems to the point where it is possible for them to operate sustainably • Gender: Extensive awareness-raising by CHWs increased acceptance of FP among low-income women
The Health Policy Project in Jordan: End of Project Report, 2010 - 2013	As part of HPP, USAID/Jordan created a country program to increase political commitment and resources to address population issues and provide high quality RH/FP services. There were three overall objectives: 1) Strengthen the government of Jordan policy environment 2) Strengthen the advocacy capacity of local partners 3) Support the Higher Population Council (HPC) and Ministry of Health in the development and use of data and tools for advocacy and policy planning.	• Designed an educational booklet on the benefits of birth spacing which was culturally relevant and appropriate for Jordan. • Designed a plan for implementing the National RH/FP Strategy to ensure sustained progress towards RH/FP uptake and achieving the Demographic Opportunity. • Provided technical analysis to support a policy allowing midwives to insert IUDs. This reduced an operational barrier to RH/FP update and service delivery, while also addressing the supply-side issue of a lack of female service providers in Jordan. • Trained MOH staff members in demographic modeling (including HPP's DemProj, RAPID, and FamPlan software) to improve evidence-based program planning and resource allocation.
Evaluation of Jordan Health Communication Program (JHCP), 2004 - 2013	Program's purpose was to promote healthy lifestyles by implementing a national health communication strategy, assisting local communities in adopting healthy behaviors, and supporting child spacing and the small family norm.	• Religious Leaders Campaign: Involving RL in FP issues was a powerful intervention that increased impact of other JHCP activities and USAID FP projects. • JHCP Internet Activities-- The website Sehetna provided international-standard health information to help counteract misconceptions and also disseminated JHCP and MOH materials. • Arab Women Speak Out Community Mobilization Activity: Presenting FP messages in the context of health and social issues helped women accept them. • Health Competent Schools Initiative: JHCP helped institutionalize this program in the Ministry of Education, and the program will continue to get USAID Office of Education Support.

Engender Health/Jordan End of Project Summary Report, 1998 - 2004	Main objectives: improve quality and availability of long acting and permanent methods of contraception within the public sector and raise awareness of Jordanian couples about long acting hormonal and permanent methods of contraception, their effectiveness, and appropriate use.	• Trained over 3,809 providers to address gaps in provider capacity and improve core competencies • Improved counseling for new clients and DMPA users • Conducted contraceptive technology updates and workshops for over 150 providers from Irbid, Mafraq, and Aqaba • Created and implemented system wide IP policies and procedures, as well as monitoring and QI tools. • Expanded contraceptive choice to meet unmet need by introducing Norplant and the IUD for post-partum use. • Helped develop and pilot a Comprehensive Integrated RH/FP Training Counseling Curriculum to integrate into existing training and QI programs.
Health Systems Strengthening Project, Final report, 2005-2010	Assist the government of Jordan in improving the health status of all Jordanians by strengthening health care delivery systems.	• Implemented an essential services package at 85 health centers. • Renovated obstetric, neonatal, and outpatient departments at 11 hospitals. • Hospital safe motherhood committees have been activated and safe motherhood quality improvement plants have been implemented in 14 hospitals. • Developed, implemented, and monitored clinical guidelines and training curricula.
Promoting the Lactational Amenorrhea Method (LAM) in Jordan Increases Modern Contraceptive Use in the Extended Postpartum Period: LINKAGES' Final report of its LAM research in Jordan, 1998 - 2004	1998-2003 the MOH collaborated with LINKAGES to expand the pilot project for promotion of LAM services in all Ministry of Health Centers.	• By 2003 the MOH and Linkages trained at least 2 health care providers in each of the 35 MCH centers in Jordan. • Training was conducted to strengthen capacity of MOH primary health care staff to integrate breastfeeding counseling, lactation management, and LAM into the service delivery system • Results illustrate that LAM has a positive impact on total modern family planning use at 12 months postpartum.
Comprehensive Postpartum Project (CPP) Final Report, 1995 - 2000	Main objective: reduce fertility rate in Jordan by providing access to high quality services.	• CPP services provided in the largest 20 hospitals in the country. • Established 21 CPP centers, meaning they can reach 58% of women delivering at hospitals in Jordan • Produced over three million copies of printed materials.

Enhancing Performance of Health Systems (HSS II Bridge) End of Project Report, 2014 - 2015	Goal is to improve the health of Jordanians through the provisioning of essential services in the public sector.	• Expanded access to equitable and sustainable facility-based FP services by: 1) Getting certain providers to adopt the FP Service Delivery Improvement Collaborative approach to improve FP service delivery and use with special emphasis on urban poor areas; and 2) Completed preparatory phases to introduce a new FP method to target traditional users. • Assisted the MOH to improve access to FP and RH through community based organizations by transforming two Community Health Committees into community based organizations that provide FP services.
Primary Health Care Initiative: Evaluation of Utilization of Health Services Delivery and Health Status, 1999 - 2004	Aimed to improve quality of primary and reproductive healthcare through an integrated package of services.	• Whether use FP method and type, changes in %s of contraception used over time. 73.5% in pre-test and 82.8% in post-test used some sort of contraceptives • Moved from 20.6% to 13% for people using traditional contraceptive methods. • Use of FP methods by intervention pre- vs post-test and study vs control groups • Distribution of difficulties getting or using FP methods by study phase (as well as types/sources of difficulties)
Public Health Reform (PHR) Project Final Report, 1995 - 2000	PHR seeks to support health sector reform and to advance knowledge about resolving health sector problems in Africa, Asia, Latin America and the Caribbean, the Middle East, and Eastern Europe. PHR in Jordan is heavily involved in reform in the very early stages of collecting evidence upon which to make policy	• More than 150 participants in 27 countries have been trained and supported in their implementation of the National Health Accounts Methodology, including the establishment of three regional networks to continue support and capacity building. • Helping MOH decentralize aspects of public hospital management • Findings from the Patient Flow Analysis at the largest MOH referral hospital have led to reduced patient waiting time in three outpatient departments and to emergency room restructuring to reduce waiting time and ensure that true emergencies receive expedited treatment.

VII. Desk Review Summary: External Evaluations and Studies

Document Name	Summary	Outcomes
Engender Health		
Tubal ligation trends in Jordan 1998-2000, 2000	Client record reviews and hospital administrator interviews from 55 hospitals of all sectors in Jordan, a total of 3,642 sterilization procedures were performed from 1998 to 2000. MOH (71%), RMS (16%) and in the private/NGO sector (13%).	• Half of all tubal ligation procedures were performed with C-section. The other half was evenly distributed between laparoscopy and mini-laparotomy. • Almost all (99%) patients had surgery with general anesthesia. • Average age for women at the MOH sites was 36.7 years; RMS, 38.1 years; and private sector, 37.8 years. • Average number of children 7.4 child • Most common reason for conducting TL, was completed family (70%) and medical indications (29%) • about half of the sites are requiring tests which are not necessary, i.e., chest X-rays and ECG
Jordanian providers' knowledge, attitudes, and practices regarding female sterilization and long-acting hormonal methods, 2002	This study was conducted to explore whether service providers' knowledge, attitudes, and practices regarding permanent and long-acting hormonal contraception affect the accessibility of these methods in Jordan.	• Data collected during this study indicates that providers' knowledge, attitudes, and practices regarding permanent and long-acting methods do not facilitate access to these methods. Physicians face institutional barriers that limit the provision of services. • In addition, many physicians lack proper training and accurate information about the methods. Physicians' use of personally determined criteria to decide whether a woman is eligible for receiving certain services also limits access. Religious beliefs and familial barriers create further obstacles to method use.
Attitudes towards tubal litigation among users, potential users, and husbands in Jordan, 2003	To explore the perspectives of user and potential users and to identify reasons for the use and non-use of tubal ligation, EngenderHealth conducted qualitative research with TL users, users of reversible contraceptive methods for birth limiting (defined as potential users), and husbands of both groups.	• Almost all focus group discussion (FGD) participants alluded to socio-cultural and religious norms as major deterrents to TL use, reiterating that in Islam TL was stigmatized as haram (a sin) in the absence of an appropriate medical justification. • Potential users seeking to limit births were commonly aware of TL, but given social and medical restrictions and religious beliefs, did not usually consider it an accessible or appropriate option in the absence of medical indications.

Client perceptions of Norplant and Depo Provera at JAFPP clinics, 2004	A focus group study with current and past users of Norplant and Depo-Provera injectables was conducted in Jordan during January - February 2002. The main objective of the study was to identify the reasons for acceptance and use or discontinuation of long acting hormonal methods (Depo-Provera and Norplant) from the client perspective at Jordan Association for Family Planning and Protection (JAFPP) clinics.	• Negative rumors in the community play a key role in limiting acceptance and encouraging discontinuation for both methods. • JAFPP information and counseling for these methods is not always detailed enough and often does not directly address women's fears and concerns. • Satisfied users prefer these methods largely because of their effectiveness and long-term protection • Although husbands may not play a large role in initial selection of the method, they are an important factor in continuation. Many husbands are dissatisfied with long acting hormonal methods because increased duration of menstrual periods and perceived decreases in libido interfere with their sex life.

PHCI		
PHCI Baseline Survey Report: Building the Foundation for Quality Services in Primary Health Care in Jordan, 2000	The review has been shaped by concern for the following underlying referral issues. Does the current process ensure appropriate referral for clients requiring additional care? Do referred clients receive the required support and care during the post referral period?	• Reproductive health services are affected by lack of service capacity, referral procedures and documentation • The ability of PHCs to provide family planning service is limited by a number of factors including the types of contraceptives stocked, the counseling skills of staff, and the availability of female physicians • Nurses, midwives, and female physicians have strong beliefs about contraceptive options and it is generally acknowledged that child spacing is the exclusive goal of family planning. • Misunderstandings about hormonal methods are particularly common and range from misinformation about eligibility for a particular method to the belief that Depo Provera is a “dangerous” drug
MOH Physicians' KAP study on hormonal methods and female sterilization, 2002	The study is part of a larger study designed and implemented by the Engender Health in order to collect data from service providers on knowledge, attitudes, and practices regarding hormonal methods (oral contraceptives, Norplant, injectables) and female sterilization.	• Family planning provision and counseling: During the year, preceding the survey, 81.2% of the respondents reported having prescribed or provided at least one method of family planning, while 84.2% reported discussing or counseling women on family planning methods. • Knowledge about family planning: Providers tended to set an age limitation when perceiving oral contraceptives. • Female sterilization: Less than one third of the providers said that they would refer women for Tubal Ligation • Attitudes and beliefs: More than a third of the providers believed that female sterilization is Haram.

Quality assurance in the Jordan primary health care system: best practices, 2004	This booklet presents examples of successful implementation of quality improvement strategies by health center staff at 10 primary health care centers across the Kingdom of Jordan. PHCI, initiated in 1999, is a five-year project designed to increase the quality of and access to public sector primary health care and reproductive health services in Jordan. The MOH runs 389 primary and comprehensive health centers and 258 village health centers, staffed by 8,616 employees, 63% of whom are in the primary health care centers.	• Seventy-seven MOH physicians, midwives, and nurses were trained to instruct all health care workers in primary and reproductive health care protocols and procedures, as well as counseling for healthier behavior. • Computers and a new reporting system are enabling health centers and directorates to input and retrieve information to improve client flow and management decisions. • An intensive health promotion campaign has been launched in the media and 42 health promoters are implementing a health promotion strategy that focuses on building resource networks to help the community become responsible for its own health. • All centers are being renovated to upgrade the physical appearance and safety of the centers and provided with new furniture and equipment.

JHCP		
Evaluation of the Consult and Choose Program, 2012	Consult and Choose (CC) is a service provision program designed to improve the quality of family planning visits. CC uses a patient-centered approach to family planning counseling.	• Patient satisfaction with clinic visits was strongly and positively associated both with the use of the CC materials and with having a provider who followed the CC counseling protocol. • The "Hayati Ahla" video is a good message dissemination tool, as 80% of women who viewed it recalled messages about family planning methods. All of the women who saw it said that it should be shown in all health centers.
Evaluation of the "Mabrouk" Initiatives in the Civil Status and Passports Department (CSPD) Offices, 2012	The two Mabrouk initiatives target newlyweds and new parents, providing them with packets that contain information on FP (birth spacing and contraceptives), post-natal care, and child development.	• Mabrouk I and II were effective forms of communication because: Information from Mabrouk I and II was highly valued by newlyweds and new parents, package reinforces new social norms. Readership associated with trends towards longer periods of birth spacing, and high levels of satisfaction with the materials, and positive outcomes, indicate that the package should continue being distributed

PSP for Women's Health		
PSP for Women's Health Report on midterm evaluation of outreach, 2008	A major project activity, and the focus of this mid-term evaluation, is outreach to women in their homes by community health workers (CHWs) to generate and increase demand for reproductive health and family planning (RH/FP) services and to refer them to the appropriate service points.	• The PSP-Jordan's outreach component has been highly successful in providing much-needed health information to women in their homes and has stimulated women to seek appropriate health services. • The project has already reached over 800,000 women against a target of 1.1 million • Rigorous CHW recruitment, training, supervision, and fair remuneration have ensured that CHWs are knowledgeable, motivated, and well accepted by the women they visit. • The referral system is a critically important component of the outreach continuum in translating demand into use of health services.

HPI		
Adolescent and Youth Reproductive Health in Jordan: Status, Issues, Policies, and Programs, 2003	Assessment of adolescent reproductive health (ARH) in Jordan. The purpose of the assessments is to highlight the reproductive health status of adolescents in each country, within the context of the lives of adolescent boys and girls.	• Legal and policy issues related to ARH: Legal barriers (Generally, adolescents have been largely neglected by policies and programs), Existing ARH policies (On the other hand, state entities do not have clear or consistent definitions of adolescents who have been largely neglected by policies and programs), ARH policy initiatives • ARH programs: Public sector, Shabab 21 campaign, "Ingaz" youth economic opportunities program, Telephone hotlines, peer education, School-based health education, Community-based interventions, Nongovernmental sector, Operations research, Programs beyond the health sector
A Trend Analysis of the Family Planning Market in Jordan: Informing policy and program planning, 2004	This is a general assessment of use and demand for FP in Jordan. Desk analysis: analyzed SES and demographics across five standard of living quintiles, compared method use, provider sources. 2007 results compared with 2002 & 1997	• Wealth is the key factor in FP utilization. The role of the NGO service provision has decreased • Private sector has picked up some of the NGO slack, but not enough.
A trend analysis of the family planning market in Jordan: informing policy and program planning, 2009	The purpose of this study was to conduct a desk-based analysis of the JPFHS 2007 to better understand and define the roles of the public, commercial, and nongovernmental organization (NGO) sectors in serving current and potential FP users.	• Fifty-seven percent of married women are currently using some method of contraception, ranging from 48 percent of the poorest quintile to 62 percent of the wealthiest quintile. • Marked disparities in contraceptive use also exist between urban and rural residence for all methods. In particular, modern method use is five to 10 times higher in urban areas versus rural areas, depending on the method. • Use of the public sector is highest among the poorest quintile, while use of the commercial sector is highest among the wealthiest quintile.

HSS		
Missed opportunities from client exist interviews, 2008	In collaboration with the Ministry of Health's Women and Child Health Directorate (WCHD), the USAID-funded Health Systems Strengthening (HSS) project assisted the Ministry in conducting an Exit Interview survey to identify missed opportunities for family planning (FP) at MOH primary health care (PHC) facilities. The purpose of this survey was to gain a better understanding of the status of FP counseling at PHC facilities, and to identify the major target groups for FP counseling provision.	• Results from the exit surveys reveal a significantly high level of missed opportunities for FP counseling. • One third of all women in the sample do not use any FP method, for a variety of reasons. The majority are either pregnant or in their post-partum period, and compared with FP users in the sample, are on average younger with fewer children. • Opportunities are missed across all levels of services, including general practitioner and vaccination visits • The vast majority of non-FP clients who did receive counseling received it from midwives.

MOH service providers knowledge on how to manage IUDs and OCs side effects, 2008	This study explores the level of knowledge among MOH Family Planning (FP) providers of the side effects associated with the use of contraceptive methods and ways of managing them.	• Providers were tested on their knowledge of FP methods' side effects. On average, performance was lower than expected given the high level of experience among providers in the sample. Thus, physicians scored 68.4% and midwives scored 75.4%. • A large number of providers were easily able to identify some of the most common side effects of IUDs; however, a good number missed other important effects. • About 35 to 40% of clients who were interviewed reported not having been informed about the method side effects by their service provider at the time of receiving the method. • Almost 50% of IUD clients and 33% of OCs clients who returned to the clinics complaining from side effects were told they were normal. However, only few were provided an explanation of what causes side effects.
Missed opportunities from client exit interviews, 2009	The Ministry of Health's Women and Child Health Directorate (WCHD), with technical assistance from the USAID funded Health Systems Strengthening (HSS) project, conducted an Exit Interview survey to identify missed opportunities for Family Planning (FP) counseling at MOH Primary Health Care (PHC) facilities. The purpose of this survey is to gain a better understanding of the extent of FP counseling at PHC facilities.	• The outlook for FP counseling at MOH PHC facilities did not seem to have improved over the past year; the rate of missed opportunities for FP counseling is significantly higher in this year's study sample. • The proportion of eligible MWRA who are not using an FP method is similar this year compared to the previous year (about one third). • Additionally, about one third of non-users have more than four children. This category of people is very important to target to ensure unwanted pregnancies. • Finally, there is significant deficiency in FP counseling among physicians and nurses. Midwives' counseling rates fare better, but are still not even close to acceptable rates.

JHAP		
JHAP Annual Performance Report, 2008	The purpose of JHAP is to improve the quality and safety of healthcare services in Jordan through the provision of technical assistance to target hospitals and other health care facilities, and by building the capacity of the now established Health Care Accreditation Council (HCAC) to develop healthcare standards, in accreditation preparedness by assisting facilities to meet the standards through consultation and training, to do surveyor certification and surveys to determine if standards are met and to award accreditation.	Goals: • To strengthen the quality and safety of services in the Jordan healthcare system through accreditation of facilities and services along the continuum from primary to tertiary care--Completed 4 out of 5 deliverables/milestones • To establish a Health Care Accreditation Commission (HCAC) that has the support of key health care sectors and the capability to carry on project activities beyond the life of the project • To build capacity in both hospitals and PHC Centers to carry out accreditation activities, meet standards, and improve the quality and safety of health services and be accredited ---14/17 deliverables/milestones completed.

HSS II		
Missed opportunities from client exist interviews, 2010	This study attempted to measure the prevalence of missed opportunities for FP in a sample of married women in reproductive age (MWRA) by conducting an Exit Interview survey at MOH health centers. The overall purpose of this study is to provide MOH planners and decision makers with information on missed opportunities for FP.	• Data indicated that half of the interviewed women (49.5%) reported a desire to use a FP method, with 26.3% of them reporting the start of a method right away • Only 24.1% of women reported having discussing FP with a staff member at the health center. • Based on the study's definition, three quarters (75.9%) of the sample were identified as missed opportunities, i.e. received no FP information or counseling. • In examining counseling by the type of provider, results showed that midwives provided most of the counseling (76.3%) followed by physicians (12.6%) and nurses (11.1%). Such counseling included partial and complete provision of FP information to women regardless of their intention to use a modern FP method.
Missed opportunities from client exist interviews, 2011	This report provides the results of a client exit interview survey conducted by the Women Child Health Directorate (WCHD) at the Jordan Ministry of Health (MOH). The survey was conducted in order to collect data on missed opportunities for provision of family planning information/counseling. The survey is conducted annually in order to monitor progress made towards reducing missed opportunities for providing family planning counseling to eligible women at MOH health centers.	• The 2011 Client Exit Interview Survey shows a decrease in missed opportunities from the 2010 survey. • More than half of the interviewed women (59.7%) reported a desire to use a FP method, with 33.9% of these women reporting the start of a method on the day of the interview (20.6% of interviewed women). • In examining counseling by the type of provider, results showed that midwives provided most of the counseling (68.9%) followed by nurses (20.1%) and physicians (11%). Such counseling included partial and complete provision of FP information to women regardless of their intention to use a modern FP method.
A decade of task sharing in Jordan; lessons for policy and delivery, 2012	This study documents the evolution of the task-sharing initiative in Jordan and presents an in-depth analysis of the policy and program interventions as well as aspects of the Ministry of Health's system that contributed to its effectiveness or resulted in setbacks	• The focus group discussions indicated that there are numerous direct and indirect inhibitors and challenges that face health care service providers providing family planning methods, including: System constraints, Personal beliefs, and circumstances of health care providers, Patient-driven reasons, Physical setting, and infrastructure. • As a general observation from the focus group discussions, there is a sense of distrust and lack of synchronization between MOH physicians and midwives.
Decision Makers' Attitudes towards Family Planning Services, 2013	To further investigate the reasons for FP indicators stagnation from the perspective of MOH supervisors, officials and decision makers	• IUD- Relatively low number of trained staff, Very high turnover in HC, Midwife needs a trained physician available at HC to provide IUD. • Implanon - low number of trained physicians, low demand due to low awareness, not available at private sector, private doctors intimidate clients from it, removal is difficult, high discontinuation due to side effects,

Health Care Providers' Practices and Beliefs Towards Family Planning Methods, 2013	Study aims to identify FP service providers KAP toward FP services and identify drivers, barriers and seek recommendations to improve FP services	• Barriers: inadequate distribution of staff, need of trained physician to supervise midwife for IUD insertion, providers have other tasks than FP, not all staff trained on FP services • Attitudes: majority of service providers do not recommend FP methods for married women prior to their first conception, some physicians don't provide Implanon as they had experienced some removal cases, rumors about Implanon lead women to discontinue even she is not facing side effects • General observation: distrust and lack of synchronization between physicians and midwives. The unity of vision and goal seems often to be unclear for both sides and no absence of teamwork • Training: need more supervision and follow-up after the training
Family planning services provided at selected MOH hospitals out-patients clinics, 2013	The overall goal of this situation analysis is to assist some MOH hospitals to provide quality family planning (FP) services at their outpatient clinics; the main objective is to assess the situation of FP services provided at 13 MOH hospitals that are providing immediate PP/PA FP services.	• Personnel at ten hospitals are not satisfied with the FP services provided at their outpatient clinics. The low number of clients served, shortage of staff and low demand from the community were the main reasons for their dissatisfaction. • 58% of specialists covering outpatient clinics provide IUD services, while only 5% of residents are doing so. • Ninety-five percent of midwives and 53% of nurses working at the Ob/Gyn clinics received formal training on FP counseling and are providing the service to clients.
Effect of Family Planning Counseling Provided to Postpartum Women before Discharge from Al-Bashir Hospital on the Adoption and Continuation of Modern Contraceptive Methods, 2014	Assess the effectiveness of FP counseling provided to postpartum (PP) women before discharge from hospital on subsequent adoption and use of modern FP methods. This was done by tracking the adoption of modern FP methods and the continuation of FP use through six months PP among both counseled and non-counseled PP women.	• There was a significant effect of PP FP counseling on the use of modern FP methods at 40+ days (40-50 days) and at three months PP. • Results show a significant effect of FP counseling provided to PP women before discharge from hospital on their early adoption and use of modern FP methods, compared to women who did not receive counseling at 40+ days and 3 months (p values <0.05 at 40+ days and three months PP).

Users of Traditional FP Methods - Needs Assessment, 2014	Assess the current situation of demand and provision of FP methods in specific areas in Jordan (Maan, Mafraq and East Amman). Identify the currently held perceptions of health care providers, decision makers, and Mafraq local community members towards the use of modern and traditional family planning methods. Assess perceptions of health care providers and decision makers concerning potential utility of introducing an additional natural method, the Standard Days Method (SDM), as a way to broaden the options of users of traditional FP methods.	• FP is a crucial issue and is being given focus, the level of effort, policy and budget is nowhere near where it should be • Especially in rural and Bedouin areas, women complaints about the treatment they get from service providers, they have been treated with disrespect and with lack of attention • Reasons for moving from modern to traditional: Magnified fear of the side effects of modern methods, Refusal of the husband for his wife to use any method for fear of her health • SDM: Awareness towards the concept and implementation of calendar type method was low in Mafraq. None of the women have used such a method. Initial reactions towards it is that it is complex and unreliable

SHOPS		
Survey on quality of JAFPP clinics, 2011	As a first step to improving the quality of service provision at JAFPP clinics, the project conducted a survey of 341 married women of reproductive age, including users, non-users, and former users of JAFPP clinics, on views and perceptions of the quality of JAFPP clinics and staff. The overall perception among respondents was that JAFPP has high quality clinics that meet the needs of most clients.	• Over half of current JAFPP user respondents (64%) stated they use JAFPP clinics because it has a good reputation. Eighty three percent of respondents who have never attended JAFPP clinics stated they had heard JAFPP has high quality services. Among former JAFPP users, only 3% stated they do not use the clinics because JAFPP has a bad reputation. • The majority of current JAFPP user respondents were happy with JAFPP operational services: • On the other hand, the majority of current JAFPP user respondents (77%) were dissatisfied with the amount of time it took to see a physician.

Provider Knowledge, Attitudes, and Practices concerning family planning methods in Jordan, A review of the literature and available data, 2011	The purpose of this review is to collect the available data on the knowledge, attitudes, and practices of providers on family planning methods in Jordan. However, most of the available literature is becoming outdated and the most comprehensive survey of providers' knowledge, attitudes, and practices found was conducted in 2002.	• Providers are generally knowledgeable and aware of most methods of modern family planning and their side effects; however, there are knowledge gaps for injectables and implants and common misconceptions/misinformation have been found. • Provider preferences are for family planning methods quickly return a woman to fertility until she has reached the completed size of her family. • Providers recognize the value of fertility and children in their religion and culture and it appears to influence their preferences in prescribing methods.
Users of Injected methods for family planning in Jordan: a review of the literature and available data, 2011	This review seeks to summarize what available literature can tell us about the use of injected methods for family planning in Jordan. There are limited data available on injected contraceptive methods in Jordan. However, the data suggest that both users and providers have limited knowledge on this method.	• Most women are aware of the method, but very few women use or have used the method. • Women use the method for spacing and limiting births • Misconceptions exist among women about the method and its side effects. • Side effects, rumored and true, particularly menstrual irregularities, cause discontinuation and prevent women from using the method. • The method is infrequently prescribed or even counseled by providers.
JAFPP Service Quality and Brand Image Report, 2011	The authors conducted nine focus groups on the perceptions of the Jordanian Association for Family Planning and Protection (JAFPP) among current and potential users, and the quality of JAFPP clinics and services.	• Some of the criteria that make JAFPP different from other providers include: professional and high quality services, affordable, close proximity to home and work, and the exclusive focus on women's health issues. They said the care is timely and professional. • Respondents also gave recommendations to improve products and services: increase number of clinical services available, provide more information on FP methods, install childcare services, install coffee/snack space, and provide clinical services in the late afternoons or evenings.
Effectiveness of evidence-based medicine on knowledge, attitudes, and practices of family planning providers: a randomized experiment in Jordan, 2013	The authors established an evidence-based medicine (EBM) program to educate doctors about a three-month contraceptive injection that is unpopular among providers and consumers. They wanted to know if the EBM (which included booklets, roundtable discussions, and educational outreach visits) increased knowledge, improved perceptions (attitudes and confidence), and increased discussions of and prescriptions for the injection among providers.	• There was little (no detectable) change in provider knowledge of side effects, and reported practices did not change. However, there was evidence of a positive impact on provider attitudes and confidence in the injection. • This intervention was not effective for making a marked difference in providers.

Evaluation Report: Reach and Effect of the Social Marketing Campaign for Oral Contraceptive Pills: 2011-2013, 2013	The report presents findings from efforts aiming to evaluate the social marketing campaign to promote the use of oral contraceptive pills (OCPs).	• Campaign impactful: Exposed respondents knew about OCPs, agreed OCPs positive, current FP users, more likely to intend to use FP in future. Benefits of OCPs higher with increased exposure, likelihood of being FP user increased, odd of not currently or intending to use FP in the future decreased with exposure. • National CYP due to OCP distribution increased over period of campaign.
Evaluation of the Reach and Effect of the IUD Social Marketing Campaign, Wave 2, 2014	From June 2013 to June 2014 Ta'ziz (USAID Strengthening Family Planning project) implemented three waves of a multichannel campaign promoting the intrauterine device (IUD). The key component of the IUD campaign is promoting awareness that IUDs are a safe, effective, reliable, and reversible contraceptive method for FP.	• Although 40% of women reported their intentions or behaviors were impacted, among all viewers only 12% discussed the IUD with their spouses, 24% discussed the IUD with others, 8% consulted a provider about the IUD, 3% decided to use the IUD, and 1% had an IUD placed. • The campaign may have helped get women to talk about the IUD and discuss it with a provider, but there is still a gap between that and actually deciding to use the IUD.
Client satisfaction pilot survey results 2014 (JAFPP clinics), 2014	The purpose of this pilot is to determine which of two methods is the most effective and valid way to measure client satisfaction, to assess if proper family planning (FP) counseling is being provided to clients, and if the clinic staff promotes FP services to women who visit the clinic for other service. The instrument also measures clients' perception of respect for privacy, appropriate client-provider interaction, safety measures, and hygiene at the clinic.	• Satisfaction among clients who received services at the sampled JAFPP clinics was generally high regardless of the service received or the interviewing methodology. • Differences in service quality were noted, however, when comparing those interviewed through exit interviews as compared to telephone interviews. FP clients interviewed through the phone were less likely to agree to statements related to good FP counseling quality as compared to those interviewed upon exiting the clinic.
Strengthening Family Planning Project: Evaluation of Careline Follow-up Calls, 2015	The Strengthening Family Planning Projects (Ta'ziz) seeks to increase demand for modern family planning (FP) products and services. To achieve this objective, Ta'ziz uses its Community Outreach Program, a key activity of community health workers (CHWs) who conduct door-to-door visits and provide FP counseling to women in their homes.	• Voucher follow-up: With follow up, more women used the voucher to obtain FP services. Those who acted on the vouchers and took up a method chose the IUD (64%), followed by COCs (10%), implants (8%), POPs (4%), injections (2%) and condoms (2%). • The follow-up calls positively affect the uptake of a modern FP method even if the women used a different source - the calls- not the vouchers and the driving factor

Research study brief: does counseling women and couples increase family planning uptake in Jordan?, 2015	SHOPS conducted a randomized controlled trial to evaluate the impact of family planning counseling on family planning outcomes and to examine whether impacts differ for couples counseling as compared with women-only counseling.	• Offering in-home family planning counseling had a positive and significant impact on uptake of modern contraceptive methods. • Counseling women alone or couples resulted in lower use of traditional methods and fewer concerns about modern methods' side effects compared with no counseling. • Participation in counseling was substantially lower in the couples' counseling group due to husbands' lack of availability and refusal to receive visits.
Effect of Postpartum Family Planning Counseling in Increasing Uptake of Modern Family Planning Methods after Delivery in Private Hospitals, 2015	The authors hypothesized that women who receive FP counseling during postpartum recovery in private hospitals were more likely to utilize a modern FP method. They conducted a randomized controlled trial and measured the impact of FP counseling on whether women intended to use a modern FP method after delivery, as well as the adoption of modern FP methods by these women 40 days and 3 months postpartum.	• In the private sector, postpartum counseling seems to be effective for increasing short-term uptake of modern FP methods • It's harder to invoke positive change in FP method use in the private sector because these women are more educated and wealthier, making them more likely to be using FP methods anyway (46% of the control group was using modern FP methods 3 months postpartum, compared to the national average of 42%). • By three months after delivery of the intervention, there were no detectable changes in FP use among women in the controlled and treatment groups.
Family planning service quality recognition award program progress report, 2015	Used a survey to assess the level of quality and client safety of 20 clinics over a period of around 40 days. The assessments covered 13 ObGyn clinics, six general medicine clinics, and one family medicine clinic. Thirteen of the clinics are in Amman, three in Balqa, two in Zarqa, and one clinic each in Irbid and Madaba.	• All of the assessed clinics were providing most reversible FP services/methods, including oral contraceptive pills, injectables, Implanon, intrauterine devices (IUDs), and condoms. • In general, there was no clear system for the handling of hazardous materials (handling, labeling, storage, transport, and disposal). In all visited clinics, there was no evidence of measures to ensure that the clinic is safe and secure.
Expanding the Network of Private Doctors to Improve Family Planning and Access Quality, 2015	Created and expanded a network of doctors in an effort to: Increase demand, increase access, improve quality. Their services were meant to respond to unmet needs for FP.	• Ta'ziz engaged select network doctors (NWD) in its national, method-specific social marketing campaigns to increase demand for modern FP and to promote the doctors' services. • Coordinated with the community outreach team to identify NWDs, who played a key role in increasing FP access. • Improved quality through standardized FP counseling and clinical training to strengthen providers' technical competency, service quality monitoring, and continuous quality improvement through feedback, technical assistance/training and approach refining

HSS II Bridge		
The family planning service delivery improvement collaborative model in MOH health centers, 2015	The WCHD and the HSS II Bridge project built on the successful accreditation collaborative through the development and use of a customized approach, the FP Service Delivery Improvement Collaborative (FP SDI Collaborative), to engage relevant stakeholders to increase access, and quality of FP services in selected MOH health centers. Implemented the FP SDI collaborative and monitored/analyzed the program.	• Improved processes and outputs in the participating Health Centers: Increased availability of LARC methods and trained providers of these methods; Improved internal referral, both postpartum and PHC clients; Increased internal and external informational sessions about family planning • Successful because truly collaborative, focused, teamwork, credible, observable, client-centered, and doable.

JCAP		
Knowledge, attitudes, and practices towards family planning and reproductive health among married women of reproductive age in selected districts in Jordan, 2015	This is a baseline survey to understand the knowledge, attitudes, and practices (KAP) of MWRA on FP/RH. Using the findings to create an implementation approach to increase the use of integrated FP services and provide baseline against which they can measure the effectiveness of their programs.	• Perceived side effects of contraceptives, 1/3 of respondents believe traditional FP is just as effective as modern FP, women reported wanting to have big families (61% wanted four or more children), male children are preferred (affecting how many children some mothers have) • The vast majority of MWRA know about FP, women are "reasonably empowered" to make decisions about their RH • Most women have been exposed to an FP method and know where to obtain contraceptives. Almost half the women wanted to limit child bearing • Syrians and Jordanians didn't differ dramatically in any of these findings.
Policies, Legislation, and Strategies Related to Family Planning in Jordan: Review and Recommendations, 2015	This study is a review of the strategies and legislations related to population challenges and family planning, in order to show what needs support and continuation as well as what needs improvement and modification.	• There are undeclared policies, which manifest themselves in personal attitudes of some FP providers towards providing the service for newly married couples, and their bias to certain methods other than methods of protection against pregnancy and IUD insertion after birth. • The school curricula in public schools and higher education include educational information on family planning, but we are not sure of the adequacy of the quantity and quality of information offered to adolescents and young men and women before marriage • The policy supports the role of the voluntary and private sectors in family planning, and access to family planning methods -even hormonal ones (except implants) - in the private sector does not require a prescription from a doctor or clinical and laboratory examinations.

Office of the Inspector General		
Audit of USAID/Jordan's Strengthening Family Planning Project: Office of Inspector General, 2014	Regional Inspector General (RIG)/Cairo conducted this audit as part of its fiscal year 2014 audit plan to determine whether USAID/Jordan's Strengthening Family Planning Project is expanding access to and improving quality and use of family planning services.	• For JAFPP, the project made clear progress toward these goals. The project made it easier to access family planning services through JAFPP, improved the quality of, and increased demand for JAFPP services. • One of the project's highlights was quality clinic renovations