Preface

Due to its high importance and influence on families and society, family planning is one of the primary health care elements on which the Ministry of Health focuses. Family planning programs assist families to take the appropriate reproductive decisions that suit their own circumstances to meet their needs and to achieve their reproductive goals. Family planning also plays a major role in improving maternal and child health and reducing maternal and infant mortality and morbidity through the use of birth spacing. In addition, the implementation of these family planning programs supports and promotes the achievement of the national objective of accelerating achievement of the demographic opportunity and its benefits.

The Ministry of Health, in partnership with all health sectors, works seriously to increase coverage and access to family planning and reproductive health services, improve their quality and ensure that comprehensive and distinguished services are provided to target groups in the entire Kingdom, always mindful that the Ministry is the largest provider of family planning services in the Kingdom. The Ministry also provides modern, highly effective and safe family planning methods for free to all other public and non-governmental organizations in Jordan to assure sustainability and availability of these methods. Moreover, the Ministry collaborates and builds strong partnerships with many national and international agencies working in the field of family planning.

These efforts have reflected positively on the quality and efficiency of family planning services in Jordan and related indicators. These indicators have improved continuously and significantly over the past two decades, placing Jordan within advanced rankings for health. Despite these achievements, the family planning program still suffers from some challenges, such as the lack of change in the total fertility rate and the rate of use of modern contraceptives in recent years, and increases in discontinuation of method use, unmet need, and missed opportunities for family planning. Therefore the Ministry of Health and its national partners are committed to work on overcoming these challenges and contributing to achievement of national goals.

The Ministry of Health Family Planning Strategic Plan of 2013 – 2017 was developed to respond to challenges and obstacles facing the family planning program within the Ministry of Health and to support national efforts to improve the family planning indicators, thus achieving the national goals. The strategy was developed through a participatory approach among all the Ministry directorates and departments working on family planning, as well as stakeholders and partners working on family planning and reproductive health. The strategy includes a clear vision and mission, specific achievable goals, and comprehensive and integrated interventions.

We extend our thanks and appreciation to all who contributed to the preparation of this strategy, particularly the Steering Committee and the Core Technical Working Group who were responsible for its development. We are confident that it will be taken seriously and will be carried out effectively by all officials and stakeholders to achieve the desired objectives.

Minister of Health
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List of Abbreviations

ABCDE Model	Assessment, Baseline, Components, Down to Specifics, and Evaluation Model
CBO	Community Based Organization
COC	Combined Oral Contraceptives
CPR	Contraceptive Prevalence Rate
CYP	Couple Years of Protection
FP	Family Planning
GIS	Geographical Information System
GP	General Practitioner
HC	Health Center
HCAC	Health Care Accreditation Council
HCAD	Health Communication and Awareness Directorate
HCP	Health Care Provider
HD	Health Directorate
HPC	Higher Population Council
HRDD	Human Resources Development Directorate
HSMC	Hospital Safe Motherhood Committee
HSS II	Health Systems Strengthening II Project
IEC	Information, Education and Communication
IS	Information System
IT	Information Technology
ITD	Information Technology Directorate
IUD	Intrauterine Device

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JAFPP	Jordan Association for Family Planning and Protection
JCLS	Jordan Contraceptives Logistics System
JFDA	Jordan Food and Drug Association
JICA	Japan International Cooperation Agency
LAM	Lactational Amenorrhea Method
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MOH	Ministry of Health
MWRA	Married Women of Reproductive Age
NGO	Non-Governmental Organization
NPS	National Population Strategy
Ob/Gyn	Obstetrics & Gynecology
PHC	Primary Health Care
PFHS	Population and Family Health Survey
PP/PA	Postpartum/Post-Abortion
RHAP	Reproductive Health Action Plan
SC	Steering Committee
SDP	Service Delivery Point
SHOPS	Strengthening Health Outcomes through the Private Sector
SWOT	Strengths, Weaknesses, Opportunities and Threats
TFR	Total Fertility Rate
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNRWA	United Nations Relief and Works Agency
USAID	United States Agency for International Development
WCHD	Woman and Child Health Directorate
WHO	World Health Organization

Summary

During the past decades the Government of Jordan achieved remarkable progress in providing quality reproductive health and family planning (FP) services to the Jordanian people. This was reflected in key performance indicators for these services which showed positive trends during the period 1976 through 2002. However, from the 2002 Population and Family Health Survey (PFHS) up to the present time, the country's total fertility rate (TFR) has been stagnant at around 3.8 and the contraceptive prevalence rate (CPR) at around 59%, with only 42% for modern methods. More than 11% of Jordanian women do not want to get pregnant but are not using contraception and 45% of modern methods users discontinue during the first year of use. These data indicate that there are still significant challenges with regard to the delivery of essential FP services in Jordan.

The Ministry of Health (MOH) is the single largest provider of FP services in the country, contributing around 43% overall. Increasing access to quality FP services is one of the main responsibilities and priorities of the MOH. Given its vital role, and its commitment to improving national family planning indicators, the MOH embarked on developing a five year FP strategic plan for 2013-2017.

The plan was developed with the full participation of concerned administrations and related directorates at the MOH, along with partners in FP at the national level. The plan is structured around the six health system building blocks identified by the World Health Organization (WHO) at a global level: 1) safe, quality health services 2)a well-performing health workforce 3) a well-functioning health information system 4) equitable access to modern contraceptive methods 5) a good health financing system, and 6) effective leadership and governance. These were used as a working framework to analyze the current situation of FP including its main issues, objectives, initiatives and activities.

The MOH intends that this strategic plan will help to enable families in Jordan to achieve their desired reproductive goals through access to high quality FP services and information. Such services should be delivered throughout MOH health facilities in a positive environment; in full alignment with empowered communities; and in partnership with other relevant stakeholders.

The FP strategic plan adheres to a set of five values that govern the implementation of services: voluntary and informed choice; access to a wide range of modern FP methods; accessibility of services for all; affordability and convenience; and client safety and quality of care. It also reflects the MOH commitment to complementing other relevant strategies and documents of the Government of Jordan with regard to FP and reproductive health.

The plan is made up of five strategic objectives:

1- Improve quality of and access to FP services and counseling.
2- Strengthen the functionality and utilization of FP information and support systems.
3- Strengthen the supportive policy environment for family planning.
4- Improve effectiveness and efficiency of FP human resources management.
5- Increase community awareness and demand for family planning.

These objectives are designed to empower the MOH to provide quality FP information and services which will contribute to timely achievement of the country's fertility goals. Each strategic objective has at least one sub-objective, followed by major initiatives to be implemented by different MOH parties to achieve the objectives. Progress towards achieving the objectives of the strategic plan will be regularly monitored through key performance indicators.

Background

Although significant progress on Jordan's FP indicators was made between 1976 and 2002, these indicators have been stagnant since then, with the following results (Jordan PFHS, 2009):

There is a persistent high TFR[1] with major differences between the governorates of the Kingdom. (Graphs1 and 2). Desired fertility remains less than actual fertility.[2]

- There is a plateauing CPR that is resisting efforts to increase provision of FP services (Graphs 4 and 5).
- There is a persistent reliance on traditional FP methods (Graph 5).
- There is a persistent high discontinuation rate for modern methods[3] (Graphs 6 and 7).
- There is less than optimal birth spacing.[4]

The MOH commitment to the improvement of the national FP indicators is of major importance, because the MOH meets approximately 43% of the demand for FP services (PFHS2009). It is thus a key contributor to the effort to assist Jordan's families to achieve their reproductive goals, and to the potential progress on FP that can be made in the nation.

The MOH's responsibility for the health of the population of Jordan includes family planning, and this MOH FP Strategic Plan is consistent with the MOH strategic objective to improve the quality and sustainability of health care services and to promote community healthy practices, including family planning. It responds to the challenges of the current FP situation and program within the MOH, and complements others' efforts to achieve national goals, including the Reproductive Health Action Plan goal of improving FP in Jordan to contribute to improving woman and child health and accelerate achievement of the demographic opportunity. It also seeks to contribute to the global Millennium Development Goal (MDG) 5B: "Achieve universal access to reproductive health." Family planning is one sub-goal of this MDG.

The following exhibits depict the trends in FP trends in Jordan using data from the Population and Family Health Survey 2009, including:

1- Total fertility rate, 1976-2009
2- Total fertility rate by governorate
3- Source of family planning methods among current users of modern methods
4- Contraceptive prevalence rate, 1990-2009
5- Contraceptive prevalence rate by governorate
6- First year discontinuation rates of modern contraceptive methods, 2009
7- First year discontinuation rate of modern contraceptives, 1990-2009

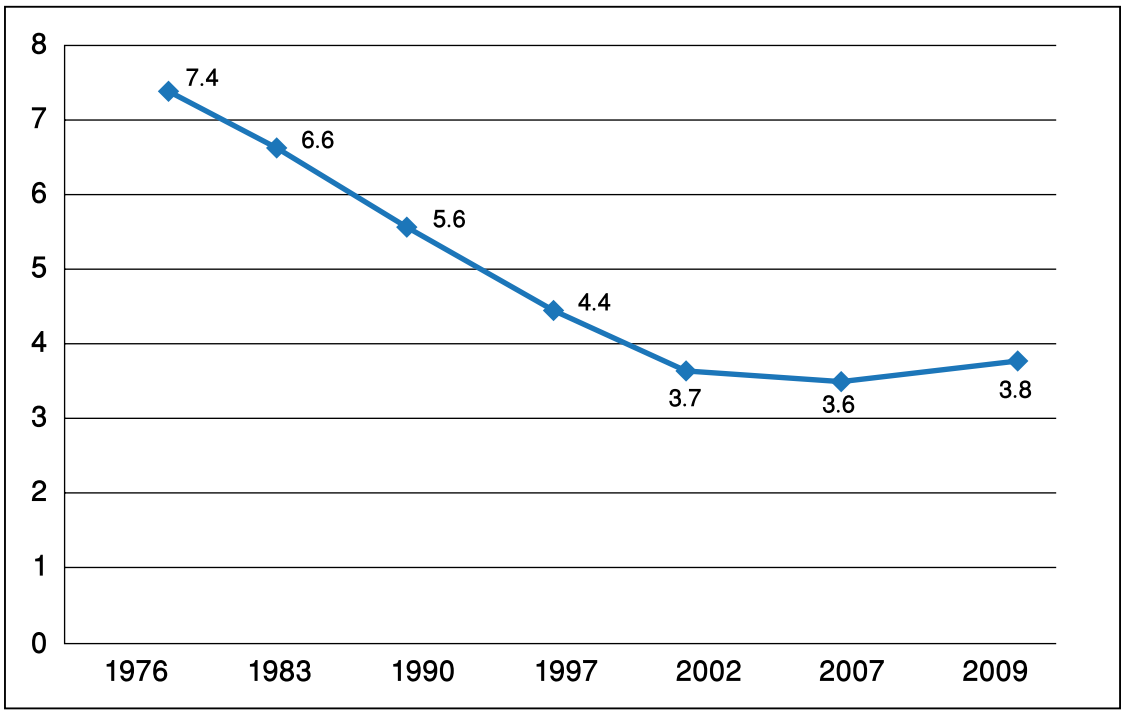
[1] In 1990 the TFR was 5.6, in 2002 it was 3.7, in 2007 it was 3.6, and in 2009 it was 3.8.

[2] Jordan PFHS, 2009: "In Jordan, if all unwanted births were prevented, the total wanted fertility rate would be 3.0 births per woman or 0.8 births less than the actual total fertility rate. Thus, the total fertility rate in Jordan is inflated by 27 percent because of unwanted births. The gap between the wanted and actual fertility rates has improved since 2002, when the TFR was inflated by 42 percent because of unwanted births (2.6 births versus 3.7 births)."

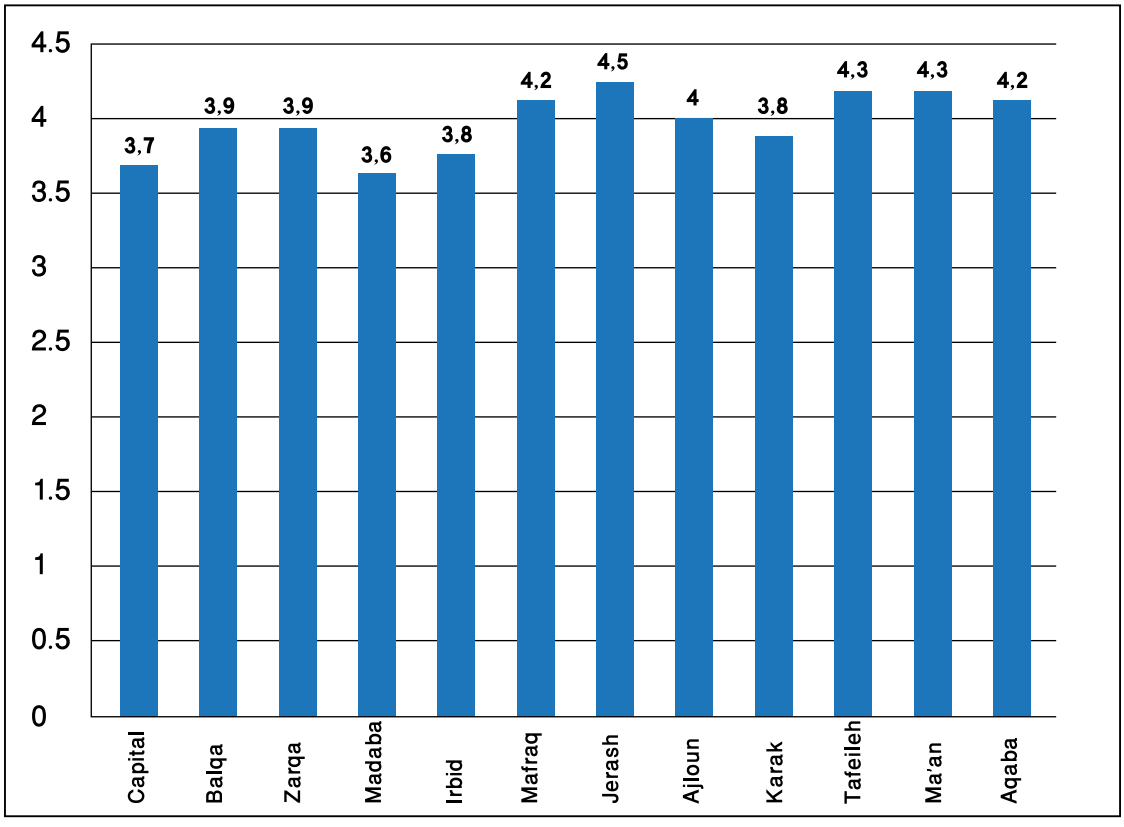
[3] Discontinuation during 1st year of use (PFHS, 2009): Oral contraceptives 50.9%; IUD- 15.1%; Injectables - 64.3%; Condoms - 51.5%.

[4] Less than 42% of births occur more than 33 months since the previous birth. (DHS, 2009)The optimal interval (in terms of health of mother and newborn) between births is 33 - 60 months (WHO, 2005).

Graph 1 – Total Fertility Rate, 1976-2009 (PFHS 2009)



Graph 2 – Total Fertility Rate by Governorate, 2009 (PFHS 2009)



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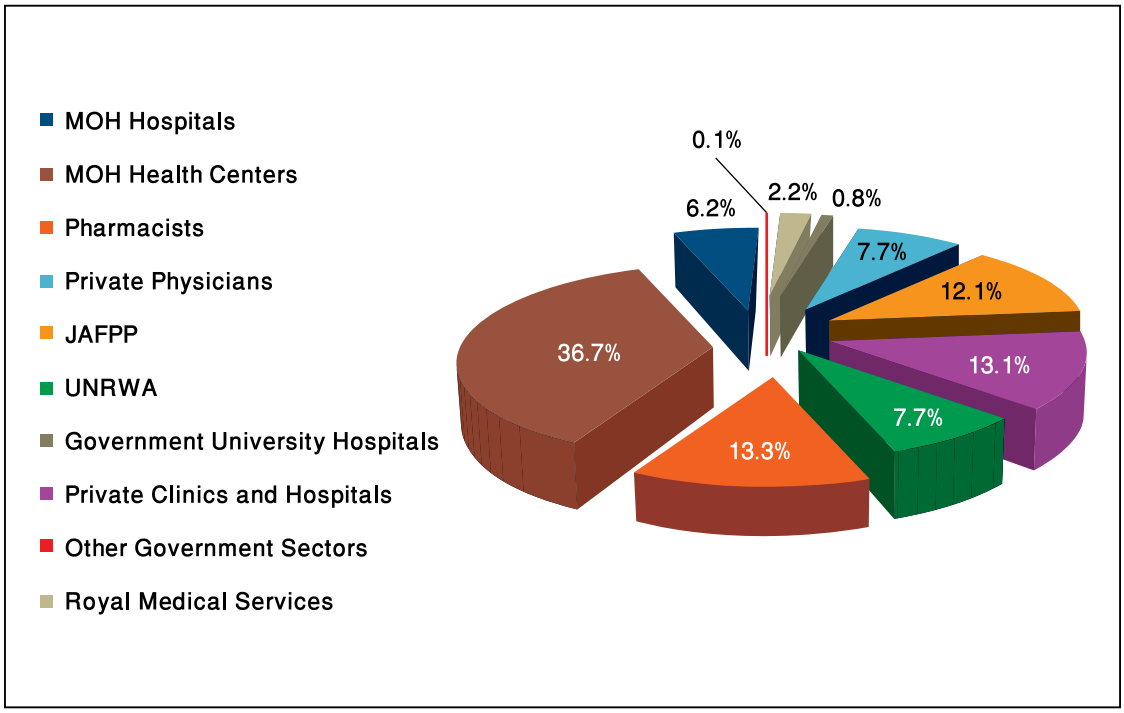
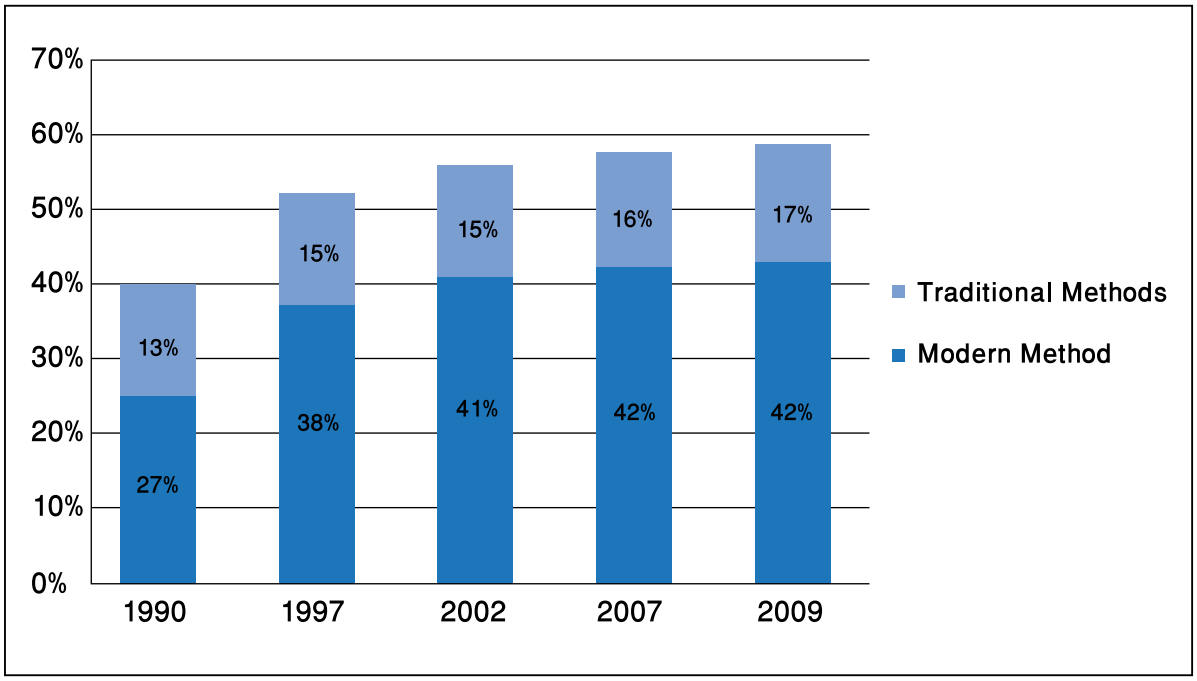
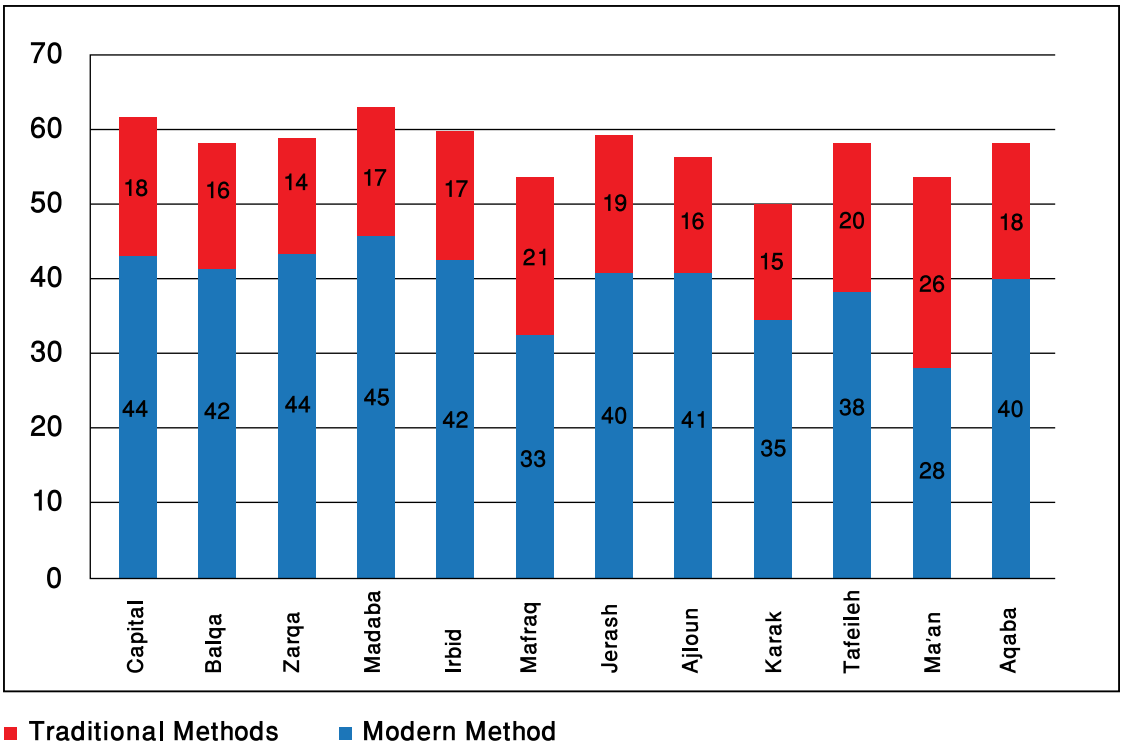
Graph 3 – Source of Family Planning Methods among Current Users of Modern Methods (PFHS 2009)



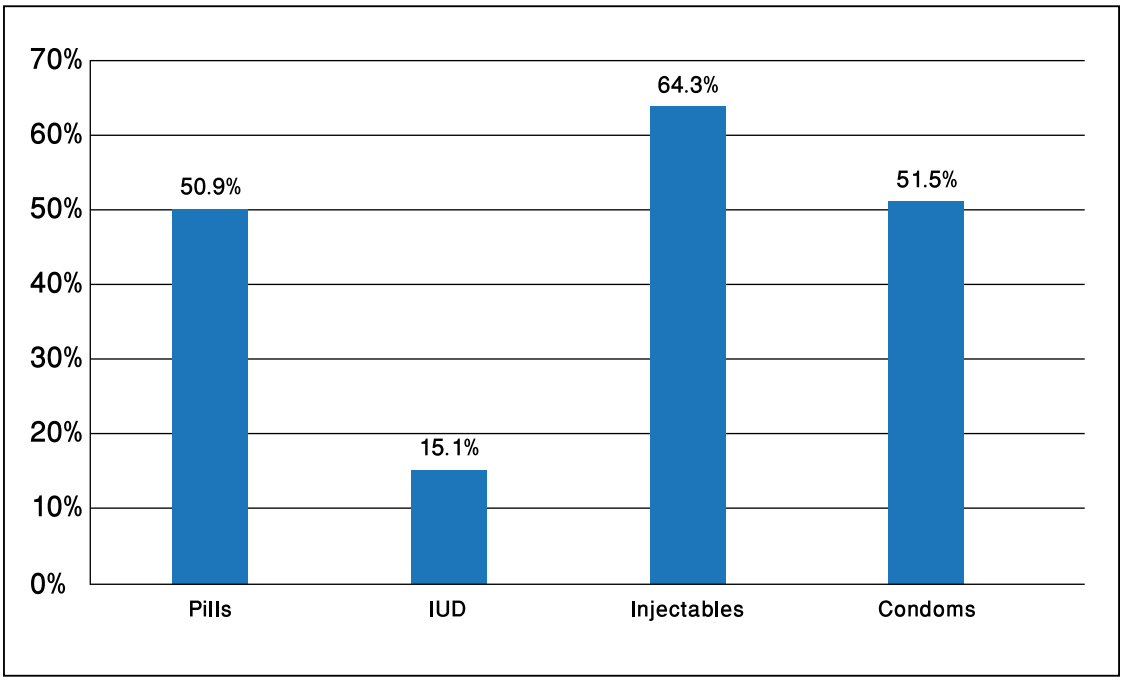
Graph 4 – Contraceptive Prevalence Rates, 1990-2009 (PFHS 2009)



Graph 5 – Contraceptive Prevalence Rate by Governorate, 2009 (PFHS 2009)



Graph 6 – First Year Discontinuation Rates of Modern Contraceptive Methods, 2009 (PFHS 2009)



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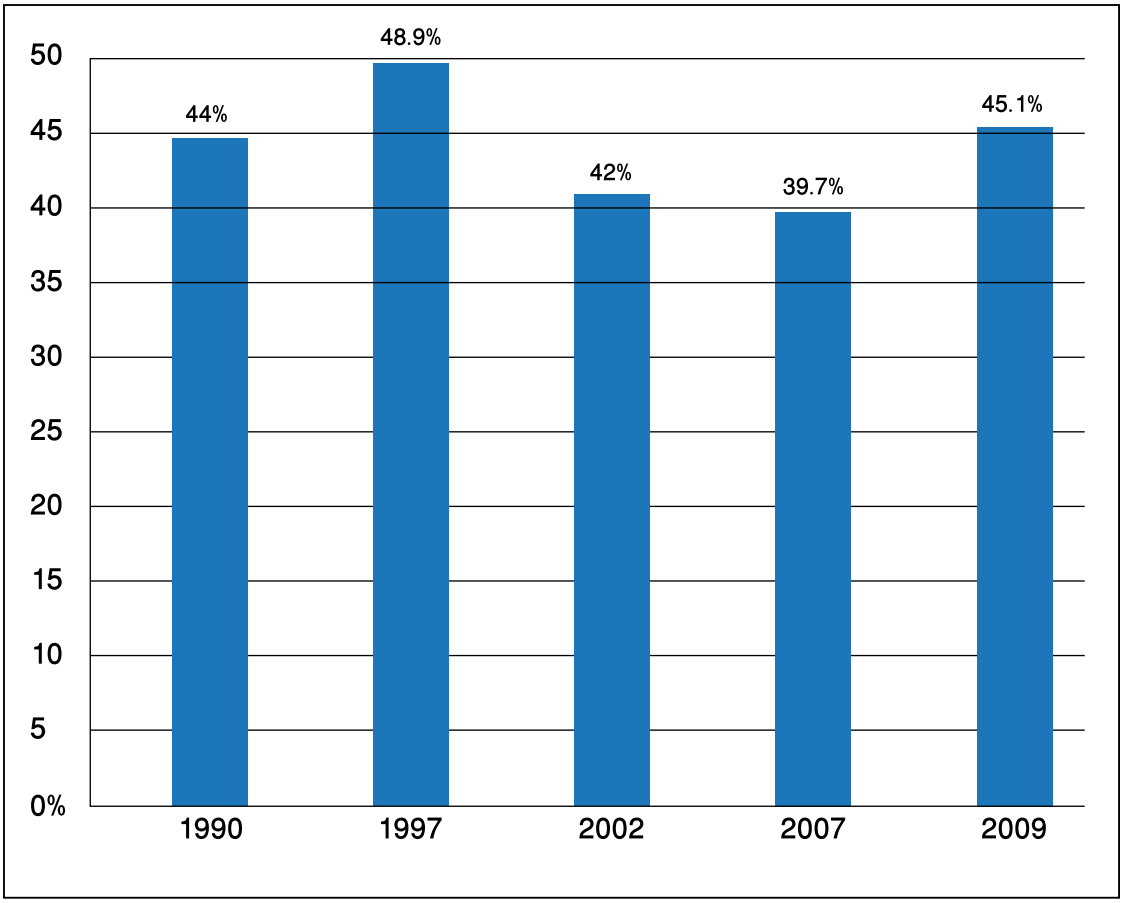
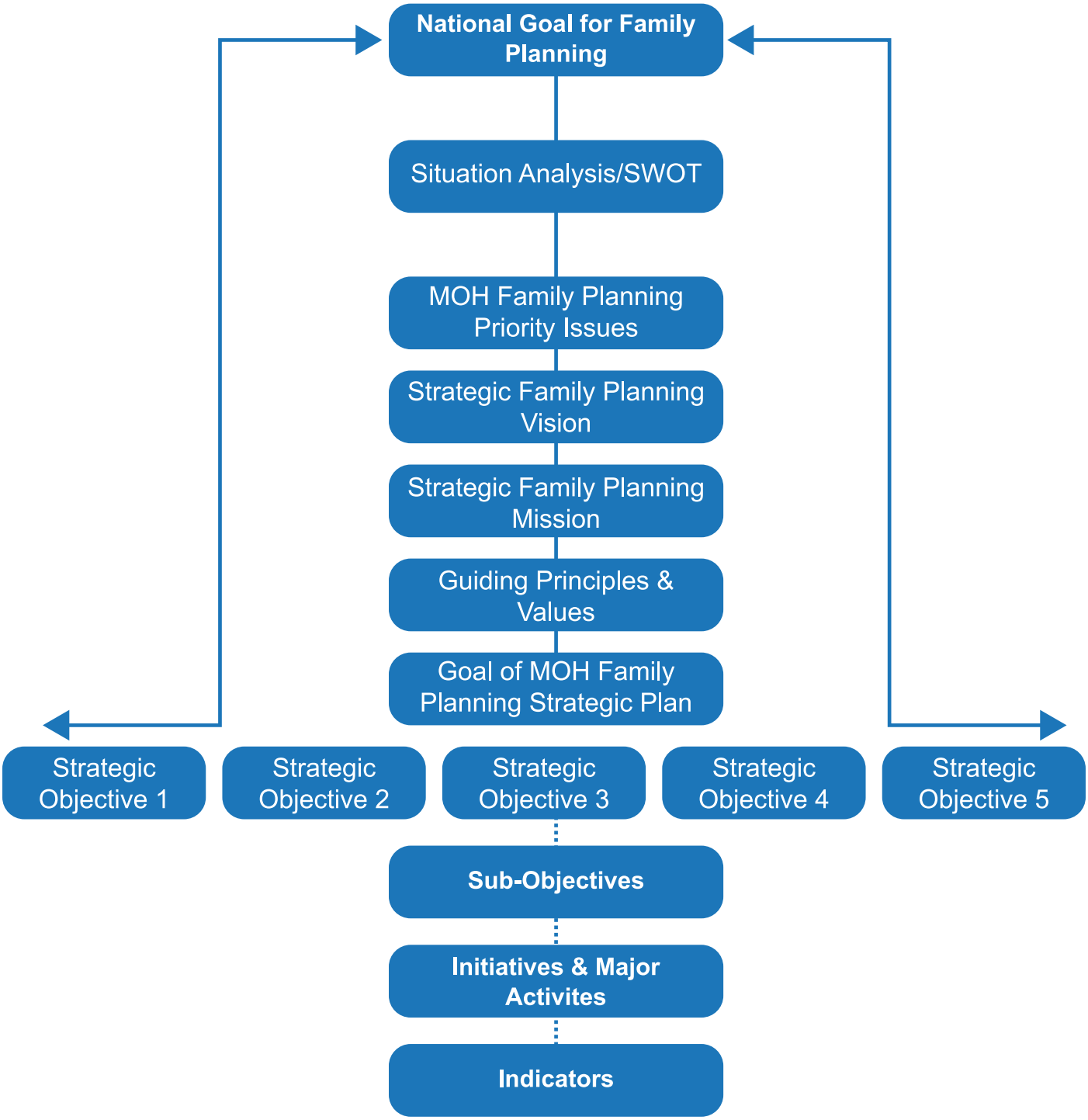
Graph 7 – First Year Discontinuation Rate of Modern Contraceptives, 1990-2009 (PFHS 2009)



Framework of the Family Planning Strategic Plan

The framework for the Family Planning Strategic Plan was developed using a combination of the Logic Strategic Planning Model and the Assessment, Baseline, Components, Down to specifics, and Evaluation (ABCDE) Strategic Planning Model, customized to the specific context of the MOH in Jordan. The Logic Strategic Planning Model defines the long-term outcome results for the MOH related to family planning in Jordan. According to the logic model, the strategic goals of the new MOH strategy are derived from those national and global level goals. Additionally, the ABCDE Strategic Planning Model was used to consider major issues for family planning in the MOH as derived from the situational analysis and Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis. The framework is illustrated in the exhibit below.

Exhibit 1 –The MOH Family Planning Strategic Plan Framework



Methodology used in Development of the FP Strategic Plan

To assure progress towards improvement in FP performance, the MOH developed this FP Strategic Planbetween June 2011 and March 2012 to cover the years 2013-2017.

First, the Minister of Health formed a Steering Committee (SC) to oversee the development of the FP Strategic Plan. The SC is led by the Secretary General, with the administrative and technical support of the Primary Health Care (PHC) Administration, specifically the Woman and Child Health Directorate (WCHD) with membership of all other relevant MOH departments. The SC approved the technical conceptual model for the FP Strategic Plan and the general timeline for its development. The SC also recommended that the Director of PHC Administration oversee a core Technical Working Group (TWG) to lead the development of a FP Strategic Plan, and approved its scope of work. The core TWG is comprised of several SC members, the WCHD staff (Director, Head of FP Section and Head of FP Logistics and Information Section), representatives of the Higher Population Council (HPC), and technical staff from the Health Systems Strengthening II (HSS II) project funded by the United States Agency for International Development (USAID). This TWG met frequently during the entire process.

Two workshops were conducted by the core TWG to obtain input from key internal and external stakeholders. Stakeholders include those who have some role and responsibility within the FP Strategic Plan, which may include development of the plan,high-level support for the plan, communication of the plan, and implementation and/or monitoring of the plan.During the two workshops, 60stakeholders contributed to the Situation Analysis/SWOT, Vision, Mission, Strategic Objectives, Sub-Objectives, and Initiatives for the FP Strategic Plan. Full attendance sheets listing the participating stakeholders are presented in Annexes B and C. The workshop participants also suggested a number of indicators to monitor progress towards fulfilling the Strategic Plan.The workshops were followed by intensive working sessions of the core TWG to complete theFP Strategic Plan.

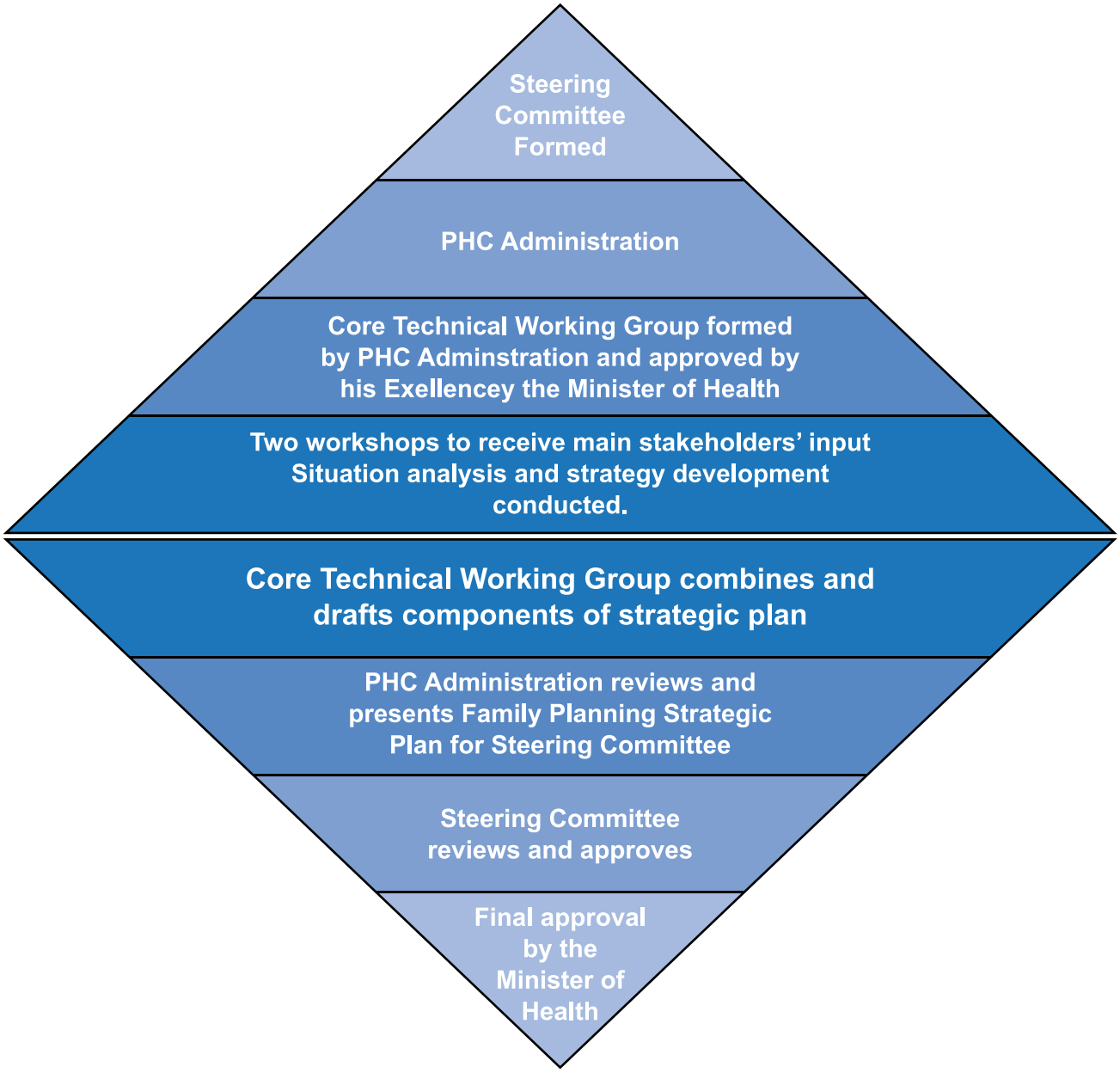
Stakeholders

Internal to MOH: PHC Administration, Health Directorates Administration, Hospitals Administration, Administrative Affairs Administration, Planning Administration, Legal Affairs Directorate, Internal Control and Auditing Directorate, WCHD, Directorate of Human Resources Development (HRDD), Information, Research and Studies Directorate, Budget Directorate, Quality Directorate, Planning and Projects Management Directorate, Supply and Procurement Directorate, Tenders and Contracts Directorate, School Health Directorate, Clinical Pharmacy Directorate, Information Technology Directorate, Nursing Directorate, Health Communication and Awareness Directorate (HCAD), Directorate of Human Resources Affairs, Health Directorate Directors, Directors of Hospitals, Chief of Obstetrics and Gynecology, Women and Child Health Units Heads and Supervisors, Health Centers(HCs).

External: USAID represented through the Health Systems Strengthening II (HSS II) Project, Higher Population Council, other USAID funded projects (Private Sector Project, Strengthening Health Outcomes through the Private Sector [SHOPS], Health Policy Project, Jordan Health Communications Project), United Nations Population Fund (UNFPA), Jordan Food and Drug Association, Joint Procurement Administration, University of Jordan.

The first full draft of the FP Strategic Plan was issued in March 2012; revision and modifications continued until July 2012. To implement this strategy, operational plans will be developed annually.The development of the strategy is illustrated in the diagram below.

Exhibit 2 – FP Strategic Plan Development Process



Analysis of the Current Situation of Family Planning in the Ministry of Health

In order to fully identify and then address all of the major issues related to family planning, the WHO six building blocks of health systems strengtheningwere utilized and adapted to bethe basis for the technical conceptual framework. Two building blocks, Community and Monitoring & Evaluation, were added in order to assure that these topics were given adequate consideration, and to indicate the level of importance of these building blocks within the MOH. The building blocks were utilized during the situation/SWOT analysis, which was then condensed into the eight major issues to be addressed by the strategy. The five Strategic Objectives of FP Strategic Plan address those issues.

The FP situation within the MOH, including challenges, is described here according to the technical framework of these building blocks. The areas used in this discussion are listed below, together with the corresponding WHO building block (if changed) and the added ones:

1- Family Planning Services
2- Human Resources (corresponds to *Health Workforce)*
3- Leadership and Policy (corresponds to *Governance and Leadership)*
4- Information and Monitoring and Evaluation (corresponds to *Health Information System)*
5- Commodities and Finance (corresponds to both *Finance* and *Medical Products, Vaccines and Technologies*)
6- Community

Monitoring and evaluation were merged with information, and supplies with finance due to similarity in issues related to analysis.

1. Family Planning Services

The goal of MOH FP services is to improve the health of Jordanian families, especially the health of women and children. The MOH provides accessible FP services in its hospitals and health centers, with good geographical coverage. The whole community benefits from such services, especially low and middle income populations. FP services are provided free of charge for Jordanians and at subsidized prices for non-Jordanians. The MOH also supports the Royal Medical Services and selectednon-governmental organizations (NGOs), including the Jordan Association for Family Planning and Protection (JAFPP), United Nations Relief and Works Agency (UNRWA) and some private sector clinics by providing them with FP methods free of charge. This is done to ensure the important role of these sectors in providing FP services. At the same time, the MOH includes these institutions' staff in selected FP training, such as training in intrauterine device (IUD) and implant services to expand the choices of FP methods provided in these sectors.

Hospitals: Fifteen MOH hospitals provide services in both the outpatient and inpatient areas.FP counseling and methodsare available within several outpatient areas, including Comprehensive Postpartum (CPP) clinics, and Gynecology clinics. In the outpatient area, FP services are provided by Ob/Gyn specialists and residents, midwives and nurses. In order to decrease missed opportunities for FP counseling and method provision, and to take advantage of the fact that 99% of women in Jordan deliver their babies in hospitals, the MOH began to provide counseling and modern methods for hospitalized postpartum/post-abortion (PP/PA) women in 2011. The number of hospitals providing such services increased from nine by the end of 2011, to thirteen by mid 2012, with plans to expand to all public hospitals throughout the Kingdom. The Hospital Safe Motherhood Committees (HSMC) will monitor the service on a monthly basis[5].

[5] HSMCs are composed of the Hospital Director, Director of Hospital Quality Unit, Directors of Obstetrics and Pediatrics/Neonatology, Head of Nursing, Head of Nursing in Maternity and Neonatal Units. The function is to provide leadership and oversight to the quality of maternal, neonatal and postpartum/post-miscarriage FP in the hospitals.

Challenges to the success and sustainability of service delivery in hospitals are related to workforce issues of staffing, workload and designation of this service as a duty. Additionally, the HSMCs do not yet fully include FP in their monthly agendas or reporting.

Health Centers: FP counseling and modern methods services are provided at the Maternal and Child Health (MCH) centers available within the PHC and comprehensive HCs. The number of MCH centers increased from 416 in 2007 to 444 in 2012. The number of modern FP methods provided at these centers range from 3–5 methods according to the availability of needed tools, supplies and staff trained in IUD and contraceptive implant services. Twenty health centers are accredited by the Health Care Accreditation Council on “Standards for PHC & Family Planning”. Preparation of another 58 HCs for accreditation is taking place now and another 30 HCs will be prepared in 2013. The responsibility for quality assurance and mentoring of FP services is assigned to the Women and Child Health Unit Heads and MCH supervisors at the Health Directorates (HDs), as well as overall management within the HCs and the WCHD. In the PHC area FP services are provided by midwives, nurses and, where available, female physicians and sometimes male physicians.

In collaboration with the Japan International Cooperation Agency (JICA), MOH through WCHD implemented the “Integrating Health and Empowerment of Women in the South Region Project”. Through this project, WCHD introduced FP counseling and services for two modern methods (male condoms and oral contraceptives) in 45 village HCs in the south and built the capacity of health workers in these HCs to provide such services. Health workers are conducting home visits providing FP health messages and referring women to appropriate public, NGO or other private sector FP providers. This project was sustained through WCHD and south governorates HDs. The project needs more support to assure sustainability and to improve and expand it to other governorates. Table 1, shows the number of MOH HCs providing FP services according to governorate and type of services provided.

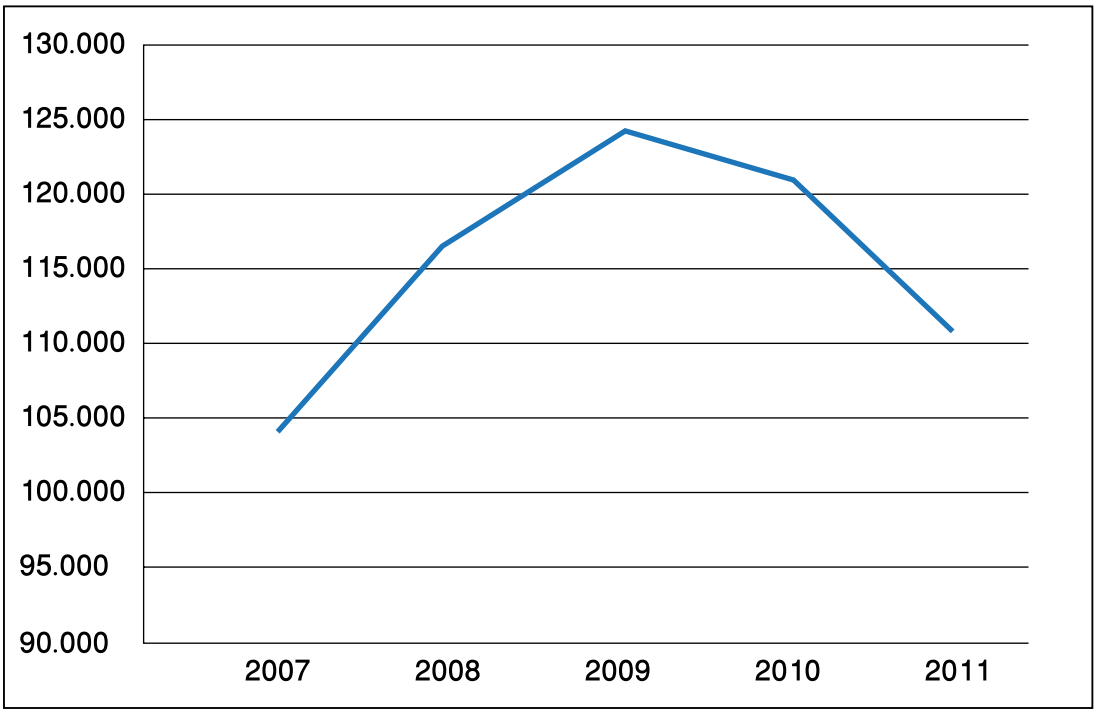
Table 1- Number and Distribution of MOH HCs Providing FP Services According to Governorate and Type of Services Provided

#	Governorate	No. of MCH centers	No. of HCs providing FP services in 2012*	No. of Village HCs in south providing 2 FP methods*	No. of HCs providing Implants services in 2012*	No. of HCs provided IUD services in 2011*	No. of HCs providing IUD services in 2012*
1-	**Capital**	71	71	-	16	42	45
2-	**Zarka**	36	36	-	13	19	23
3-	**Madaba**	16	15	-	1	8	8
4-	**Balqa**	49	49	-	2	16	14
5-	**Irbid**	100	100	-	9	22	35
6-	**Ajloun**	24	24	-	3	3	3
7-	**Jerash**	18	18	-	6	5	7
8-	**Mafraq**	45	46	-	5	3	3
9-	**Karak**	41	41	23	8	16	15
10-	**Tafieleh**	16	16	3	4	7	6
11-	**Ma'an**	19	19	11	1	4	2
12-	**Aqaba**	9	9	7	2	5	4
TOTAL		**444**	**444**	**44**	**70**	**150**	**165**

* Number includes any HC that provided the service during the year, even if only for one month.

The couple years of protection (CYP) provided through all MOH hospitals and HCs was 110,719 in 2011, which represented 55.8% of all couples protected through all sectors included within the Jordan Contraceptives Logistics System (JCLS). Figure 8 shows CYP at MOH hospitals and HCs for the last five years. The CYP was rising until 2009, and then it started decreasing from 123,727 in 2009 to 110,719 in 2011.

Graph 8 – Couple Years of Protection at MOH Hospitals and HCs, 2007-2011



Challenges to the provision of quality FP counseling and services in the HCs are related to overwork of staff and staff values/beliefs regarding appropriateness of FP in general or of specific FP methods. FP counseling takes time, as does provision of some methods such as IUD or implants. Also challenging is the desire of clients to receive these services from a female physician.

A sentinel surveillance of discontinuation of IUD and combined oral contraceptives (COCs) conducted by the MOH WCHD in MOH facilities showed discontinuation rates of 14% for IUDs and 42% for COCs during the first year of use. Many discontinuers (42%) converted to another method, mainly condoms, which is a less effective method. Side effects are the most important reason for discontinuation or moving to another method (47%), which indicates a need to improve counseling services and focus on how to deal with side effects during counseling and follow-up visits (MOH and HSS II Report 2011). The "Missed Opportunities for FP Counseling Study" done by WCHD shows that the missed opportunities for FP counseling for MWRA visiting MOH HCs decreased from 75% in 2010 to 64.6 in 2011, but it is still high. According to the 2011 study, the highest level of missed opportunities was in the middle region (71%) while it was 57% in the northern region and 62% in the southern region (MOH and HSS II Report 2011). The discontinuation rate and rate of missed opportunities are considered important indicators of client satisfaction and quality of care in addition to their effect on improvement of national FP indicators.

Contraceptives Provided: Most of the MOH health facilities (hospitals and health centers) provide at least three modern FP methods. By mid-2012, about 28.7% of these facilities provide at least four modern FP methods, including one long-acting method (IUD or implants). The MOH aims to increase this percentage by expanding the number of health facilities that provide a mix of at least four modern methods including IUD or implants.These methods are provided after individual counseling that includes discussion of the clients' FP goals and appropriate methods to achieve those goals.The methods discussed include oral contraceptives (combined and progestin-only), male condoms, injectables, IUDs, implants, and tubal ligation. Graph 9 shows the distribution of temporary modern methods used by clients in MOH facilities in 2011.

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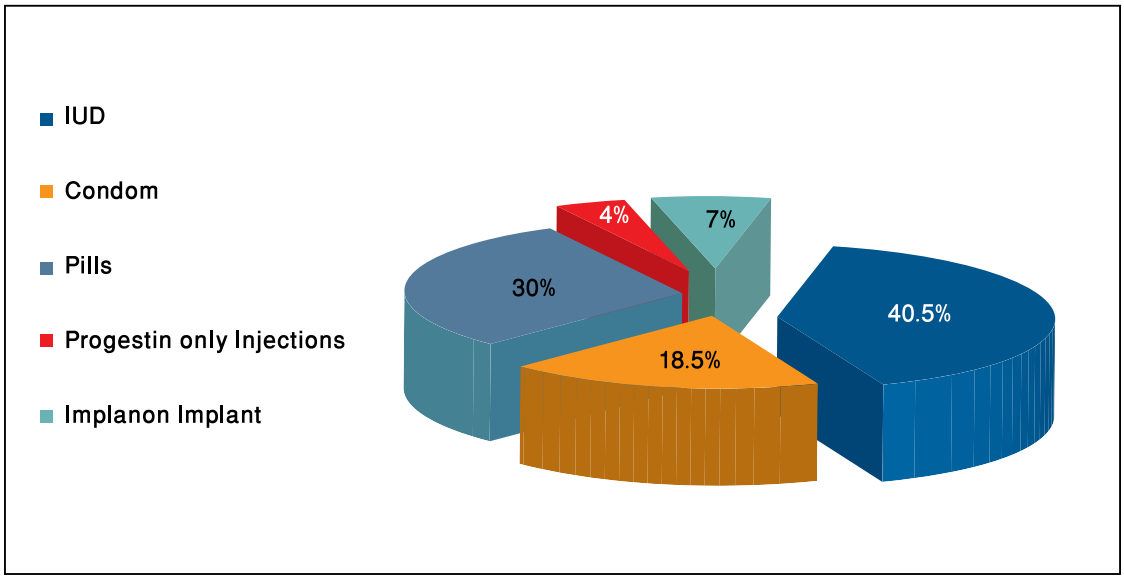
Graph 9 –Distribution of Temporary Modern Methods Used by Clients of MOH Facilities, 2011



Contraceptive continuation rates appear to be substantially higher among women who use long-acting contraceptive methods. Global experience confirms that without widespread availability and use of long-acting methods of contraception, a country cannot cost-effectively meet its lowered fertility goals. For these reasons, the MOH is striving to increase access to these long acting contraceptive methods.

- **Implanon:**The MOH started providing the contraceptive implant "Implanon" as a method within the logistics system for modern contraceptives in 2005.To build the capacity of service providers to provide such services, the MOH trained MOH physicians and those from other sectors involved with FP services. The number of facilities providing such services rose from 3 facilities in 2005 to 78 facilities in 2012.

  The main challenge to increasing use of this method is the insufficient number of skilled providers to insert and remove implants. Despite extensive capacity building, many of the skilled physicians do not provide the service. The reasons for this non-provision include relocation or attrition from the MOH, and lack of willingness to provide the service.

- **IUD:** The IUD is the preferred method of modern contraception for Jordanian women. According to PFHS 2009, 22% of total FP users were relying on an IUD for contraception. According to the 2011 logistics system reports (see graph 9); the IUD contributed to 40.5% of methods distributed to MOH facilities FP clients. Because of the high demand for this long-acting method, and the client preference for a female provider to deliver the service, there is always a need to have more female providers available. To meet this demand,the MOH has allowed midwives to provide this service and included IUD insertion and removal in the formal job description of midwives. In 2011, 34% of MOH facilities were providing IUD services.

2. Human Resources

The MOH deploys health care providers (HCPs) to provide FP counseling and services within their respective sites of practice. These duties are detailed within the job descriptions and/or within the guidelines for practice atthe service delivery site, whether hospital or HC. In 2011, the MOH updated more than 400 job descriptions, including those for midwives and nurses at both hospitals and HCs, to specifically address FP counseling and services. Challenges to disseminating and assuring compliance with the job descriptions remain.

Physicians: The MOH relies heavily on physicians to provide or supervise provision of modern FP methods. Because of the desire of women in Jordan to have female providers for FP counseling and provision of methods, the MOH struggles to increase the availability of female physicians to provide these services. Both male and female general practitioners (GP) assist to:

- Decrease missed opportunities for FP by relaying messages or referring clients for FP counseling and services;
- Decrease discontinuation of FP methods by appropriately managing side effects; and
- Increase use of some long acting methods by either providing those methods (e.g., implants), or by supervising midwives to provide IUDs.

The GPs are part of the MOH effort to increase FP messages to any non-FP using MWRA presenting for any reason to a primary health center.Challenges include the shortage of female physicians, high turnover in physician staff, and frequent lack of commitment among GPs to provide FP services or particular methods even after receiving training to do so.

Midwives: Midwives play a major role in the provision of FP services, including both counseling and methods, in both hospitals and HCs. Midwives are responsible for assuring and providing FP counseling, and they participate in key MOH FP studies, such as the FP Sentinel Surveillance on discontinuation of methods. In 2004 the MOH piloted a program for midwives to provide insertion and removal of IUDs, through which 182 midwives received training on IUD insertion and removal and were allowed to provide the service. The program continued successfully through 2009 and the number of HCs providing IUDs increased gradually, from 119 HCs in 2004 to 193 HCs in 2009. The proportion of IUDs inserted by midwives also increased (from 20% in 2004 to 46.5% in 2009). In 2010 questions were raised regarding the legal basis of midwife insertions, including whether legal regulations allowed them to practice this service. Accordingly many midwives stopped providing the service,which led to a decrease in the percentage of IUDs inserted by midwives to 20%. This also contributed to the stagnation in FP indicators. In late 2011 the MOH included this duty in the job description of midwives working at MOH. This might help to fulfill the demand for IUD and improve the range of modern contraceptives available to women. However, some challenges remain: midwives may provide IUD services only if specially trained, and if supervised by a trained physician. In addition, physical examinations must be performed by a physician, and prescriptions for contraceptives must be written and signed by a physician.

Nurses: Nurses may provide counseling, education for FP and other nursing duties. They are not currently able to provide FP methods themselves unless there is no midwife available to provide the services.

Village Health Workers: Forty five village health workers in the South have been trained to provide FP counseling for two methods of modern contraception (male condoms, oral contraceptives). They may also refer clients to appropriate public, NGO or other private sector providers to obtain other modern methods. In addition they conduct home visits to raise awareness, provide health education and encourage women to use health services.

The enabling environment: Five elements are required to enable health care providers (HCP) to effectively provide FP services:

- *HCPs and their supervisors know what is expected of them*: Job descriptions, clinical guidelines, protocols and references, and clear assignments from management or the head of the department are provided or present in the job site. However, use of and adherence to these items are inconsistent.
- *Knowledge and skills*: The central MOH, through the WCHD, provides Clinical Guidelines on Women's Health that include family planning, and job aids such as posters and information, education and communication (IEC) materials. It provides workshops, trainings (didactic and, where appropriate, clinical), and on-the-job training and mentoring for service providers. Topics covered include FP counseling, contraceptive technology updates,

insertion and removal of IUDs and contraceptive implants, FP orientation for non-MCH providers, standards for postpartum and post-abortion FP services in hospitals and FP logistics. Certificates are provided to trainees, which are often helpful or necessary for promotion. Challenges regarding performance of the HCPs after the trainings need to be addressed by improving selection of trainees according to criteria, as well as supervision that supports and assures that staff duties are performed as assigned.

- *Equipment and supplies*: Contraceptives, equipment, appropriate venue, log books and forms (for documentation, reporting, etc.) are supplied by MOH. The supply of contraceptives is usually maintained, with acceptable stock-out rates at service delivery points (SDPs).There are challenges with the availability of equipment and supplies for IUD and implant services. Computers are not always available, accordingly registration of services, development of reports and calculation of indicators are done manually, which increases the burden on service providers and sometimes leads to inaccuracy.
- *Management*: Management of FP services at health facilities is the responsibility of the director of the HC or obstetrics unit or outpatient clinic in the hospital. Each facility's management staff undergoes some training in leadership and management, planning, and quality improvement among other topics. However, the level of support and effective management of FP services depends on the manager's knowledge and attitude regarding the importance of these services.
- *Supervision*: In addition to the day-to-day supervision of staff and services that occurs at the point of service by HC managers, the WCHD staff and the health directorate's MCH supervisors provide monitoring, mentoring and observation to the provider staff on a regular basis. A supportive supervision system for MCH and FP services, including the supervisory tools at the HD level, was established and implemented. There are definite challenges in this system related to compliance of supervisors to the supportive supervision procedures. Additionally, supervisors report that they are often unable to makes cheduled supervision visits due to lack of transportation or other issues related to their multitude of tasks and insufficient time available for supervisory visits.

3. Leadership and Policy

Organizational structure of family planning within the Ministry of Health: Family planning services are managed at the central MOH level by the WCHD in the PHC Administration. Within WCHD, the FP Section is responsible for MOH FP services; the Information and Logistics Section is responsible for the MOH FP Logistics System, all issues related to assurance of FP contraceptives and other FP commodities, and for the MCH/FP Information System. These two sections need strengthening of their institutional capacity and provision of additional administrative and technical staff.

At the Health Directorate level, HDs are administratively under the HD Administration, and they oversee HCs in their directorates, including MCH clinics. In each HD, the Woman and Child Health section is technically responsible for MCH and FP services at MCH clinics within the HCs. Each HC Director reports to the Health Director and manages the services at the HC.

Hospitals are administratively under the jurisdiction of both the Health Directorate and the Hospitals Administration of the central MOH. In each hospital, the head of the Ob/Gynsection reports to the hospital director, and is responsible for FP services within the hospital, assisted by the Hospital Safe Motherhood Committee.

Others within the MOH also contribute to the FP work of the MOH. The Health Awareness and Communication Directorate manages the community health program within the MOH. The Quality Directorate is responsible for accreditation of both hospitals and HCs, including assurance of achievement of HCAC standards related to family planning. Among the main challenges in this area is the unclear role of the WCHD/FP section in supervising FP services at the hospital level.

Commitment: The MOH Commitment to FP is demonstrated by the following examples:

- The MOH provides FP services free of charge to Jordanian citizens at all of its health facilities.
- The MOH provides modern FP methods free of charge to other health sectors under the MOH contraceptive logistics system.
- Multiple national documents demonstrate the commitment the Government of Jordan has made to FP, including the following:
  - The **National Agenda, 2006-2015** includes objectives and population indicators on the national level.
  - The **MOH Strategic Plan** is under development for the years of 2013-2017. Family planning is found within the current MOH Strategic Plan under the 3rd Strategy theme: Promote Best Reproductive Health Practices; FP program.
  - The **Reproductive Health Action Plan (RHAP), second phase (2008-2012)** was developed and is being implemented by the HPC in close collaboration with many parties working on FP in Jordan.
  - The **Demographic Opportunity** and accompanying work plan developed by the HPC advocates for policies for investing in and achieving the population opportunity and maximizing the benefits from the accompanying changes – the demographic opportunity. By doing so, the national goal on social welfare is more likely to be met. (National Agenda, 2006-2015)
  - The **National Population Strategy (NPS)** seeks to contribute to a sustainable base for economic development through a decrease in the nation's TFR to <2.5[6] children per woman of reproductive age by 2020**.** One of the principal elements of the NPS is the reinforcement of the "Right of families to produce an appropriate number of children and to have access to information and FP methods in order to make their decisions freely in line with religious and cultural values."
  - The **National Family Planning Communications Strategy** provides a summary of the FP communication situation in Jordan, sheds light on priority issues, and outlines the vision, mission, values as well as the strategic objectives. It also lists the main communication domains that will be implemented by different partners.

MOH Regulations and Policies: Numerous regulations and policies deal with FP, including the following:

- **Public Health Law:** Family planning and reproductive health are mentioned as part of the scope of work of MOH in coordination of concerned parties.
- **Civil health insurance system:** This states that MCH and FP services are to be provided free of charge to Jordanians.
- **Job description:** The MOH added IUD insertion to the job description of midwives.

Major challenges to family planning are related to the policies that restrict recruiting necessary FP staff, including community workers and counselors at the level of HCs and community, and insufficient policies to reduce staff migration and increase staff satisfaction and commitment. Policies are needed to increase the number of female physicians working on FP, motivate HCPs to receive training and stay committed to provide FP services, improve stability of cadre after training, maximize opportunities for FP counseling and services, provide an appropriate and continuous budget for FP method and services, simplify the procedures for purchase of contraceptives, and support PP/PA FP services in hospitals.

Partnership, Cooperation and Coordination: The MOH collaborates and builds partnerships with national and international organizations working in the field of reproductive health and FP, and benefits from the support ofinternational projects, including those sponsored by USAID, JICA, UNFPA, and WHO. External projects are not well institutionalized and could be better coordinated. Internally, there is limited coordination within the MOH regarding its FP programs, including between the WCHD and other central HDs.

[6] The TFR target, according to HPC's Demographic Opportunity document, is 2.7 by 2020.

4. Information and Monitoring and Evaluation

Studies: The MOH conducts and uses the results of a number of studies and routinely gathers information to measure its progress, to track its effectiveness, and to adjust its interventions if needed. Challenges to the use of data for decision making and for operational planning exist.

These studies include the Client Exit Interview for Missed Opportunities (for FP counseling) and the Sentinel Surveillance for Discontinuation of IUD and Combined oral contraceptives (COC). These studies are conducted annually by WCHD and their results indicate the level of access to full and accurate information regarding family planning, which is presumed to have a positive effect on use of modern methods (including decreasing discontinuation).

Jordan FP Logistics Information System: The FP Logistics Information System provides the MOH with details about distribution of contraceptives throughout the Kingdom, and for both public and private sectors that receive commodities from the MOH. It is a rich source of information on method mix, use and other key indicators. The system features unified registration tools, processes, and defined variables. Monthly reports are prepared by all sectors involved in the system and all service delivery points (SDP). Information generated from this system is known for its quality and accuracy. It was established by the MOH in 1997 in collaboration with USAID. It is managed centrally by the Information and logistics section of the WCHD. The system is in the process of being updated and improved to make its use faster and friendlier. Soon it will be accessible through the MOH web site to enable all entities engaged in the program to generate reports and indicators related to contraceptives dispense for decision making.

Maternal and Child Health Information System (MCH IS): The MCH IS reports information on FP, antenatal and postpartum care, and child health collected at the HC level. It helps to assess provision of services, including counseling. It is readily accessible to all via the MOH website. It is currently being updated and improved to make it friendlier and easier to use and to ensure availability of information and indicators needed for planning, monitoring and evaluation that are consistent with the changing situation of service provision.

Perinatal Information System (PIS) for Hospitals: The PIS was recently developed for data related to antenatal, delivery and postnatal care at hospitals. It includes data related to PP/PA FP services. The system will be linked to the MCH IS. The challenge will be activating and sustaining the PIS.

5. Commodities and Finance

In 2005, USAID started gradually phasing out financial support for contraceptive purchases. As of 2009, the MOH purchases all contraceptives for all of the sectors under the Jordan Contraceptives Logistics System (JCLS). Beside the MOH facilities, the system includes 662 SDPs from Royal Medical Services, UNRWA, JAFPP, University hospitals, all other NGOs, and some private sector clinics through the USAID-funded “Taziz” project. The system is highly effective with regards to availability of modern FP methods in SDPs providing FP services. FP methods provided through the system are: IUD, pills (combined and progestin-only), injections, implants, and male condoms. There is only a 5% stock out rate at SDPs, which is considered to be an acceptable figure.

The main challenges are the long and complicated procurement procedures and high prices, as well as the limited available brands in the Jordanian market. At present, local suppliers are not interested in registering and entering other contraceptives to Jordan due to the small Jordanian market. This stymies expansion of the method mix.

Since 2011, a budget line item for contraceptive procurement has been included in the MOH budget under “Reproductive Health and Family Planning Project” within “Primary Health Care/Services and Health Centers Program”. On a yearly basis, the MOH allocates a budget under this line item for purchase of contraceptives. At the same time, some money is allocated for staff capacity building in areas of reproductive health implemented by WCHD including FP activities. However, the WCHD still depends on donor, projects (especially those funded by USAID) to fund such activities, which limits the MOH’s ability to implement the range of activities needed to

improve the performance of service providers and improve the quality of FP services.

There are clear financial challenges to the continuation of provision of contraceptives throughout all sectors because of the increase in cost of contraceptives due to globally increased prices and increased demand. Sufficient funds also need to be allocated in the MOH budget for other FP program components and activities, such as: training, expansion of SDPs, recruiting service providers, equipment and supplies, taking into consideration the gradual increase in number of MOH beneficiaries all over the Kingdom.

6. Community

The MOH community health program aims to develop mechanisms for partnerships between health care services and the community. It seeks to empower communities to ensure that they play a role not only in managing their own health, but also in using the system effectively and responsibly through appropriate health seeking behavior. One of the community health program's specific objectives is to increase the use of modern FP methods. It identifies and links community resources to HCs. It supports the establishment and strengthening of Community Health Committees to address the determinants of health through community mobilization, and it conducts FP mobilization campaigns that target both men and women to increase demand for modern FP methods.

Health workers in the South village health centers conduct community based activities through their home visits. They provide messages to raise awareness on FP, and refer clients for FP services to appropriate public, NGO or other private sector providers to obtain other modern methods. In addition they conduct home visits.

Health promotion is also conducted through the production and use of IEC materials, the delivery of awareness sessions (e.g., through Arab Women Speak Out, youth programs, and some programs directed towards men), and mass media campaigns for FP.

Some of the challenges related to the community work include the fact that there are insufficient community-based initiatives within the MOH. Voluntarism is not a concept well adopted by the community. Additionally, cultural barriers to FP exist, including the desire for large family size, the rush to have a child directly after marriage, insufficient practice of healthy birth spacing, especially between the first and second child, the urge to have a male child, high reliance on traditional FP methods, and the belief that FP is only a woman's role and not a man's role. In addition, the MOH fully depends on donors' projects to implement community health promotion activities, especially community awareness activities. A strong need is for increased money for such activities.

Strengths, Weaknesses, Opportunities and Threats (SWOT)

The situation analysis regarding MOH family planning included the use of an approach that analyzes the Strengths, Weaknesses, Opportunities and Threats (SWOT) within the framework of the building blocks described above. The information for the SWOT was obtained from national and MOH data sources, including the DHS 2009, the FP Logistics Information System, and the MCH IS. The stakeholders involved in the SWOT analysis included the 60 persons who attended the first workshop in October 2011, as well as the core TWG and other informants.

The priority issues that follow the SWOT in this document were consolidated from the MOH FP situation analysis and the SWOT, as well as from the national indicators for FP.

Strengths	Weaknesses
Service Delivery 1- Availability of manuals, guidelines and media material. 2- Good geographical coverage of centers providing family planning (FP) services (444 centers). 3- Availability of objectives and activities related to FP in the operational plans of HDs and some hospitals. 4- Majority of SDPs provide 3 FP methods. **Human Resources** 1- The presence of Nursing and Midwifery colleges under the authority of the Ministry of Health. 2- Trained staff at all levels (FP services, data collection, data entry, counseling, long-acting hormonal contraceptives;contraceptive implants, PP/PA FP, IUD insertion, logistics, and commodities management). 3- Availability of qualified trainers for FP services. 4- Availability of approved job descriptions for all staff working in FP. **Leadership** 1- Supportive MOH laws, regulations and instructions (Public Health law, FP and MCH services instructions, health insurance system, and inclusion of "providing IUD services" in midwives' job description). 2- MOH commitment to provide other sectors with FP methods free of charge. **Information and Monitoring & Evaluation** 1- Availability and accessibility of information systems at the MOH (Logistics, MCH, Perinatal, Geographical and Training).	**Service Delivery** 1- Weak quality of FP services: 1.1 Poor compliance with protocols and guidelines by service providers. 1.2 Provider bias to personal beliefs and specific methods. 1-3 Insufficient numbers of trained personnel (doctors, midwives and nurses) at the level of SDPs. 2- Poorly functioning supportive systems: 2.1 Supportive supervision 2.2 Referral and appointment 2.3 Monitoring and evaluation 2.4 Equipment maintenance 3- High level of missed opportunities for family planning and high discontinuation rates. 4- Limited access to FP services for PP/PA at hospitals. 5- Lack of FP services in village HCs in the north and center regions. 6- Limited access to long acting contraceptives. **Human Resources** 1- Shortage of staff providing/supporting FP services due to cadre mal-distribution, turnover - including migration and attrition. 2- Insufficient implementation of job description related to staff providing/supporting FP services . 3- Weak professional development. 4- Low commitment of some trained staff to provide services. **Leadership** 1- FP is not a key issue in the MOH strategy. 2- FP is described under MOH budget as a project not a program, which limits its resources. 3- Insufficient monitoring and evaluation system for FP and limited accountability. 4- Inappropriate positioning of FP within MOH structure. 5- Inappropriate policies to reduce the staff migration and to increase staff satisfaction. 6- Limited coordination between WCHD and other central HDs. 7- Policies restrict recruiting some needed FP staff including social health workers and counselors. 8- Inadequate regulations/bylaws to support community based initiatives.

2- Standardized user manual and forms for MCH and logistic systems. 3- Missed Opportunities for FP Counseling and Contraceptives Discontinuation studies are conducted by MOH on regular basis. 4- FP and logistics system are managed centrally at WCHD. **Finance & Commodities** 1- Special line item within the budget for contraceptives. 2- Availability of good range of choices for FP methods. 3- FP services at MOH facilities are free of charge. **Community** 1- Media campaigns exist. 2- Existence of Community Health Committees and community mobilization campaigns. 3- Existence of empowerment programs such as youth and Arab Women Speak Out.	**Information and Monitoring & Evaluation** 1- MCH/FP Management IS is not user friendly, lacks some important indicators, and needs updating. 2- Insufficient dissemination/utilization of data for decision making at all levels. 3- Limited information technology (IT) infrastructure, equipment and human resources. **Finance and Commodities** 1- Bidding procedures for contraceptives are too lengthy (bureaucracy). 2- Limited choices for contraceptive brand alternatives. 3- Reliance on donors for implementing some areas of FP activities such as community based activities, capacity building and marketing. 4- Waste of costly methods. **Community** 1- Insufficient community based initiatives within MOH. 2- Marketing and awareness challenges.
Opportunities **Service Delivery** 1- More than one institution/organization providing FP services, including NGOs. 2- FP information is available within curricula at universities, schools and colleges. **Human Resources** 1- Availability of qualified HCPs all over Jordan. 2- Availability of good number of female physicians in the private and NGO sector. 3- Availability of social workers on the community level in some NGOs and in Ministry of Social Development. **Leadership** 1- Support from national organizations and international projects. 2- Availability of supportive documents and policies on the national level (RHAP II and demographic policies). 3- Legislation for minimum age of marriage. **Information and Monitoring & Evaluation** 1- PFHS collects information on the national level. 2- Increasing demand on information by national entities (MOP, HPC). 3- National broadband network and IT infrastructure. **Finance and Commodities** 1- Availability of organizations from which FP methods can be purchased. 2- Contribution of the private sectors and NGOs in financing FP services. **Community** 1- Good coverage of communication channels and infrastructure. 2- High literacy rate. 3- Support of Ministry of Awqaf and Islamic Affairs. 4- Availability of local Community-Based Organizations (CBOs) that can integrate FP within their programs.	**Threats** **Service Delivery** 1- Implants are not available in the private sector. 2- The high cost of FP methods in the private sector. 3- Insufficient networking between different entities and institutions. **Human Resources** 1- Influence of culture on availability of trained staff in some remote areas. 2- Staff leaving MOH (attraction from the Gulf and other competitive markets). **Leadership** 1- External projects are not well institutionalized. 2- Economic situation and its reflection on MOH budget. 3- The impact of the global financial crisis on the priorities & grants. **Finance and Commodities** 1- Increased cost of contraceptive methods; due to the globally increased prices and increased demand which might affect MOH ability to purchase commodities. 2- Small Jordanian contraceptives market which leads to: 2.1 Absence of national manufacturers for FP methods. 2.2 Limited suppliers of FP methods. 3- Some manufacturers have stopped producing some contraceptives, such as the injectable, and this makes it difficult to assure contraceptive security. 4- Multiple medicines/methods are not registered with the Jordan Food and Drug Association. **Community** 1- Voluntarism concept is not well adopted by the community. 2- Cultural barriers for FP such as: 2.1. Demand for big family size 2.2. Male preferences 2.3. Role of FP is linked only to women 3- High reliance on traditional methods.

Components of the MOH Family Planning Strategic Plan

MOH Family Planning Priority Issues

Derived from the MOH SWOT/situation analysis and the national situation, the following are the priority issues that the FP Strategic Plan addresses.

- Stagnation of national FP indicators
- Quality of FP counseling and services
- Access to FP services
- Family planning support system functionality
- Enabling policy environment for family planning
- Efficiency of FP human resources management
- Family planning information systems functionality
- Effectiveness of FP community based initiatives and marketing
- Financial sustainability for FP program and commodities

Strategic Family Planning Vision

Families in Jordan have information, knowledge and access to high quality family planning services.

Strategic Family Planning Mission

To enable families in Jordan to achieve their desired reproductive goals through provision of high quality FP services and information implemented efficiently and effectively within an enabling environment and active participation of community and other relevant organizations.

Guiding Principles and Values

The following principles have guided and informed the development of the FP Strategic Plan:

- The Strategic Plan should be consistent with or complementary to other major documents, strategies, etc., of the Government of Jordan. These documents include the RHAP II and the MOH Strategy.
- The Strategic Plan should improve options for modern methods of FP at all SDPs, including inpatient areas for PP/PA women.
- The Strategic Plan should build on the existing strengths of the system to assureits values.
- The MOH is accountable for the strategy implementation and monitoring and evaluation.

The FP Strategic Plan adheres to the following values:

- *Voluntary and informed choice*: Women and men should freely decide the number, spacing and timing of their children and have access to the information and means to practice this choice.
- *Method mix*: Women and men should have access to the widest possible range of safe and effective modern FP methods and should participate fully in defining the FP services they need.
- *Accessible services*: FP activities/services should be available to all couples to minimize unmet need.
- *Affordability and convenience*: Comprehensive and factual information and FP services should be accessible, affordable and convenient to all users.
- *Client safety and quality of care*: There should be a focus on patient/client safety, and systems and procedures that improve safety.

Goal of the MOH Family Planning Strategic Plan

The overall goal of this FP Strategic Plan is to enable the MOH to provide FP information and services to the people of Jordan in an effective and efficient manner in order to contribute to improvements in national goals related to FP.

Strategic Objectives, Sub-objectives and Initiatives

In order to respond to priority issues and to advance improvements in family planning, the MOH will address the following five strategic objectives:

1- Improve quality of and access to FP services and counseling.

2- Strengthen the functionality and utilization of FP information and support systems.

3- Strengthen the supportive policy environment for FP.

4- Improve the effectiveness and efficiency of FP human resources management.

5- Increase community awareness and demand for FP.

Each strategic objective has at least one sub-objective, followed by major initiatives to be implemented over the life of the strategy. The matrix within this document (Exhibit 7) lists illustrative major activities to further achieve the strategic objectives.

Strategic Objective 1: Improve quality of and access to family planning services and counseling.

Sub-objective 1.1: Increase availability and accessibility of high quality family planning services at MOH.

Initiatives:

1.1.1. Increase number of SDPs providing FP services.

1.1.2 Increase number of SDPs providing expanded choices of contraceptivemethods.

1.1.3 Network with other institutions providing FP services in order to expand choices available.

1.1.4 Expand FP services to postpartum and post-abortion clients at MOH hospitals.

Sub-objective 1.2: Decrease missed opportunities[7] for family planning counseling and services.

Initiatives:

1.2.1 Integrate health messages, education and/or counseling for FP within all health services provided at MOH health facilities.

Sub-objective 1.3: Enhance service providers› knowledge, skills, practices and attitudes regarding family planning.

Initiatives:

1.3.1 Improve service providers' compliance with MOH FP approved and disseminated guidelines and protocols at HCs and Hospitals.

1.3.2 Strengthen skills and knowledge of service providers in the field of FP.

1.3.3 Improve attitude and change behavior of providers relative to FP.

[7] A missed opportunity is an opportunity at a HC to provide FP information to non- users of modern FP methods, but that was not taken (regardless of types of service provision). It is calculated as the percentage of MWRA (age 15-49) who are non-users of modern FP methods, but who have not been provided with any type of FP counseling.

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Strategic Objective 2: Strengthen family planning information and support systems functionality and utilization.

Sub-objective 2.1: Improve the quality of family planning information systems.

Initiatives:

2.1.1 Upgrade information systems for FP.

2.1.2 Assure quality of FP data and information, including collection, inputs, data checks and outputs (e.g., reports).

Sub-objective 2.2: Improve the utilization of family planning information.

Initiatives:

2.2.1 Improve access to FP information.

2.2.2 Enhance FP information-based decision making processes.

Sub-objective 2.3: Enhance family planning supporting systems, including but not limited to supportive supervision, referral & appointment and monitoring & evaluation.

Initiatives:

2.3.1 Improve the functioning of the MCH/FP supportive supervision system.

2.3.2 Improve the referral mechanisms related to FP.

2.3.3 Improve monitoring and evaluation mechanisms related to FP services.

Strategic Objective 3: Strengthen the supportive policy environment of family planning.

Sub-objective 3.1: Enhance the level of support and commitment for FP program.

Initiatives:

3.1.1 Strengthen leadership and management of FP program.

3.1.2 Gain the support of the decision makers with regard to FP.

3.1.3 Adopt policies/decisions/actions supporting FP.

Sub-objective 3.2: Ensure contraceptive security and financial sustainability for the FP program.

Initiatives:

3.2.1 Assure allocation of sufficient budget to provide the FP methods, equipment, supplies, and activities.

3.2.2 Strengthen Jordan Contraceptives Logistics System.

Strategic Objective 4: Improve effectiveness and efficiency of family planning human resources management.

Sub-objective 4.1: Ensure appropriate staffing for FP services.

Initiatives:

4.1.1 Ensure sufficient and appropriately deployed human resources to provide FP services.

4.1.2 Activate the job descriptions.

4.1.3 Strengthen capacities of MOH staff to manage, monitor and provide high quality FP services.

4.1.4 Ensure functional replacement and/or task shifting of workers in health centers.

Strategic Objective 5: Increase community awareness and demand for family planning.

Sub-objective 5.1: Promote FP community based and marketing initiatives.

Initiatives:

5.1.1 Assure appropriate networking/collaboration with other organizations implementing community based FP campaigns and programs.

5.1.2 Activate the local communities' role in FP.

5.1.3 Support the FP promotion program.

Critical Factors for Success of the MOH Family Planning Strategic Plan

In order to assure success of this MOH FP Strategic Plan, the following critical success factors should be considered:

- There should be full support from the highest levels of the MOH for FP in general, and for the implementation of the MOH FP Strategic Plan in particular.
- This MOH FP Strategic Plan should be consulted and used during the development of the new MOH Strategic Plan, 2013-2017.
- There should be advocacy of senior MOH officials to all appropriate policy levels.
- There should be sufficient funding to be able to implement the plan:
  - for services;
  - for adequate and appropriate health workforce to provide services;
  - for contraceptives and equipment/supplies to provide FP methods;
  - for the implementation of supportive supervision, including transportation of the supervisors to the SDP; and
  - for equipment and other resources for data collection, reporting, analysis and use at all levels of the health system, including SDPs.
- Adherence to the strategic plan while developing annual operational and action plans needs to occur.
- There should be clear accountability for the MOH FP Strategic Plan on the part of all levels of the MOH system.
- To successfully implement the strategic plans objectives, management should designate employees responsible for implementing key aspects of the document. Defining roles is important to avoid duplicating efforts, or worse, neglecting tasks that need attention. Clear communication is needed throughout the system as to details of the OH FP Strategic Plan, including expectations for responsible parties, reporting and other aspects of the plan.
- There should be coordination with other stakeholders, both internal and external to the MOH.

Communicating the Strategy

Strategic plans are more likely to succeed when workers get intimately involved with the process. This concept is known as ownership.

The MOH will communicate this strategy and/or the appropriate content of the strategy to internal and external stakeholders in the most appropriate manner. A detailed dissemination plan will be developed by the MOH, and will be updated annually to assure that any progress, strategy modifications and implementation points are made available. In particular, those who are responsible for specific strategy initiatives, activities, etc., will be made aware of that detail.

Central Level: The MOH will communicate the strategic plan to other Ministries as appropriate, MOH Directors of Administrations, Directors of Central MOH Directorates, Health Directors, Hospital Directors, Chiefs of Obstetrics and Gynecology in hospitals, partners, etc.

Health Directorate Level: Health Directors will be responsible for distributing and discussing expectations regarding the FP Strategic Plan to relevant staff. These will include the Woman and Child Health Unit, Quality Unit, PHC unit, Health Center Directors, Hospital Directors, and any others.

Health Center Level: Health Center Directors will be responsible for distributing and discussing the FP Strategic Plan with all staff, and especially with MCH Center staff, GPs, Quality team staff, and others as appropriate.

External stakeholders: The MOH will assure that the FP Strategic Plan is disseminated to other relevant stakeholders, including HPC, international organizations (e.g., UNFPA, WHO), NGOs providing or referring for FP services, the professional councils and syndicates, the university medical centers, donors and other appropriate partners.

The public: MOH will work with the community as per the Strategic Plan, and work with appropriate communications partners, including media, to assure that the community is made aware of relevant parts of the strategy.

Implementing the Strategy

Organizations successful at strategy implementation effectively manage six key supporting factors:

1- Action Planning

2- Organizational Structure

3- Human Resources

4- Annual Plan

5- Monitoring and Control

6- Linkage[8]

Implementation of the FP Strategic Plan by the responsible parties will begin in January 2013. Communications will ensure that there is concurrence of the MOH FP Strategic Plan with the overall MOH Strategic Plan. Any changes to the FP Strategic Plan that are necessitated by the new MOH Strategic Plan will be made immediately, and communicated as per the communication plan.

All relevant MOH directorates, including the Central level, Health Directors, Hospital Directors and Health Center Directors will assure that annual Operational Plans and Action Plans include activities that are in line with the FP Strategic Plan. The Central and Hospital Safe Motherhood Committees will assure that these FP activities are within their plans, and are monitored, reported, discussed and documented at their regular meetings.

Strategy Monitoring and Evaluation

Monitoring and evaluation is a main part of the FP Strategic Plan. All related MOH entities should monitor the implementation of strategic plan activitiesto identify progress toward achieving the strategic objectives. This should be done using the identified key performance indicators which are benchmarks toward the improvement of FP services at MOH. Assessment of performance against these indicators depends on information gathered from MOH hospitals and HCs and aggregated and analyzed through the FP related information systems; the contraceptives logistics IS and theMCH/FP IS, in addition to special studies and surveys.

The monitoring and evaluation mechanism includes:

- PHC Administration and WCHD will be responsible for supervising the monitoring and evaluation of implementation of the FP Strategic Plan.
- Each related Administration, Directorate, or Hospital is responsible for monitoring and evaluating the implementation of FP Strategic Plan objectives, activities and key performance indicators included within their yearly operational plans.
- Administrations, Directorates and Hospitals should:

[8] Linkage is the tying together of all the activities of the organization to make sure that all of the organizational resources are moving in the same direction. Linking occurs internally within the MOH both vertically and horizontally. Vertical linkages establish coordination and support between Central departments/directorates, HD, Hospital and HC plans. Horizontal linkages are those linkages that occur across departments, across HDs, and across divisions. Horizontal linkages require coordination and cooperation to get the MOH units all playing in harmony, while linking externally with other strategies, stakeholders, programs, and projects.

- Include FP Strategic Plan objectives, activities and key performance indicators within their yearly operational plans. The part related to FP should be submitted to the PHC Administration with a copy to WCHD and concerned administrations.
- Develop and review regular progress reports, take necessary correction actions and submit these reports to PHC Administration with a copy to WCHD and concerned administrations.

• PHC Administration and WCHD should:

- Ensure that appropriate and needed activities to achieve the FP Strategic Plan objectives are included within related administrations, directorates and hospitals operational plans and provide them with feedback.
- Review the regular progress reports submitted by related administrations, directorates and hospitals along with the correction actions taken and provide them with feedback.
- Prepare semiannual and annual progress reports toward the achievements of the FP Strategic Plan and progress toward achieving its objectives and key indicators and submit the reports to the MOH Secretary General.
- Conduct semiannual and annual meetings with Directors of related administrations, directorates and hospitals under the patronage of the MOH Secretary General to discuss the achievements in implementing the activities and progress toward achieving the FP Strategic Plan objectives and indicators.
- Conduct FP Strategic Plan annual review and take necessary modifications.

A detailed Monitoring and Evaluation plan will be developed.

Exhibit 3 – MOH Family Planning Strategy Matrix

1. Improve Quality of and Access to FP Services and Counseling:			
Key Indicators		**Baseline (2011)**	**Target (2017)**
Percentage of SDPs providing 4 modern contraceptives		21.8%	35%
Contraceptive discontinuation rate		for IUD 14% for COCs 42%	(2016) 12% (2016) 39%
Percentage of postpartum clients receiving modern FP method before discharge from hospitals		17.8%	35%
Percentage of post-abortion clients receiving modern FP method before discharge from hospitals		19.3%	25%
Percentage of yearly increase in Couple Years of Protection (CYP)		-9%	1%
Percentage of missed opportunities for FP counseling		65%	50%
Percentage of SDPs stocked out from a FP method		4.5%	3%
Sub-objective	Initiatives	Major Activities	Responsibility
1.1Increase availability and accessibility of high quality FP services at MOH.	1.1.1 Increase number of SDPs providing FP services.	1.1.1.1 Assess the feasibility and introduce FP to appropriate village HCs in north & central HDs.	WCHD, north & central HDs
		1.1.1.2 Support Hospitals' obstetric and postnatal clinics to provide FP services.	WCHD, Hospitals Administration, Hospitals.
	1.1.2 Increase number of SDPs providing expanded choices of contraceptive methods.	1.1.2.1 Increase # of SDPs providing long acting methods including IUD, implants &injectables.	WCHD, HDs, Hospitals Administration, Hospitals
	1.1.3 Network with other institutions providing FP services in order to expand choices available.	1.1.3.1 Actively participate in FP meetings/ activities with partners providing FP services.	WCHD
		1.1.3.2 Continue supporting other institutions providing FP services such as in training and contraceptives supply.	WCHD
	1.1.4 Expand FP services to PP/PA clients at MOH hospitals.	1.1.4.1 Introduce PP/PA FP to all MOH hospitals.	WCHD, Hospitals Administration, Hospitals
1.2 Decrease missed opportunities for FP counseling & services.	1.2.1 Integrate health messages, education and/or counseling for FP within all health services provided at MOH health facilities.	1.2.1.1 Introduce FP counseling within the premarital examination visits.	WCHD, Non-communicable Diseases Directorate, HDs
		1.2.1.2 Build the capacity of non- FP service providers on FP.	WCHD, HDs, HRD
		1.2.1.3 Monitor missed opportunities for FP through conducting a yearly study.	WCHD, HDs
		1.2.1.4 Establish an internal HC referral mechanism for MWRA visiting non-MCH providers and needs FP.	WCHD, HDs

1.3 Enhance service providers knowledge, skills, practices and attitudes regarding family planning.	1.3.1 Improve service providers' compliance with MOH FP approved and disseminated guidelines and protocols at HCs and Hospitals.	1.3.1.1 Assure guidelines and protocols are updated and disseminated to health facilities. Also refer to 2.3.1 & 4.1 related activities.	WCHD, HDs, Hospitals Administration, Hospitals
	1.3.2 Strengthen skills and knowledge of service providers in the field of FP.	1.3.2.1 Build the capacity of service providers at HCs and Hospital on FP counseling and services.	WCHD, HDs, ,HRDD Hospitals Administration, Hospitals
	1.3.3 Improve attitude and change behavior of providers relative to FP.	1.3.3.1 Develop Behavior Communication Change program for service providers.	WCHD, HDs HCAD

2. Strengthen FP Information and Support Systems Functionality and Utilization:

Key Indicators	Baseline (2011)	Target (2017)
Percentage of HDs using data for developing their annual operational plan	100%	100%
Percentage of HDs with functioning MCH supervision system	41.6%	100%

Sub-objective	Initiatives	Major Activities	Responsibility
2.1 Improve the quality of FP information systems.	2.1.1 Upgrade information systems for FP.	2.1.1.1 Review and update the MCH information system.	WCHD, ITD
		2.1.1.2 Review and update the logistics information system.	WCHD, ITD
		2.1.1.3 Establish FP training data base system.	WCHD
	2.1.2 Assure quality of FP data and information, including collection, inputs, data checks and outputs (g.g., reports).	2.1.2.1 Build the capacity of service providers responsible of data on data management, including collection, inputs, data checks, and outputs.	WCHD, HDs, HRDD
		2.1.2.2 Build the capacity of IT staff at HDs on trouble shouting & maintenance of FP information systems.	ITDs
2.2 Improve the utilization of FP information	2.2.1 Improve access to FP information.	2.2.1.1 Build capacity of MOH staff to use the FP information system.	WCHD, HDs, HRDD
		2.2.1.2 develop and upload/present dashboards/dash walls for main FP data and indicators.	WCHD, ITDs

Sub-objective	Initiatives	Major Activities	Responsibility
		2.2.1.3 Update the GIS system of reflect FP SDPs and include FP indicators on maps.	ITD
		2.2.1.4 Expand access of health facilities to internet.	ITD
	2.2.2 Enhance FP information based decision making processes.	2.2.2.1 Assist HDs to use FP data to develop/update their yearly operational plans.	WCHD, Planning Directorate
		2.2.2.2 Assist HCs and hopitals to use FP data to develop/update their yearly operational plans.	WCHD, Planning Adminstration
		2.2.2.3 Increase th use of FP information for supervision and monitoring & evaluation.	HDs, Hospitals Adminstration
2.3 Enhance FP supporting systems including but not limited to supportive supervision referral & appointment and monitoring & evaluation.	2.3.1 Improve the functioning of the Maternal & Child Health/FP supportive supervision system	2.3.1.1 Conduct an assessment to evaluate current MCH/FP supportive supervision system and modify accordingly.	WCHD
		2.3.1.2 Support MCH/FP supervisors at HDs to conduct their regular supportive supervisory visits.	HDs
		2.3.1.3 Allocate more MCH/FP supportive supervisiors to big HDs.	HDs
		2.3.1.4 Monitor and improve compliance of HDs to the MCH/FP supportive supervision system.	WCHD, HDS
	2.3.2 Improve the referral mechanisms related to FP.	2.3.2.1 Review current referral system & tools in relation to FP services.	WCHD
		2.3.2.2 Establish & implement a formal referral process for FP between HCs and hospitals.	WCHD, Hospitals Adminstration, HDs
	2.3.3 Improve Monitoring & Evaluation (M&E) mechanisms related to FP service.	2.3.3.1 Develop and M&E process related to FP serivices.	WCHD, HDs Hospitals
		2.3.3.2 Conduct appropriate FP studies, such as: sentinel surveillance, counseling assessment, IUD assessment, etc.	WCHD

3. Strengthening the Supportive Policy Environment of FP:

Key Indicators	Baseline (2011)	Target (2017)
Number of approved policies/regulations/decisions/actions supporting FP	2	7
Percentage of FP commodities covered by related MOH budget line item	51%	75%

Sub-objective	Initiatives	Major Activities	Responsibility
3.1. Enhance the level of support and commitment for FP program.	3.1.1 Strengthen leadership and management of FP program.	3.1.1.1 Enhance the institutional and technical capacity of FP section within WCHD.	Secretary General, PHC Administration
		3.1.1.2 Strengthen management of FP program at HD and HC levels.	PHC Administration, HDs Administration
		3.1.1.3 Expand the role of MOH FP steering committee to oversee FP program.	Secretary General, PHC Administration
	3.1.2 Gain the support of the decision makers with regard to FP.	3.1.2.1 Establish a mechanism to ensure coordination and cooperation between the WCHD and the concerned Central Directorates.	WCHD, PHC Administration, concerned directorates and administrations
		3.1.2.2 Integrate FP strategy within the MOH strategic and action plans.	Planning Directorate, HCAD, HRDD, Budget Directorate, School Health Directorate, ITD, HDs, Hospitals, PHC Administration, HD Administration, Hospitals Administration
	3.1.3. Adopt policies/ decisions/actions supporting FP.	3.1.3.1 Identify top needed priority FP policy issues and define policies/regulations/decisions/ actions to resolve them, (such as staff turnover, staff satisfaction, staff deployment, commitment of trained staff, provision of services, establishment of new job titles, FP methods procurement procedures, method mix, FP budget, etc.).	WCHD, PHC Administration
		3.1.3.2 Submit the suggested policies / regulations/decisions/actions) for approval.	
3.2 Ensure contraceptive security and financial sustainability for the FP program.	3.2.1 Assure allocation of sufficient budget to provide the FP methods, equipment, supplies, and activities.	3.2.1.1 Allocate sufficient budget for FP methods, in the MOH budget line for procurement of contraceptives.	Budget Directorate
		3.2.1.2 Allocate sufficient budget for FP activities in the MOH budget.	Budget Directorate
		3.2.1.3 Mobilize funds for FP from non-MOH resources.	WCHD, PHC Administration, Planning Directorate
	3.2.2 Strengthen Jordan Contraceptives Logistics System.	3.2.2.1 Enhance the institutional and technical capacity of information and logistics section within WCHD.	Secretary General, PHC Administration
		3.2.2.2 Identify more appropriate and simple procurement procedures for procurement of contraceptives.	WCHD, Budget Directorate, PHC Administration
		3.2.2.3 Expand choices of FP methods within the MOH.	WCHD, Budget Directorate

4. Improve Effectiveness and Efficiency of FP Human Resources Management:

Key Indicators	Baseline (2011)	Target (2017)
Number of service providers who received FP counseling training	397*	1100**
Number of physicians and midwives trained on IUD services	36***	190**
Number of physicians trained on implant services	41*	150**
Precentage of MCH centers with female physician providing FP services	Not available for 2011, calculation will start in 2013	increase 10%
Precentage of MCH centers with appropriate team, including at least on physician and midwife providing FP Service	Not available for 2011, calculation will start in 2013	increase 10%

Sub-objective	Initiatives	Major Activities	Responsibility
4.1 Ensure appropriate staffing for FP services.	4.1.1 Ensure sufficient and appropriately deployed human resources to provide FP services.	4.1.1.1 Provide sufficient human resources for MCH/FP services (at least one physician and one midwife in each MCH center) including female physicians through recruitment or redistribution.	Administrative Affairs Administration, Human Resources Directorate, HDs
		4.1.1.2 Assign staff at Ob/Gyn wards to provide PP/PA FP services and assure provision of services.	Hospitals Administration, Hospitals
	4.1.2 Activate the job descriptions.	4.1.2.1 Assure distribution of job descriptions to MCH/FP service providers.	WCHD, HDs
		4.1.2.2 Assure use of job descriptions within yearly appraisal of MCH/ FP service providers.	HD Administration, HDs
		4.1.2.3 Update MCH/ FP related job descriptions.	Administrative Affairs Administration, WCHD, HDs
	4.1.3 Strengthen capacities of MOH staff to manage, monitor and provide high quality FP services.	4.1.3.1 Build the capacity of directors and heads of sections on management including M&E. Also refer to 1.3.2.1	HRDD, Planning Directorate
	4.1.4 Ensure functional replacement and/or task shifting of workers in health centers.	4.1.4.1 Expand IUD services by midwives.	WCHD, HDs
		4.1.4.2 Expand the task of FP counseling to. the nursing staff	WCHD, HDs
		4.1.4.3 Include FP counseling to the tasks of health workers at village health centers	WCHD, HDs

* This number represents the total number of those received training during 2011

** This number represents cumulative increase until 2017

*** This number represents the total number of physicians received training on IUD insertion during 2011, as there was no training conducted for midwives

5. Increase Community Awareness and Demand for FP:

Key Indicators	Baseline (2011)	Target (2017)
Number of FP community based activities conducted by MOH	Not available for 2011, will start calculation in 2013	12% increase
Number of people reached through FP community based activities		12% increase

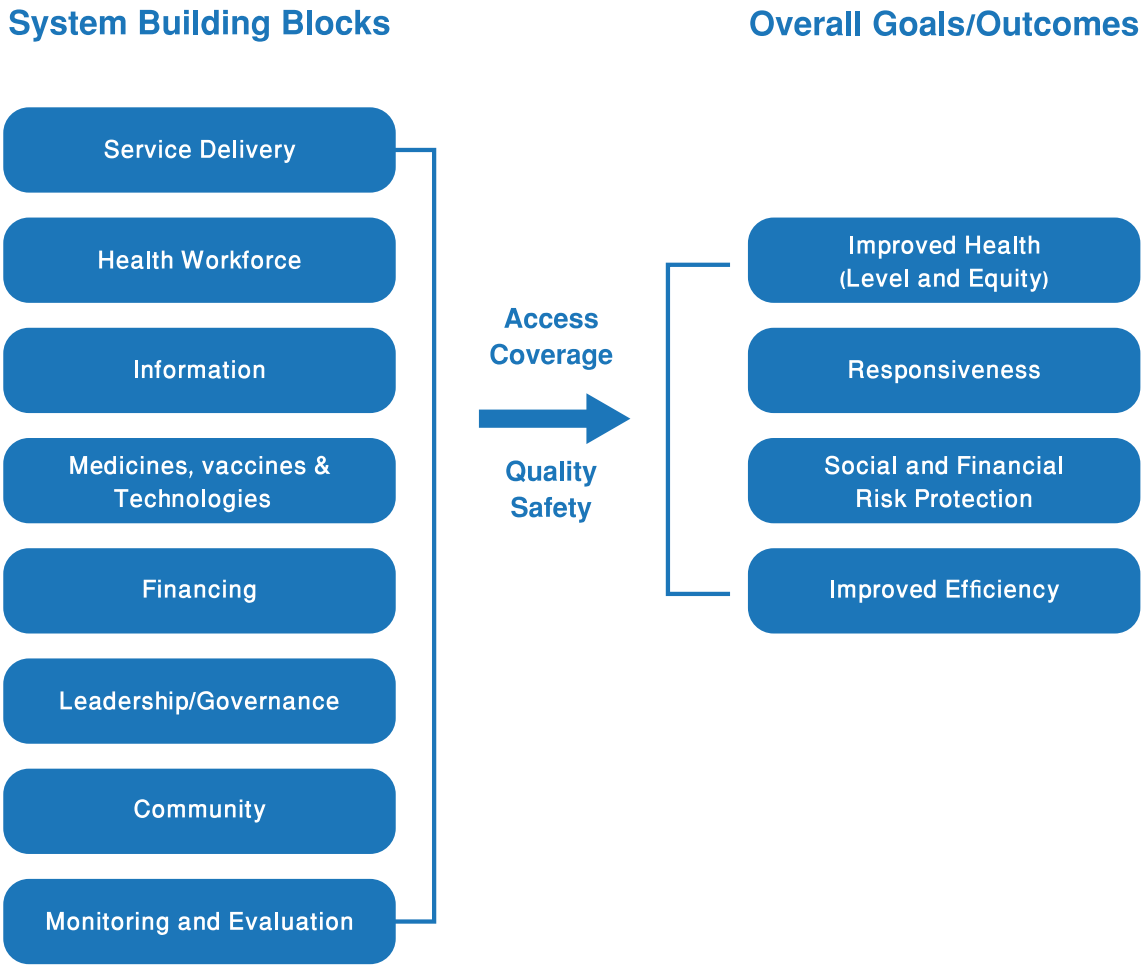
Sub-objective	Initiatives	Major Activities	Responsibility
5.1 Promote FP community based and marketing initiatives.	5.1.1 Assure appropriate networking/ collaboration with other organizations implementing community based FP campaigns and programs.	5.1.1.1 Network and collaborate with other agencies working in the field of community based and marketing for FP.	WCHD HCAD
		5.1.1.2 Include FP promotion activities within School Health services.	School Health Directorate
	5.1.2 Activate the local communities' role in FP.	5.1.2.1 Build the capacity of HDs and HCs staff to plan, design, implement, monitor and evaluate local communities' FP activities to increase demand on FP.	HCAD
		5.1.2.2 Design, implement, monitor and evaluate local communities' FP activities to increase demand on FP.	HCAD, HDs
		5.1.2.3 Increase the number of Community Health Committees.	HCAD
		5.1.2.4 Develop and activate the local communities' database.	HCAD, HDs
	5.1.3 Support the FP promotion program.	5.1.3.1 Continue and expand national campaigns for FP promotion.	HCAD, WCHD, HDs
		5.1.3.2 Continue and expand FP promotion activities at health centers.	HCAD, WCHD, HDs
		5.1.3.3 Develop/update & print FP educational materials for clients and service providers.	WCHD,HCAD, HDs
		5.1.3.4 Conduct FP community awareness sessions.	WCHD, HDs, HCAD

* This number represents the total number of those received training during 2011

** This number represents cumulative increase until 2017

*** This number represents the total number of physicians received training on IUD insertion during 2011, as there was no training conducted for midwives

Annex A:World Health Organization Six Building Blocks for Health Systems Strengthening, Adapted for the Family Planning Strategic Plan*



* WHO Six Building Blocks for Health Systems Strengthening (WHO 2007)

The World Health Organization utilizes the six building blocks as a framework to strengthen health systems in order to tackle the health challenges in each country within which it works. Without a strong and functioning health system, health services cannot adequately address the health issues of citizens collectively, or individually.

Each of the building blocks contains and interrelates with at least some of the other building blocks. Strengthening (or weakening) of any building block will have an effect on the other building blocks. A brief description of the building blocks follows:

- **Good health services:** are those which deliver effective, safe, quality personal and non-personal health interventions to those that needthem, when and where needed, with minimum waste of resources.
- **A well-performing health workforce:** is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e., there are sufficient staff, fairly distributed; they are competent, responsive and productive).
- **A well-functioning health information system:** is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.

A well-functioning health system ensures equitable access to **essential medical products, vaccines and technologies** of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.

- **A good health financing system:** raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.

Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability.

- **Community:** is one of the "building blocks" added to the list for the FP Strategic Plan. Community is usually considered to be part of the "services" building block. The MOH feels that it should be one of the priority areas.
- **Monitoring and Evaluation** was also added to the list, and is often part of the information or services section of the building blocks. Progress monitoring is necessary in order to assure the implementation of the strategy and to make any modifications based on the data available.

Annex B: Attendance Sheet – Family Planning Strategy Development Workshop, October 30, 2011

No.	Name	Title	Work Location
Meeting Coordinators			
1-	Dr. Ruwaida Rashid	WCHD Director	MOH
2-	Ms. Donna Vivio	FP/RH Team Leader	HSS II Project
Group 1: Service Delivery			
Group Facilitator			
3-	Dr. Khawla Kawwa	Head of FP Section	WCHD - MOH
Group Members			
4-	Dr. Mufeed Abu-Baker	Head of Ob/Gyn	King Hussein Hospital – Balqa
5-	Dr. HithamDweri	Head of Standard Development Unit	Quality Directorate - MOH
6-	Dr. AmalAbdelkarim	Head of WCH Unit	Mafraq HD
7-	Dr. Hamdeh Abu-Saleh	Physician	HCAD – MOH
8-	Ms. FadiaJaber	Midwifery Supervisor	WCHD – MOH
9-	Ms. Khitam Othman	Midwife	Al-Taj Health Center – Amman
10-	Dr. Nisreen Bitar	FP/RH Team Manager	HSS II Project
Group 2: Health Workforce			
Group Facilitator			
11-	Dr. Manal Jrasat	FP/RH Senior Task Manager	HSS II Project
Group Members			
12-	Dr. Bashar Abu Salim	Director of Capital HD	Capital HD
13-	Dr. Hiam Al-A'raj	Director of Nursing Directorate	MOH
14-	Mr. Galeb Qawasmi	Director of Human Resources Directorate	MOH

15-	Dr. Mohammad Shehadeh	Head of Continuous Education Section	HRDD
16-	Dr. Malak Al-Uree	MCH Doctor	WCHD
17-	Dr. Bilal Hmoud	School Health Unit Head	Irbid HD
18-	Ms. Manal Al-Ghazzawi	/ National RH/FP Plan Coordinator Assistant for the Program Unit	HPC
19-	Dr. Maha Al-Saheb	Service Delivery Program Manager	TAZIZ Project
Group 3:Finance & Commodities			
Group Facilitator			
20-	Dr. Abeer Mwaswas	Head of Logistics & Information Section	WCHD
Group Members			
21-	Mr. Hamza Talafah	HE Minister Consultant for Supply Affairs	Ministry of Health
22-	Dr. Wafa'a Al-Nsour	Minister of Health Consultant for Legal Affairs	MOH
23-	Mr. Jamal Afaneh	Minister of Health Consultant for Pharmacy Affairs	MOH
24-	Mr. Moayad Barmawi	Director of Budget Directorate	Budget Directorate
25-	Ms. Lina Bajali	Director of Medicine Registration Section	Jordan Food & Drug Association
26-	Dr. Nadia Safadi	Pharmacist	Logistics & Information Section - WCHD
27-	Mr. Ekbal Abu-Kabesh	Procurement Officer	Joint Procurement Administration
28-	Ms. Hiam Ayoub	Midwifery Supervisor	Jerash HD
Group 4:Leadership			
Group Facilitator			
29-	Dr. Ibrahim Aqel	Management Senior Task Manager	HSS II Project
Group Members			
30-	Dr. Raeda Al-Qutob	HPC Secretary General	HPC
31-	Dr. Bassam Hijjawi	Director of PHC Admin	PHC Admin. - MOH
32-	Dr. Khaldoun El-Edwan	Director of HD Admin	HD Admin. - MOH
33-	Dr. Safa Al-Qusous	Director of Quality Directorate	Quality Directorate - MOH
34-	Dr. Leil Al-Faiez	Director of Zarka HD	Zarqa HD
35-	Dr. Ali Al-Sa›ed	Director of Irbid HD	Irbid HD
36-	Dr. Issa Jaber	Head of Ob/Gyn	Al-Bashir Hospital
37-	Ms. Samar Al-Bazz	Legal Affairs	MOH
38-	Ms. Basma Ishaqat	Director of HPP	HPP

39-	Ms. Layali Abu-Sir	Program Analyst	UNFPA
Group 5:Information, and Monitoring & Evaluation			
Group Facilitators			
40-	Ms. Samar Abdelnour	Monitoring & Evaluation Manager	HSS II Project
41-	Mr. Raed Fassesi	Knowledge Management Team Manager	
Group Members			
42-	Dr. Kasem Al-Rabee	Director of Planning and Projects Management Directorate	MOH
43-	Dr. Fares Dababneh	Director of Information, Research & Studies Directorate	MOH
44-	Ms. Fatima Hamad	Head of Programming Department	Information Technology Directorate – MOH
45-	Dr. Farihan Al-Bqour	Quality Unit Head	Balqa HD
46-	Ms. Muna Quirem	Public Health Technician	Logistics & Information Section – WCHD - MOH
47-	Dr. Issa Massarweh	Demographer	Jordan University
48-	Ms. Rania Abadi	Assistant Secretary General for Technical Affairs	HPC
Group 6: Community			
Group Facilitator			
49-	Ms. Hala Al-Sharif	Community Health Team Leader	HSS II Project
Group Members			
50-	Dr. Malek Habashneh	Director of HCAD	HCAD - MOH
51-	Eng. Basima Steitieh	Health Awareness Department	
52-	Dr. Randa Bqaeen	Head of Communication Department	
53-	Dr. Samar Batarseh	Head of Educational Institutions Section	School Health Directorate - MOH
54-	Eng. Maisoun Makahleh	Health Promotion Supervisor	Capital HD
55-	Ms. Amal Abu-Shawish	Midwifery Supervisor	FP Section - WCHD
56-	Ms. Kholoud Abbadi	Midwife	Mahes Health Center – Balqa
57-	Ms. Huda Murad	Service Delivery & Community Senior Specialist	JHCP
58-	Lina Qardan	Senior Technical Advocacy & Medical Affairs Advisor	JHCP
Other			
59-	Ms. Raneem Kayed	Operations Officer/ HSS II Project	HSS II Project
60-	Ms. Thoraya Majdoub	Operations Officer/ HSS II Project	

وزارة الصحة

Annex C: Attendance Sheet – Family Planning Strategy Development Workshop, December 12, 2011

No.	Name	Title	Work Location
Meeting Coordinators			
1-	Dr. Ruwaida Rashid	Director of WCHD	WCHD - MOH
2-	Donna Vivio	FP/RH Team Leader	HSS II Project
Group 1: Improve quality of and access to family planning services and counseling			
Group Facilitators			
3-	Dr. Khawla Kawwa	Head of FP Section	WCHD - MOH
4-	Dr. Nisreen Bitar	FP/RH Team Manager	HSS II Project
Group Members			
5-	Dr. Leil Al-Faiez	Director of Zarka HD	Zarqa HD
6-	Dr. Mufeed Abu-Baker	Head of Ob/Gyn Department	Al-Hussein/Salt Hospital - Balqa
7-	Dr. HithamDweri	Head of Standard Development Unit	Quality Directorate – MOH
8-	Dr. Amal Abdelkarim	Head of WCH Unit	Mafraq HD
9-	Ms. Fadia Jaber	Midwifery Supervisor	FP Section – WCHD /MOH
10-	Ms. Khitam Othman	Midwife	Al-Taj Health Center /Capital
11-	Ms. Hiam Ayoub	Midwifery Supervisor	JerashHD
Group 2: Strengthen family planning information and support systems functionality and utilization			
Group Facilitator			
12-	Ms. Samar Abdelnoor	Monitoring &Evaluation Task Manager	HSS II Project
Group Members			
13-	Dr. Fares Dababneh	Director of Information & Research Directorate	Information & Research Directorate – MOH
14-	Ms. Fatima Hamad	Head of Programming Department	ITD – MOH
15-	Dr. Farihan Al-Bqour	Quality Unit Head	Balqa HD
16-	Ms. Mona Qirem	Public Health Technician	Logistics & Information Section – WCHD
17-	Dr. Issa Massarweh	Demographer	Jordan University
18-	Ms. Rania Abadi	Assistant Secretary General for Technical Affairs	HPC
19-	Mr. Ra›ed Fassesi	Knowledge Management Team Leader	HSS II Project

Group 3: Enhance enabling policy environment for family planning			
Group Facilitator			
20-	Dr. Abeer Mwaswas	Head of Logistics & Information Section	WCHD – MOH
21-	Dr. Ibrahim Aqel	Management Senior Task Manager	HSS II Project
Group Members			
22-	Dr. Raeda Al-Qutob	HPC Secretary general	HPC
23-	Dr. Ahmad Qutaitat	Hospitals Directorate Director	Hospitals Directorate - MOH
24-	Dr. Khaldoun Al-Adwan	Director of HD Admin	HD Admin. - MOH
25-	Mr. Hamza Talafah	HE the Minister Consultant for Supply Affairs	MOH
26-	Dr. Wafa Al-Nsour	HE the Minister Consultant for Legal Affairs	MOH
27-	Mr. Radwan Abu Dames	Director of Legal Affairs Directorate	MOH
28-	Dr. Hikmat Abu Al-fool	Director of Control and Internal Audit	MOH
29-	Dr. Safa Qussous	Quality Directorate Director	MOH
30-	Mr. Moayad Barmawi	Director of Budget Directorate	MOH
31-	Ms. Suha Salah	Director of Tenders and Contracts	MOH
32-	Dr. Haitham Saudi	WCHD Director Assistant	WCHD - MOH
33-	Ms. Basma Khraisat	HPP Director	HPP
34-	Dr. Maha Shadid	PSP Deputy Chief of Party	PSP
35-	Ms. Lina Bajali	Director of Medicine Registration Section	Jordan Food and Drug Association
36-	Ms. Aysha Qasem	Head of Planning and Development	
37-	Dr. Eqbal Abu-Kebash	Procurement Officer	Joint Procurement Administration
Group 4: Improve effectiveness and efficiency of family planning human resources management			
Group Facilitator			
38-	Dr. Manal Jrasat	FP/RH Senior Task Manager	HSS II Project
Group Members			
39-	Dr. Bashar Abu Salim	Director of Capital HD	Capital HD
40-	Dr. Hiam Al-A'raj	Director of Nursing Directorate	MOH
41-	Mr. Galeb Qawasmeh	Director of Human Resources Directorate	Human Resources Directorate – MOH
42-	Dr. Mohammad Shehadeh	Head of Continuous Education Section	Directorate of Human Resources Development
43-	Dr. Malak Al-Uree	MCH Doctor	WCHD - MOH
44-	Dr. Maha Al-Saheb	Service Delivery Program Manager	TAZIZ Project

45-	Dr. Bilal Hmoud	Head of School Education Unit	Irbid Health Directorate
46-	Dr. Ibtisam Al-Ne'amat	Pharmacist	Control and Internal Audit Directorate - MOH
Group 5: Increase community awareness and demand for family planning			
Group Facilitators			
47-	Ms. Hala Al-Sharif	Community Health Team Leader	HSS II Project
Group Members			
48-	Dr. Randa Bqaeen	Head of Communication and Media Department	HCAD - MOH
49-	Eng. Basema Statieh	Health Awareness Dept	
50-	Dr. Hamdeh Abu-Saleh	Physician	
51-	Dr. Samar Batarseh	Head of Educational Institutions Section	School Health Directorate - MOH
52-	Eng. Maisoun Makahleh	Health Promotion Supervisor	Capital HD
53-	Ms. Amal Abu-Shawish	Midwifery Supervisor	FP Section – WCHD/MOH
54-	Ms. Khuloud Abbadi	Midwife	Mahes Health Center – Balqa
55-	Ms. Lina Qardan	Senior Technical Advocacy & Medical Affairs Advisor	JHCP
56-	Ms. Huda Murad	Service Delivery & Community Senior Specialist	JHCP
Others			
57-	Ms. Zahriyah Abushehab	Operations Officer	HSS II Project
58-	Ms. Thoraya Majdoub	Operations Officer	HSS II Project

Annex D: Indicators

1- Percentage of service delivery points offering FP services with at least 4 types of modern methods including IUD or Contraceptive implants

2- Percentage of health centers that meet the FP Health Care Accreditation Council Standards

3- Contraceptive discontinuation rate for IUD and COC during the first year of use at MCH centers

4- Number of MOH hospitals providing postpartum/post-abortion FP services

5- Percentage of postpartum clients receiving FP counseling before discharge from MOH Hospitals

6- Percentage of postpartum clientsreceivinga modern FP method before discharge from MOH Hospitals

7- Percentage of postpartum clients receivinga modern FP method from health centers

8- Percentage of post-abortion clients receiving FP counseling before discharge from MOH Hospitals

9- Percentage of post-abortion clients receiving a modern FP method before discharge from MOH Hospitals

10- Percentage of yearly increase in couple-years of protection at MOH facilities

11- Percentage of missed opportunities for FP counseling at MOH health centers

12- Percentage of service delivery points providing IUD services

13- Number of service delivery points providing contraceptive implant services

14- Percentage of service delivery points stocked out of at least one modern FP method within six months

15- Percentage of MOH Health Directorates using FP information systems to develop/update their yearly operational plans

16- Percentage of MOH Health Directorates with functioning MCH supportive supervision system

17- Number of yearly policies/regulations/actions supporting FP approved by MOH

18- Percentage of FP methods and commodities costs covered by the related MOH allocated budget line item

19- Number of service providers who received training on counseling for family planning

20- Number of physicians and midwives trained on IUD services

21- Number of physicians trained on contraceptive implant services

22- Percentage of MCH centers with female physicians providing FP services

23- Percentage of MCH centers with a team that consists of at least one female/male physician and one midwife providing FP services

24- Number of FP community based activities conducted by MOH

25- Number of people reached through FP community activities

Annex E: MOH Family Planning Strategic Plan Indicator Sheets

Indicator name	1. Percentage of MOH Service Delivery Points Providing 4 Modern Contraceptives including IUD or Contraceptive Implants						
Rationale / justification for use	Availability of a full cafeteria of contraceptive methods is proven to increase the use of family planning (FP) and increase clients satisfaction since a woman will be able to choose her preferable FP method and receive it immediately. This indicator measures access to modern contraceptive methods, with focus on long term methods such as IUD and implants.						
Definition	Percentage of MOH service delivery points (SDP)* offering family planning services with at least 4 types of modern methods** including IUD or contraceptive implants *SDP could be a health center or an out-patient clinic within a hospital ** Modern methods calculated within this indicator are: IUD, implants, injectables, pills, and male condoms.						
Unit of measurement	MOH SDP						
Validation Criteria	An SDP will be considered if it dispenses 4 modern methods, one of which is IUD or implants during a period of 2 months each quarter. On a yearly basis, an SDP will be considered if it provided 4 modern methods, one of which is IUD or implants during at least 3 quarters out of 4 quarters per year.						
Numerator	Total number of SDPs providing FP services with at least 4 types of modern methods including IUD or contraceptive implants during certain period of time						
Denominator	Total Number of SDPs providing FP services during the same period of time						
Inclusion/exclusion	Exclude: 1) Village health centers; 2) Obstetric wards providing FP services; 3) Lactational Amenorrhea Method (LAM) from the modern contraceptives calculated in this indicator; 4) SDPs providing 4 methods during less than 2 months out of 3 per quarter; 5) SDPs providing 4 methods during less than 3 quarters per year.						
Risk adjustment/ stratification	N/A						
Interpretation	A higher number of SDPs offering 4 modern FP methods means better access to FP services provided to women in country.						
Data source / Method	Jordan Contraceptives Logistics System (JCLS) reports						
Frequency of Data Acquisition	Monthly. The indicator will be calculated on quarterly & yearly basis.						
Data analysis	Data will be collected from the JCLS, calculated according to above mentioned equation nominator and denominator and multiplied by 100%.						
Responsible entity	Woman & Child Health Directorate						
Values	Baseline 2011	2012	2013	2014	2015	2016	2017
	21.8%	27.7%	29%	31%	33%	35%	37%

Indicator name	2. Percentage of Health Centers that Meet the PHC/FP Accreditation Standards						
Rationale / justification for use	In 2011, the Health Care Accreditation Council (HCAC) issued the PHC/FP standards. Gaining the accreditation certificate means health centers are meeting the standards and providing quality PHC/FP services. Such centers considered as an attractive agents for clients seeking quality FP services since these centers are meeting all clients' rights.						
Definition	Percentage of health centers that meet the FP Health Care Accreditation Council (HCAC)* Standards * Health Care Accreditation Council is a National institution located in Jordan, responsible for accrediting health facilities by inspecting their compliance with an international list of standards with clear definitions and measurable elements. The certificate provided is valid for two years.						
Unit of measurement	MOH Health Centers						
Validation criteria	Health centers will be considered if they received the PHC/FP accreditation certificate from the HCAC.						
Numerator	Total number of MOH HCs that meet the PHC/FP HCAC Standards						
Denominator	Total number of MOH HCs (primary and comprehensive)						
Inclusion/exclusion	Exclude: Health centers that received the accreditation before 2011 since before that time, no FP standards were included						
Risk adjustment/ stratification	N/A						
Interpretation	A higher percentage of accredited health centers means better access to high quality FP services provided to women in country.						
Data source / method	MOH Quality Directorate Reports						
Frequency of data acquisition	Yearly. The indicator will be calculated yearly too.						
Data analysis	Data will be collected from MOH Quality Directorate on yearly basis. Indicator will be calculated according to above mentioned equation nominator and denominator and multiplied by 100%.						
Responsible entity	MOH Quality Directorate						
Values	Baseline 2011	2012	2013	2014	2015	2016	2017
	0	6%	6%	11%	12%	13%	14%

Indicator name	3. Contraceptive Discontinuation rate for IUD and COCs During the First Year of Use					
Rationale / justification for use	This indicator measures quality of services provided at health centers, especially the quality of counseling for FP Literature shows thatproviding quality counseling, respecting the client,and providing her with her method of choice will increase the continuation rate. On the other hand, a high discontinuation rate during the 1st year of use is considered as one of the main problems within the Jordan FP program, so keeping an eye on this indicator is very important.					
Definition	Contraceptive discontinuation rate for IUD and COCs during the first year of use					
Unit of measurement	Married Woman of Reproductive Age (15 – 49 years) using an IUD or COC					
Validation criteria	N/A					
Numerator	Calculations done using life tables.					
Denominator						
Inclusion/exclusion	Include: Clients who accept to participate in the study					
Risk adjustment/ stratification	N/A					
Interpretation	A lower discontinuation rate means better quality of FP services provided to women in MOH health centers and a stronger FP program.					
Data source / method	Demographic Health Statstics (DHS)					
Frequency of data acquisition	Every Five years					
Data analysis	From Statistics Department					
Responsible entity	Woman & Child Health Directorate					
Values	Baseline 2010/2011		2012/2013		2016/2017	
	IUD	COCs	IUD	COCs	IUD	COCs
	14%	42%	13.5%	40%	12%	39%

Indicator name	4. Number of Hospitals Providing Postpartum/Post-abortion FP Services						
Rationale / justification for use	Most of deliveries in Jordan take place at hospitals, and post-abortion care is the second reason for admission to obstetric wards in MOH hospitals. Not providing these women with FP counseling and services is a big missed opportunity and is a gap in the FP program. Providing post-partum/post-abortion (PP/PA) clients with FP services will decrease unmet need for FP and will lead to improve contraceptive prevalence rate (CPR) and reduce unplanned pregnancies.						
Definition	Number of MOH hospitals providing postpartum/post-abortion FP services						
Unit of measurement	MOH Hospital						
Validation criteria	A hospital is considered to be providing PP/PA FP services when its PP/PA clients receive FP health education/counseling and appropriate contraceptive methods before discharge. The hospital should have trained staff on counseling for FP, contraceptives logistics system and also on provision of FP methods.						
Numerator	Number of MOH hospitals providing postpartum/post-abortion FP services						
Denominator	N/A						
Inclusion/exclusion	N/A						
Risk adjustment/ stratification	N/A						
Interpretation	A larger number of hospitals means better FP program and services, and fewer missed opportunities for FP counseling and services.						
Data source / method	Jordan Contraceptives Logistics System (JCLS) reports						
Frequency of data acquisition	Monthly: The indicator will be calculated on semiannually basis.						
Data analysis	Data collected from hospitals through JCLS will be aggregated and the indicator will be calculated.						
Responsible entity	Woman & Child Health Directorate/Hospitals Administration						
Values	Baseline 2011	2012	2013	2014	2015	2016	2017
	9	13	14	17	17	19	22

Indicator name	5. Percentage of Postpartum Clients Receiving FP Counseling Before Discharge from MOH Hospitals						
Rationale / justification for use	Providing counseling for FP to postpartum clients means that one of the main missed opportunities for FP counseling and services is addressed. According to the 2007 DHS, around 64% of total deliveries took place in public hospitals. Providing such services means that the clinical guidelines for FP services at postpartum are developed and service providers are trained on providing counseling for FP and meet clients need for FP information.						
Definition	Percentage of postpartum clients receiving FP counseling before discharge from MOH Hospitals						
Unit of measurement	Postpartum woman						
Validation criteria	A postpartum woman is considered if she delivered at a MOH hospital and received counseling for FP from the hospital staff before discharge.						
Numerator	Number of post-partum clients receiving FP counseling before discharge at selected MOH hospitals during a certain period of time						
Denominator	Total number of post-partum clients at the same selected MOH hospitals during the same period of time						
Inclusion/exclusion	N/A						
Risk adjustment/ stratification	Hospitals might be providing the services; however, clients are not registered in the correct way. This should be tackled through follow-up from the hospital safe motherhood committees (HSMC)to assure compliance with providing quality services and good registration and reporting.						
Interpretation	A higher percentage of PP clients receiving counseling for FP means better quality of services and more commitment to clients' rights for information.						
Data source / method	From the FP log books at the obstetric wards within hospitals, data is aggregated by hospital staff and sent as a monthly report to WCHD, using a unified form prepared for that purpose. Data could be collected too from the Perinatal Information System.						
Frequency of data acquisition	Monthly: The indicator will be calculated on quarterly basis.						
Data analysis	Data collected from hospitals will be aggregated and the indicator will be calculated according to the above mentioned nominator and denominator multiplied by 100%.						
Responsible entity	Woman & Child Health Directorate/Hospitals Administration						
Values	Baseline[9] 2011	2012	2013	2014	2015	2016	2017
	32.8%	38.3%	45%	50%	52%	55%	57%

[9] The baseline value covers a 6-month period (July - December 2011) for 8 hospitals and for Al-Bashir Hospital from September - December 2011.

Indicator name	6. Percentage of Postpartum Clients Receiving a Modern FP Method Before Discharge from MOH Hospitals						
Rationale / justification for use	Providing FP methods to postpartum clients means that one of the main missed opportunities for FP services and information is addressed; around 64% of total deliveries took place in public hospitals. Providing such services means that the clinical guidelines for FP services at postpartum are developed and service providers are trained to provide FP contraceptives and meet clients' needs for FP information and services.						
Definition	Percentage of postpartum clients receiving a modern FP method* before discharge from MOH Hospital * Modern FP methods provided at hospitals for PP women include: Lactational Amenorrhea Method (LAM), pills, condoms, IUD and tubal ligation.						
Unit of measurement	Postpartum woman						
Validation criteria	A postpartum woman is included if she delivered at a MOH hospital, received counseling for FP and decided to depend on LAM as her FP method; or did a tubal ligation; or received pills condoms or IUD from the hospital staff before discharge.						
Numerator	Number of postpartum clients receiving a modern FP method before discharge at selected MOH hospitals during a certain period of time						
Denominator	Total number of postpartum clients at the same selected MOH hospitals during the same period of time						
Inclusion/exclusion	N/A						
Risk adjustment/ stratification	Hospitals might be providing the services; however, clients are not registered in the correct way. This should be tackled through follow-up from the HSMCs, field visits from WHCD and WCH sections at health directorates to assure compliance with providing quality services and good reporting.						
Interpretation	A higher percentage of postpartum clients receiving modern methods means better quality of services and less unmet need.						
Data source / method	The FP log books at the obstetric wards within hospitals, data aggregated by hospital staff and sent as a monthly report to WCHD. Data can be collected from the Perinatal Information System.						
Frequency of data acquisition	Monthly. The indicator will be calculated on quarterly basis.						
Data analysis	Data collected from hospitals will be aggregated and the indicator will be calculated according to the above mentioned nominator and denominator multiply by 100%.						
Responsible entity	Woman & Child Health Directorate/Hospitals Administration						
Values	Baseline[10] 2011	2012	2013	2014	2015	2016	2017
	17.8%	24%	30%	32%	35%	37%	40%

[10] The baseline value covers a 6-month period (July - December 2011) for 8 hospitals and for Al-Bashir Hospital from September - December 2011.

Indicator name	7. Percentage of Postpartum Clients Receiving a Modern FP Method from Health Centers						
Rationale / justification for use	Most recent studies show that the best birth spacing period between deliveries is 3-5 years, which will reduce both maternal and child mortality and morbidity. Providing a modern FP method to a postpartum woman will protect her from unwanted pregnancy. This will also decrease unmet need and increase use of modern methods, and will contribute to increase CPR.						
Definition	Percentage of postpartum* women registered at MCH centers and receiving a modern FP method** * Postpartum period starts from delivery of placenta till 42 days after delivery. ** Modern FP methods provided at MCH centers for postpartum women include LAM, pills, condoms, IUD, injectables and contraceptive implants.						
Unit of measurement	Postpartum woman						
Validation criteria	A postpartum woman is included if she is registered at a MOH MCH center, received counseling for FP and either decided to depend on LAM as her contraceptive method or received another modern FP method from the MCH center.						
Numerator	Number of postpartum women registered at MCH centers and receiving modern FP method including LAM during a certain period of time						
Denominator	Total number of postpartum women registered at the same MCH centers during the same period of time						
Inclusion/exclusion	Include: Postpartum women visiting MCH during the first 42 days from delivery Exclude: Women visiting MCH after day 42 of their last delivery.						
Risk adjustment/ stratification	Registration of postpartum clients at MCH centers might not be done correctly. This should be tackled through follow-up visits from the WHCD staff and MCH supervisors at health directorates to assure compliance with providing quality services and good registration and reporting.						
Interpretation	A higher percentage of postpartum clients receiving modern methods from MCH centers means better quality of services and less unmet need for FP.						
Data source / method	FP log books available at MCH centers. Data accumulated through the monthly MCH reports entered into MCH information system.						
Frequency of data acquisition	Monthly. The indicator will be calculated on quarterly basis.						
Data analysis	Data collected from MCH centers are aggregated by the MCH information system which calculate the indicator according to the above mentioned nominator and denominator multiply by 100%.						
Responsible entity	Woman & Child Health Directorate						
Values	Baseline 2011	2012	2013	2014	2015	2016	2017
	43.4%	47.4%	49%	51%	53%	55%	57%

Indicator name	8. Percentage of Post-abortion Clients Receiving FP Counseling Before Discharge from MOH Hospital						
Rationale / justification for use	Providing FP counseling to post-abortion clients means that missed opportunities for FP services and information are addressed. Providing such services means that the clinical guidelines for FP services at post-abortion are developed, and service providers are trained on providing counseling for FP and meet clients need for FP information.						
Definition	Percentage of post-abortion clients receiving FP counseling before discharge from MOH Hospital						
Unit of measurement	Post-abortion woman						
Validation criteria	A post-abortion woman is included if she is hospitalized at a MOH hospital for post-abortion services and received counseling for FP from the hospital staff before her discharge from the hospital.						
Numerator	Number of post-abortion clients receiving FP counseling before discharge at selected MOH hospitals during a certain period of time						
Denominator	Total number of post-abortion clients at the same selected MOH hospitals during the same period of time						
Inclusion/exclusion	N/A						
Risk adjustment/ stratification	Hospitals might be providing the services; however, clients are not registered in the correct way. This should be tackled through follow-up from the HSMC, field visits from WHCD and WCH sections at health directorates to assure compliance with providing quality services and good reporting.						
Interpretation	A higher percentage of PA clients receiving counseling for FP means better quality of services and more commitment to clients' rightsto information.						
Data source / method	The FP log books at the obstetric wards within hospitals, data aggregated by hospital staff using a unified form and sent as a monthly report to WCHD. Data could be collected from the Perinatal information system.						
Frequency of data acquisition	Monthly. The indicator will be calculated on quarterly basis.						
Data analysis	Data collected from hospitals will be aggregated and the indicator will be calculated according to the above mentioned nominator and denominator multiplied by 100%.						
Responsible entity	Woman & Child Health Directorate/Hospitals Administration						
Values	Baseline[11] 2011	2012	2013	2014	2015	2016	2017
	41%	41.2%	45%	50%	52%	55%	57%

[11] The baseline value covers a 6-month period (July - December 2011) for 8 hospitals and for Al-Bashir Hospital from September - December 2011.

Indicator name	9. Percentage of Post-abortion Clients Receiving a Modern FP Method Before Discharge from MOH Hospitals						
Rationale / justification for use	The Jordan PAC clinical guidelines recommend that a post-abortion woman should postpone pregnancy for at least 6 months to improve her health and the outcome of her next pregnancy. Providing modern FP methods to post-abortion women before discharge from hospital will protect them from unwanted pregnancy and allow them to meet their reproductive goals. On the national level this will contribute to decrease unmet need, increase use of modern methods and increase CPR.						
Definition	Percentage of post-abortion clients receiving a modern FP method* before discharge from MOH Hospital * Modern FP methods provided at hospitals for post-abortion women include pills, condoms, IUD, injectables, implants and tubal ligation.						
Unit of measurement	Post-abortion woman						
Validation criteria	A post-abortion woman is included if she is hospitalized at a MOH hospital, received counseling for FP and received a modern contraceptive method from the hospital staff before discharge.						
Numerator	Number of post-abortion clients receiving a modern FP method before discharge at selected MOH hospitals during a certain period of time						
Denominator	Total number of post-abortion clients at the same selected MOH hospitals during the same period						
Inclusion/exclusion	N/A						
Risk adjustment/ stratification	Hospitals might be providing the services; however, clients are not registered in the correct way. This should be tackled through follow-up from the HSMCs, field visits from WHCD and WHD sections at health directorates to assure compliance with providing quality services and good reporting.						
Interpretation	A higher percentage of PA clients receiving modern methods means better quality of services and less unmet need.						
Data source / method	The FP log books at the obstetric wards within hospitals, data aggregated by hospital staff using a unified form and sent as a monthly report to WCHD. Data could be collected from the Perinatal information system.						
Frequency of data acquisition	Monthly. The indicator will be calculated on quarterly basis.						
Data analysis	Data collected from hospitals will be aggregated and the indicator will be calculated according to the above mentioned nominator and denominator multiplied by 100%.						
Responsible entity	Woman & Child Health Directorate/Hospitals Administration						
Values	Baseline[12] 2011	2012	2013	2014	2015	2016	2017
	19.3%	19.4%	20%	23%	23%	25%	25%

[12] The baseline value covers a 6-month period (July - December 2011) for 8 hospitals and for Al-Bashir Hospital from September - December 2011.

Indicator name	10. Percentage of Yearly Increase in Couple Years of Protection (CYP) at MOH Facilities					
Rationale / justification for use	This indicator measures improvement of the FP program from year to year. It identifies whether the program is improving and more couples are protected from unwanted pregnancies or if the program is not making progress. This will allow correction measures to be taken if needed.					
Definition	Percentage of yearly increase in number of couple years of protection					
Unit of measurement	Couple protected from pregnancy for one year					
Validation criteria	N/A					
Numerator	CYP for a certain year – CYP for the previous year					
Denominator	CYP of previous year					
Inclusion/exclusion	N/A					
Risk adjustment/ stratification	N/A					
Interpretation	A higher percentage increase in CYP indicates improvement in use of FP products and services.					
Data source / method	Jordan Contraceptives Logistics System reports					
Frequency of data Acquisition	Yearly. The indicator will be calculated on yearly basis.					
Data analysis	Data collected from MCH centers and aggregated through the JCLS and the indicator will be calculated according to the above mentioned nominator and denominator multiplied by 100%.					
Responsible entity	Woman & Child Health Directorate					
Values	Baseline 2011	2013	2014	2015	2016	2017
	Will be calculated for 2012	1% increase	1% increase	1% increase	1% increase	1% increase

Indicator name	11. Percentage of Missed Opportunities for FP Counseling at MOH Health Centers			
Rationale / justification for use	In spite of the large network of PHC services in Jordan, a significant proportion of women eligible for FP do not receive effective counseling. This indicator will reflect the capability of PHC service delivery units to provide counseling to married women of reproductive age (MWRA) attending PHC services.			
Definition	Percentage of missed opportunities for FP counseling at MOH health centers			
Unit of measurement	MWRA attending MOH health facilities			
Validation criteria	A woman is considered to be a missed opportunity for FP if she is a MWRA currently not using a modern FP method and does not receive FP counseling when attending a MOH PHC facility.			
Numerator	Number of MWRA not using modern FP attending MOH PHC clinics participating in the study, who are not counseled on FP services at a certain point of time			
Denominator	Total number of MWRA not using modern FP who are eligible for FP counseling at same MOH facilities participating in the study, at the same point of time			
Inclusion/exclusion	Include: A random sample of PHC health centers			
A lower risk adjustment/ stratification	It is anticipated that data collection bias may occur; accordingly WCHD will perform quality checks during data collection and data entry. Data cleaning will be done in order to assure quality of data.			
Interpretation	A lower percentage of missed opportunities for FP counseling indicates that the FP program is better responding to clients' needs for FP.			
Data source / method	This indicator will be measured through a client exit study at a random sample of PHC centers.			
Frequency of data acquisition	Yearly. The indicator will be calculated on yearly basis.			
Data analysis	Data collected from the client exit survey will be analyzed and percentage will be calculated.			
Responsible entity	Woman & Child Health Directorate			
Values	Baseline 2011	2015	2016	2017
	65%	60%	57%	55%

Indicator name	12. Percentage of SDPs Providing IUD Services						
Rationale / justification for use	Jordan's national goal is to reach a total fertility rate (TFR) of 2.1 by 2030. This will not be met unless the FP program becomes more effective and more efficient; to do so, Jordan should depend more on long acting methods.The literature shows that the discontinuation rate for these methods is less than for other temporary methods. Also, clients should return to a service provider for removal, which provides an opportunity to counsel clients and to either help them to continue with the method or provide them with another modern method of their choice. IUD is a long acting method that lasts for 12 years with a high effectiveness rate.						
Definition	Percentage of service delivery points (SDPs)* providing IUD services *SDP could be a health center or an out-patient clinic within a hospital.						
Unit of measurement	SDP						
Validation criteria	An SDP will be considered to be providing IUD services if IUDs were provided to clients for at least 2 months out of 3 per quarter. On yearly basis, an SDP will be considered to be providing IUD services if IUD were provided to clients for at least 3 quarters per year.						
Numerator	Number of SDPs providing IUD services during a certain period of time						
Denominator	Total number of SDPs providing FP servicesduring the same period of time						
Inclusion/exclusion	Exclusion: 1) Obstetric wards within hospitals providing FP services; 2) Village health centers; 3) SDPs providing IUD services for less than 2 months out of 3 months; 4) SDPs providing IUD services for fewer than 3 quarters out of 4 per year.						
Risk adjustment/ stratification	Trained service providers often transfer from their work place to another SDP which doesnt have infrastructure needed for IUD insertion. The stability of staff nominated to training should be agreed upon with the HD Director before starting the training, and the stability of those trained staff in providing the service should be assured.						
Interpretation	A higher percentage of SDPs providing IUD services indicates better access to such service for women in Jordan.						
Data source / method	Jordan Contraceptives Logistics System						
Frequency of data acquisition	Monthly. The indicator will be calculated on quarterly & yearly basis.						
Data analysis	Data will be collected from the JCLS, calculated according to above mentioned equation nominator and denominator multiplied by 100%.						
Responsible entity	Woman & Child Health Directorate						
Values	Baseline 2011	2012	2013	2014	2015	2016	2017
	22%	23.4%	27%	29%	31%	33%	35%

Indicator name	13. Number of SDPs Providing Implant Services						
Rationale / justification for use	Jordan's national goal is to reach a total fertility rate (TFR) of 2.1 by 2030. This will not be met unless the FP program becomes more effective and more efficient; to do so, Jordan should depend more on long acting methods. The literature shows that the discontinuation rate for these methods is less than for other temporary method. Also, clients should return to a service provider for removal, which provides an opportunity to counsel clients and to either help them to continue with the method or provide them with another modern method of their choice. Implants are a long acting method that last for 3 years with a high effectiveness rate.						
Definition	Number of SDPs providing implant services *SDP could be a health center or an out-patient clinic within a hospital.						
Unit of measurement	SDP						
Validation criteria	An SDP will be considered to be providing implant services, if implants were provided to clients during 2 months out of 3 per quarter. On a yearly basis, an SDP will be considered to providing implant services if implants were provided to clients for at least 3 quarters per year.						
Numerator	Number of SDPs providing implant services during a certain period of time						
Denominator	N/A						
Inclusion/exclusion	Exclusion: 1) Obstetric wards within hospitals providing FP services; 2) Village health centers; 3) SDPs providing implant services fewer than 2 months out of 3 months; 4) SDPs providing implants services fewer than 3 quarters out of 4 per year.						
Risk adjustment/ stratification	Trained service providers transfer from SDP to another which doesn›t provide implant services. Agreement with HD Director to assure stability of trained service providers should be done before the training and the stability of those trained staff in providing the service should be assured.						
Interpretation	The higher number of SDPs providing implant services, the better access to such service is provided to women in Jordan.						
Data source / method	Jordan Contraceptives Logistics System						
Frequency of data acquisition	Monthly: The indicator will be calculated on quarterly & yearly basis.						
Data analysis	Analyze reports generated from the Jordan Contraceptives Logistics System.						
Responsible entity	Woman & Child Health Directorate						
Values	BASELINE 2011	2012	2013	2014	2015	2016	2017
	23	18	30	37	44	51	58

Indicator name	14. Percentage of SDPs Stocked Out of a FP Method						
Rationale / justification for use	An effective FP program depends on the continuous availability of contraceptives at SDPs. One of the main client rights is continuity of care, which cannot be met if there is a shortage of contraceptives.						
Definition	Percentage of SDPs stocked out of at least one modern FP method within six months						
Unit of measurement	SDP						
Validation criteria	SDP* will be considered stocked out, if a contraceptive method** from those usually provided at this site is not available (stock = zero) or the available items are expired for any reason. *SDP could be a health center (comprehensive, or primary or village), a clinic within a hospital, or a hospital ward where contraceptives are provided. ** Modern contraceptive methods are: IUD, Implants, injectables, COC, progestin only pills and condoms.						
Numerator	Total number of stock-out incidences of modern FP methods that happened at MOH service delivery points within the last six months						
Denominator	Total number of MOH service delivery points providing FP services at the same period						
Inclusion/exclusion	Include: Village health centers providing FP services. Exclude: Hospitals not providing FP services within their outpatient clinics or within the obstetric ward.						
Risk adjustment/ stratification	There can be delay in sending the reports from some parties. This should be resolved through more follow-up.						
Interpretation	A lower percentage of SDPs stocked out indicates better commitment and functioning of the logistics system and better quality of FP services.						
Data source / method	Jordan Contraceptives Logistics System reports						
Frequency of data acquisition	Monthly: The indicator will be calculated on biannually basis.						
Data analysis	Data will be collected from the JCLS, calculated according to above mentioned equation nominator and denominator multiply by 100%.						
Responsible entity	Woman & Child Health Directorate						
Values	Baseline 2011	2012	2013	2014	2015	2016	2017
	4.5%	8%	4.2%	3.9%	3.6%	3.3%	3%

Indicator name	15. Percentage of MOH Health Directorates Using FP Information Systems for Developing/Updating their Annual Work Plan						
Rationale / justification for use	The MOH has developed several information systems (ISs) related to FP that provide data and information for decision makers. However, many decisions are made without using data. This indicator will measure the use of FP IS by health directorates (HDs) while updating their annual work plans.						
Definition	Percentage of MOH Health Directorates using FP information systems to develop/update their yearly operational plans						
Unit of measurement	MOH health directorates						
Validation criteria	A health directorate will be included; if its annual operational plan contains data/numbers taken from the MCH or logistics ISs related targets and interventions are included to improve FP situation in their HD.						
Numerator	Number of health directorates using FP information systems to develop/update their yearly operational plans for a certain year						
Denominator	Total number of health directorates for the same year						
Inclusion/exclusion	N/A						
Risk adjustment/ stratification	N/A						
Interpretation	A higher percentage of HDs using FP information system indicates a high utilization and increased effectiveness of these systems.						
Data source / method	Health directorates' annual operational work plans						
Frequency of data acquisition	Yearly: The indicator will be calculated on yearly basis.						
Data analysis	HDs annual work plans will be reviewed to identify whether FP data is included and whether it is the same data within the FP IS systems. Indicator will be calculated according to above mentioned equation nominator and denominator multiplied by 100%.						
Responsible entity	Woman & Child Health Directorate						
Values	Baseline 2011	2012	2013	2014	2015	2016	2017
	100%	100%	100%	100%	100%	100%	100%

Indicator name	16. Percentage of Health Directorates with a Functioning MCH Supervision System						
Rationale / justification for use	Effective facilitative supervision contributes to improvements in quality of care. Monitoring this indicator will reflect the improvement of supervision skills and the institutionalization of such system to monitor quality of care provided at MCH facilities.						
Definition	Percentage of MOH Health Directorates with functioning MCH supportive supervision system						
Unit of measurement	MOH Health Directorate						
Validation criteria	The supervision system is considered active if it meets all of the following criteria: Annual supervision visits schedule is developed by the WCH Unit at HD and submitted to WCHD. At least 60% of scheduled visits occur. The supervision visit is documented using the MCH supervision reports form. Monthly supervision reports are submitted to the WCHD by the HD.						
Numerator	Number of health directorates with functioning FP supportive supervision system during a certain period of time						
Denominator	Total number health directorates during the same period of time						
Inclusion/exclusion	Include: supervisory visits reports filled on agreed forms distributed to HD by planning directorate.						
Risk adjustment/ stratification	The quality of supervisory visits done is questionable; accordingly, WCHD will conduct its own supervisory visits to assure quality of FP supervisionprovided at different HDs.						
Interpretation	A higher percentage of HDs with active supervisory systems indicates greater progress on institutionalization and commitment from MOH for the system.						
Data source / method	Supervisory forms sent by HDs and received by WCHD including the yearly supervision visits schedule and monthly visits reports.						
Frequency of data acquisition	Quarterly: The indicator will be calculated semiannually.						
Data analysis	Review the supervisory reports sent by HDs MCH supervisors' to the WCHD and compare to their annual supervision schedules to identify commitment of implementing the scheduled visits. Indicator will be calculated according to above mentioned equation nominator and denominator multiplied by 100%.						
Responsible entity	Woman & Child Health Directorate and Health Directorates						
Values	Baseline 2011	2012	2013	2014	2015	2016	2017
	38%	67%	75%	83%	100%	100%	100%

Indicator name	17. Number of Yearly Policies/Regulations/Actions Supporting FP Approved by MOH						
Rationale / justification for use	A sustainable and effective FP program should be supported by an appropriate and supportive political environment. Such support is reflected through a number of policies and regulations and actions that support and facilitate provision of FP services.						
Definition	Number of yearly policies/regulations/actions supporting family planning approved by MOH						
Unit of measurement	Policy or regulation or action						
Validation criteria	A policy or a regulation or action is considered if it is supporting FP program to facilitate the provision of FP services, improve access, assure sustainability, or improve the quality or quantity of FP services provided within MOH facilities. The policy/regulation/action should be approved by HE the Minister of Health or a higher Jordanian institution such as the Cabinet or the Parliament.						
Numerator	Number of policies/regulations/actions supporting family planning approved by MOH within a year						
Denominator	N/A						
Inclusion/exclusion	N/A						
Risk adjustment/ stratification	N/A						
Interpretation	A higher number of policies/regulations/actions approved indicates better support and commitment to FP program from MOH policy makers.						
Data source / method	MOH correspondence related to FP						
Frequency of data acquisition	Quarterly. The indicator will be calculated yearly.						
Data analysis	N/A						
Responsible entity	Woman & Child Health Directorate						
Values	Baseline 2011	2012	2013	2014	2015	2016	2017
	2[13]	2	4	5	6	7	8

[13] The approved midwives' job description includes ability to provide IUD services and PP/PA FP services at hospitals.

Indicator name	18. Percentage of FP Methods and Commodities Costs Covered by the Related MOH Budget Line Item						
Rationale / justification for use	Sustainability and continuity of the FP program depends on the availability of FP contraceptives and commodities. The MOH purchases needed quantities of contraceptives, although not always from the budget line item related to contraceptives purchasing. It is more sustainable to cover all purchases from that specific line item.						
Definition	Percentage of FP methods and commodities cost covered by the budget allocated in the MOH budget line item related to contraceptives purchasing						
Unit of measurement	Jordanian Dinar						
Validation criteria	The amount to be considered should be allocated in the related MOH budget line item for purchasing contraceptives and used for purchasing contraceptives and other commodities related to FP.						
Numerator	Jordanian dinars allocated and paid from the MOH related budget line for contraceptives purchasing during a certain year						
Denominator	Total actual cost of FP commodities purchased by MOH during the same year						
Inclusion/exclusion	N/A						
Risk adjustment/ stratification	N/A						
Interpretation	A higher the coverage from the related MOH budget line indicates higher commitment to and sustainability of the FP program.						
Data source / method	Yearly MOH Budget Document						
Frequency of data acquisition	Yearly. The indicator will be calculated yearly.						
Data analysis	N/A						
Responsible entity	MOH Finance Directorate						
Values	Baseline 2011	2012	2013	2014	2015	2016	2017
	51%	55%	65%	65%	67%	70%	70%

Indicator name	19. Number of Service Providers who Received FP Counseling Training						
Rationale / justification for use	Providing quality FP services requires staff who have the appropriate knowledge, skills and attitudes. To date the pre-service training does not appropriately cover FP counseling. Accordingly, there is a need to provide FP service providers with in-service training on FP counseling to assure compliance with the FP clinical guidelines.						
Definition	Number of service providers received training on counseling for family planning						
Unit of measurement	Service provider						
Validation criteria	Service providers will be calculated within this indicator if they are MOH employees, attend training for FP counseling and receive the related certificate. The training should be equal to not less than 18 training hours, and cover the following items: Contraceptive technology updates Communication skills REDI framework for counseling Counseling role plays						
Numerator	Number of service providers trained and certified on counseling for FP during a certain period of time						
Denominator	N/A						
Inclusion/exclusion	Exclude: Service providers who attend less than half the training hours.						
Risk adjustment/ stratification	N/A						
Interpretation	A higher number of trained service providersindicates better quality of FP services provided to clients and a better FP program.						
Data source / method	Reports generated from the WCHD training data base, including lists of names and total numbers of trainees.						
Frequency of data acquisition	Quarterly. The indicator will be calculated yearly.						
Data analysis	Analyze reports generated from the training data base, including lists of names and total numbers of trainees.						
Responsible entity	Woman & Child Health Directorate						
Values	Baseline 2011	2012	2013	2014	2015	2016	2017
	442[14]	556	850	1000	1040	1080	1120

[14] This value represents the number of trainees for 2011, as for the values in the subsequent years, they are agreegate.

Indicator name	20. Number of Physicians and Midwives Trained in IUD Services						
Rationale / justification for use	Jordan's national goal is to reach a total fertility rate (TFR) of 2.1 by 2030. This will not be met unless the FP program becomes more effective and more efficient; to do so, Jordan should depend more on long acting methods. Literature shows that the discontinuation rate for long acting methods is less than for other temporary methods. Also,clients should return to service providers for removal, which provides an opportunity to counsel clients to either help them to continue with the method or provide them with another modern method of their choice. An IUD is a long acting method with a high effective rate that lasts for 12 years.						
Definition	Number of physicians and midwives trained in IUD services						
Unit of measurement	Physician or midwife						
Validation criteria	Physicians and midwives are included within this indicator if they are MOH employees and attended both the didactical and practical training on IUD insertion conducted by MOH, and we recertified for providing such service.						
Numerator	Number of physicians and midwives trained in IUD insertion and services						
Denominator	N/A						
Inclusion/exclusion	Exclude: Service providers who didn't pass the practical training or didn't successfully complete the needed number of cases.						
Risk adjustment/ stratification	N/A						
Interpretation	A higher number of trained physicians and midwives indicates that better access to such service is provided to women in Jordan.						
Data source / method	Reports generated from the WCHD training data base, including lists of names, total number of trainees and training reports and WCHD lists of certified staff.						
Frequency of data acquisition	Quarterly. The indicator will be calculated yearly.						
Data analysis	Analyze reports generated from the training data base, including lists of names and total numbers and compare with lists of certified trainees.						
Responsible entity	Woman & Child Health Directorate						
Values	Baseline 2011	2012	2013	2014	2015	2016	2017
	36	100	120	140	140	170	190

Indicator name	21. Number of Physicians Trained in Contraceptive Implant Services						
Rationale / justification for use	Jordan's national goal is to reach a total fertility rate (TFR) of 2.1 by 2030. This will not be met unless the FP program becomes more effective and more efficient; to do so, Jordan should depend more on long acting methods. The literature shows that the discontinuation rate of long acting methods is less than that of other temporary methods. Also,clients should return to service provider for removal, which provides an opportunity to counsel clients to either help them to continue with the method or provide them with another modern method of their choice. Implanon implants are a long-acting hormonal method with a high effective rate that lasts for 3 years.						
Definition	Number of physicians trained in contraceptive implant (CI) services						
Unit of measurement	Physician						
Validation criteria	A physician is calculated within this indicator if he/she is a MOH employee and attended both the didactical and practical training on CI insertion conducted by MOH and was certified for providing such service.						
Numerator	Number of physicians trained on contraceptive implant services during a certain period of time						
Denominator	N/A						
Inclusion/exclusion	Exclude: Service providers who didn't pass the practical training or didn't complete successfully the needed number of cases.						
Risk adjustment/ stratification	N/A						
Interpretation	A higher number of trained physicians meanbetter access to FP service is provided to women in Jordan.						
Data source / method	Reports generated from the WCHD training data base, including lists of names, total number of trainees and training reports and WCHD lists of certified staff.						
Frequency of data acquisition	Quarterly: The indicator will be calculated yearly.						
Data analysis	Analyze reports generated from the training data base, including lists of names and total numbers and compare with lists ofcertified trainees.						
Responsible entity	Woman & Child Health Directorate						
Values	Baseline 2011	2012	2013	2014	2015	2016	2017
	57	79	100	120	120	140	160

Indicator name	22. Percentage of MCH Centers with Female Physician Providing FP Services					
Rationale / justification for use	Jordanian women prefer to receive FP services from a female provider. Greater availability of a female physician at MCH centers to provide FP services will meet the clients' needs and encourage more women to get their FP services from MOH MCH centers.					
Definition	Percentage of MCH centers with female physicians providing FP services					
Unit of measurement	MCH center					
Validation criteria	A MCH center is calculated within this indicator if a female physician is available on daily basis and providing FP services to the health center›s clients. On quarterly basis the female physician should be available for at least 2 months out of 3. On a yearly basis the female physician should be available for at least 3 quarters out of 4 per year.					
Numerator	Number of MCH centers with female physicians providing FP services during a certain period of time.					
Denominator	Total number of MCH centers during the same period of time					
Inclusion/exclusion	Exclude: 1) MCH centers with a female physician who is not providing FP services; 2) MCH centers with a female physician for less than 2 months out of 3 per quarter; 3) MCH centers with a female physician for less than 3 quarters out of 4 per year.					
Risk adjustment/ stratification	N/A					
Interpretation	A higher number of MCH centers with female physicians providing FP services, indicates better access to FP services for women in Jordan.					
Data source / method	MCH Information System reports					
Frequency of data acquisition	Monthly. The indicator will be calculated quarterly and yearly.					
Data analysis	Data will be collected from MCH Information system calculated according to above mentioned equation nominator and denominator, multiplied by 100%.					
Responsible entity	Woman & Child Health Directorate					
Values	Baseline 2011	2013	2014	2015	2016	2017
	Not available, will be calculated for 2013		1% increase	1% increase	1% increase	1% increase

Indicator name	23. Percentage of MCH Centers with an Appropriate Team that Consists of at least a Female/Male Physician and one Midwife Providing FP Services					
Rationale / justification for use	This indicator measures the readiness of MCH centers to provide MCH services; availability of an appropriate team means better quality of services that meets clients' needs and expectations.					
Definition	Percentage of MCH centers with a team that consists of at least 1 female/male physician and 1 midwife					
Unit of measurement	MOH Health Center					
Validation criteria	All of the team members mentioned above are assigned to provide MCH services including FP. An MCH center will be considered if the team was available in the MCH and providing services during at least 2 months out of 3 per quarter. On yearly basis, an MCH center will be considered if the team was available for at least 3 quarters per year.					
Numerator	Number of MCH centers with teams comprising at least 1 female/male physician and 1 midwife during a certain period of time					
Denominator	Total number of MCH centers during the same period of time					
Inclusion/exclusion	Include: MCH center that has a team for at least 2 months during a quarter of three months. Exclude: 1) MCH center with such a team for less than 2 months out of 3 months; 2) MCH center with such a team for less than 3 quarters out of 4 per year.					
Risk adjustment/ stratification	N/A					
Interpretation	A higher number of MCH centers with an appropriate team indicates a better quality of services provided and greater client satisfaction.					
Data source / method	MOH MCH Information System					
Frequency of data acquisition	Monthly: The indicator will be calculated quarterly and yearly.					
Data analysis	Data will be collected from MCH Information system calculated according to above mentioned equation nominator and denominator, multiplied by 100%.					
Responsible entity	Woman & Child Health Directorate					
Values	Baseline 2011	2013	2014	2015	2016	2017
	Not available, will be calculated for 2013		1% increase	1% increase	1% increase	1% increase

Indicator name	24. Number of FP Community-based Activities Conducted by MOH					
Rationale / justification for use	Although Jordanians have a high level of knowledge of FP services, utilization of FP services is still minimal in many health centers. Accordingly, community-based activities are necessary to increase community awareness of availability of FP services within MOH facilities and encourage clients to visit these facilities requesting FP services.					
Definition	Number of FP community-based activities conducted by MOH during a certain period of time					
Unit of measurement	Activity					
Validation criteria	An activity will be considered if it is conducted at the level of communities, targeting lay people, and its objective is to increase FP awareness and encourage people to use FP services provided at MOH facilities.					
Numerator	Number of FP community based activities conducted by MOH					
Denominator	N/A					
Inclusion/exclusion	Include: Activities conducted by other institutions when MOH participates in the implementation.					
Risk adjustment/ stratification	N/A					
Interpretation	A higher number of FP community-based activities, indicates a higher knowledge level of people living in Jordan regarding FP and higher demand for FP services.					
Data source / method	Health Communication & Awareness Directorate Reports					
Frequency of data acquisition	Quarterly: The indicator will be calculated quarterly and yearly.					
Data analysis	Review and analyze the reports related to FP community-based interventions conducted by MOH.					
Responsible entity	Health Communication & Awareness Directorate					
Values	Baseline 2011	2013	2014	2015	2016	2017
	Not available, will be calculated for 2013		3% increase	6% increase	9% increase	12% increase

Indicator name	25. Number of People Reached through FP Community-based Activities					
Rationale / justification for use	Although Jordanians have a high level of knowledge of FP services, utilization of FP services is still minimal in many health centers. Accordingly, community-based activities are necessary to increase community awareness of availability of FP services within MOH facilities and encourage them to visit these facilities requesting FP services.					
Definition	Number of people reached through FP community-based activities					
Unit of measurement	Person					
Validation criteria	A person will be considered as reached by FP community-based activities if he/she attends the activity and signs on the participants' list.					
Numerator	Number of people reached through FP community activities during a certain period of time					
Denominator	N/A					
Inclusion/exclusion	Include: People attending FP community based activities conducted by other institutions when MOH participates in the implementation.					
Risk adjustment/ stratification	N/A					
Interpretation	A higher number of people reached through FP community-based activities means a higher knowledge level of people living in Jordan regarding FP and higher demand for FP services.					
Data source / method	Health Communication & Awareness Directorate Reports					
Frequency of data acquisition	Quarterly. The indicator will be calculated quarterly and yearly.					
Data analysis	Review and analyze the reports related to FP community based interventions conducted by MOH including the attendance Sheets.					
Responsible entity	Health Communication & Awareness Directorate					
Values	Baseline 2011	2013	2014	2015	2016	2017
	Not available, will be calculated for 2013		3% increase	6% increase	9% increase	12% increase

Annex F: MOH Family Planning Steering Committee Members

- MOH Secretary General – Dr. Deif Allah Allozi/Chairman
- Director of PHC Administration – Dr. Bassam Hijawi /Deputy Chairman
- Director of Hospital Administration – Dr. Ahmad Qutaitat
- Director of Planning Administration – Dr. Khaled El-Edwan /Dr. Ghassan Fakhoury (previously) & Dr. Khaled Abu Hudei (previously)
- Director of Administrative Affairs Administration – Dr. Abd Al-Rahman Al-Mani
- Director of Health Directorates Administration — Dr. Bashar Abu-Saleem/Dr. Khldoon Al Edwan (previously)
- Director of Legal Affairs Directorate – Legal Advisor Radwan Abu Al-Dames
- Director of Internal Control and Auditing Directorate – Dr. Hikmat Abu Al-Fool/Dr. Asmi Al-Hadid (previously)
- Director of Woman and Child Health Directorate – Dr. Nidal Al-Azab/Dr. Ruwaida Rashid (previously)/Zakaria Al- Omari (previously), Committee Secretary
- Director of Planning and Project Management Directorate – Dr. Saed Kharabshe/Dr. Kasem Al-Rabee' (previously)/ Dr. Ghassan Fakouri (previously)
- Director of Budget Directorate – Mr. Mo'ayyad Barmawi
- Director of Information & Studies Directorate – Dr. Fares Dababneh
- Director of Health Awareness & Communication Directorate – Dr. Malek Al-Habashneh
- Director of Quality Directorate – Dr. Ghassan Fakhouri/Dr. Safa Al-Qusoos (previously)
- Director of Nursing Directorate – Ms. Haiam Al-A'araj
- Director of Information Technology Directorate – Mrs. Samar Samouh/Mr. Eyad Fakhoury(previously)
- Procurement & Supply Directorate – Dr. Musalam Qatarneh
- Human Resources Development Directorate – Dr. Fadoua Shawabkeh/Dr. Ayoub Saiedeh (previously)
- Director of Capital Health Directorate – Dr. Leil Al-Fayez /Dr. Bashar Abu Salim (previously)
- Director of Irbid Health Directorate – Dr. Ali Al Saad/Dr. Abdel RahmanTbeishat (previously)
- Director of Karak Health Directorate – Dr. Adel Khatatneh/Dr. Sultan Al-Tarawneh (previously)
- Director of Al-Bashir Hospital – Dr. Issam Shraideh /Dr. Abdel HadiBrezat (previously)
- Director of Karak Hospital – Dr. Zakaria Al-Nawayseh
- Director of Princess Rahma Hospital – Dr. Abdallah Al-Sharman
- Chief of Ob/Gyn – Dr. Issa Jaber/Dr. Issam Al-Shraideh (previously)
- WCHD – Dr. Khawla Kawwa/Head of Family Planning Section – Liaison Officer
- WCHD / Head of Information & Logistics Section – Dr. Abeer Mwaswas
- Capital Governorate Health Directorate/Head of Woman and Child Health Section – Dr. Iman Sbeih
- Irbid Governorate Health Directorate/Head of Woman and Child Health Section– Dr. Lutfieh Al-Shalabi
- Karak Governorate Health Directorate/Head of Woman and Child Health Section– Dr. Haiam Hameyeh
- Health Awareness & Communication Directorate – Dr. Hamdah Abu Saleh
- WCHD / MCH Supervisor Fadia Al-Jabr
- WCHD / MCH Supervisor Amal Abu Shaweesh
- WCHD / MCH Supervisor Maisa Abu Sa'adah

Health Systems Strengthening Project II (HSS II) Steering Committee Members:

- Chief of Party of HSS II Project - Dr. Sabry Hamza
- FP/RH Team Leader – Ms. Donna Vivio

Annex G: Family Planning Strategic Plan Development Core Technical Working Group

- Director of Primary Health Care Administration – Dr. Bassm Hijjawi/Chief
- Director of Women and Child Health Directorate –Dr. Nidal Al-Azab/Dr. Ruwaida Rashid (previously)
- MOH, Chief of Obstetrics & Gynecology, Dr. Issa Al-Jaber /Dr. Issam Shraideh (previously)
- WCHD, Head of Family Planning, Dr. Khawla Kawwa
- WCHD, Head of Information and Logistics, Dr. Abeer Mowaswas
- Higher Population Council,Coordinator for the National RH/FP Plan,
- Assistant for the Program Unit,Ms. Manal Al-Ghzawi
- HPC, Secretary General Assistant for Technical Affairs, Ms. Rania al-Abbadi/Ms. Asma Fasho (previously)
- HSSII, Team Leader for Family Planning/Reproductive Health, Ms. Donna Vivio
- HSS II, Team Manager, FP/RH, Dr. Nisreen Bitar
- HSS II, Senior Task Manager, FP/RH, Dr. Manal Jrasat
- HSS II, Senior Task Manager, Management, Dr. Ibrahim Aqel, Advisor to the Technical Working Group
- HSS II, Deputy Chief of Party for Services and FP/RH Team Leader, Ms. Susan Wright

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