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USAID HEALTH SERVICE DELIVERY REVISED MONITORING, EVALUATION, AND LEARNING (MEL) PLAN

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USAID HEALTH SERVICE DELIVERY REVISED MONITORING, EVALUATION & LEARNING (MEL) PLAN

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ACRONYMS

Activity MEL Plan	Activity Monitoring, Evaluation and Learning Plan
ANC	Antenatal Care
AOR	Agreement Officer Representative
CHC	Community Health Committees
CLA	Collaborating, Learning and Adapting
COP	Chief of Party
CPR	Contraceptive Prevalence Rate
CSPro	Census and Survey Processing System
CYP	Couple-Years of Protection
DCOP	Deputy Chief of Party
DDL	Development Data Library
DEC	Development Experience Clearinghouse
DHS	Demographic and Health Survey
DO	Development Objective
DQA	Data Quality Assessment
DSP	Data Security Plan
FP	Family Planning
FY	Fiscal Year
GFA	Geographic Focus Areas
GP	General Practitioners
HCAD	Health Communications and Awareness Directorate
HC	Health Center
HAD	Health Affairs Directorate
HMIS	Health Management Information System
HO	Home Office
HQ	Head Quarter
HRH 2030	Human Resources for Health 2030
IR	Intermediate Results
IRB	Institutional Review Board
ISD	Integrated Service Delivery
ISDIC	Integrated Service Delivery Improvement Collaborative
IT	Information Technology
JCAP	Jordan Communication, Advocacy and Policy
JPFHS	Jordan Population and Family Health Survey

JUH	Jordan University Hospital
KaMP	Knowledge Management Portal
M&E	Monitoring and Evaluation
MCH	Maternal Child Health
MESP	Monitoring and Evaluation Support Project
MIS	Management Information System
JMMSR System	Jordan Maternal Mortality Surveillance and Response System
MOH	Ministry of Health
NCD	Non-Communicable Disease
NCDD	Non-Communicable Disease Directorate
NGO	Non-Governmental Organization
PMSS	Performance Management Support System
PIRS	Performance Indicator Reference Sheet
RMNCH+	Reproductive, Maternal, Newborn and Child Health integrated with other key services (NCDs, GBV and nutrition)
RMS	Royal Medical Services
SDI	Service Delivery Improvement
SDP	Service Delivery Point
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Fund
USAID	US Agency for International Development
USG	US Government
WCHD	Woman and Child Health Directorate
WHO	World Health Organization

I. INTRODUCTION TO THE USAID HEALTH SERVICE DELIVERY MEL PLAN

Purpose

USAID Health Service Delivery is designed to stimulate management, clinical, and behavioral changes within Jordan's public and private health service system that will lead to improvements in access to and quality of reproductive, maternal, newborn and child health services including nutrition and NCDs. As a result of improved access and quality, by the end of the USAID Health Service Delivery, health status of women of reproductive age and children under five in Jordan will be improved that is expected to contribute to the intermediate result of "Health status improved" in the Mission PMP that will feed into Mission DO3 of "Improved social sector quality".

The purpose of this Monitoring, Evaluation, & Learning (MEL) Plan is to describe how Abt Associates will monitor and evaluate the USAID Health Service Delivery. The MEL Plan proposes indicators developed systematically to measure progress relative to each of the expected results. It also describes the processes that will be used to perform M&E throughout the life of the USAID Health Service Delivery with Performance Indicator Reference Sheets (PIRS) defining indicators, targets, data sources, and data limitations with proposed actions to overcome them.

This MEL Plan is a guide to the collection and use of data to monitor progress towards the USAID Health Service Delivery outcomes, compile lessons learned, facilitate management and communicate key findings to USAID/Jordan and other stakeholders. Key sections of this document detail data collection, storage, analysis and reporting processes and procedures, define data collection and analysis methodologies, and describe M&E organization. The MEL Plan is also an internal management tool, facilitating learning from implementation and identification of any USAID Health Service Delivery performance gaps. The MEL plan will inform recommendations for program improvement and evidence-based decision making among staff and counterparts.

The steps involved in the design of the MEL Plan include describing the intended results and theory of change; designing appropriate indicators and measurements at different stages of to assess USAID Health Service Delivery's progress towards those results; identifying and managing critical assumptions and risks; setting performance measure baselines and targets for monitoring and evaluations; developing quality control mechanisms and data collection processes; establishing reporting schedules; and promoting learning from and use of M&E results in program management decisions.

The MEL Plan is a dynamic and flexible document that will be reviewed and updated annually to incorporate new targets or approaches based on activity performance and results, as well as to respond to changes in the Mission's priorities. At the same time, USAID Health Service Delivery recognizes the importance of having consistent indicators throughout the project in order to measure the progress over time. The annual review process will include:

1. Discussions with the USAID AOR to ensure continued alignment of USAID Health Service Delivery activities with intended results.

2. Review and updating of the Performance Indicator Reference Sheets (PIRS) and Data Quality Assessment (DQA) Checklists as needed.
3. Identification of additional tools and mechanisms, including Information Technology (IT) systems, to ascertain data accuracy, data aggregation capacities, and sustainability.
4. Review of the use of and learning from M&E and research data to guide USAID Health Service Delivery, USAID, and local stakeholder management decisions.

Through the annual review process, USAID Health Service Delivery will work closely with USAID/Jordan in strengthening its interventions, including monitoring and evaluation processes, using continuous evidence-based analysis of progress toward results.

Information and Context

Description

USAID Health Service Delivery is a \$50 million Activity implemented by Abt Associates Inc. under the agreement AID-278-A-16-00002, during the period from March 15, 2016 to March 14, 2021. The Activity has four subcontractors: Jordan Health Care Accreditation Council, East Mediterranean Public Health Network, Population Council and American College of Nurse-Midwives.

USAID Health Service Delivery will improve access to key high quality, integrated reproductive, maternal, newborn and child health services including nutrition and identification and referral for (RMNCH+) services in both public and private sectors. As a result, by the end of the performance period of USAID Health Service Delivery, women of reproductive age and children under 5 in Jordan will receive higher quality services which will contribute to improving their health status. USAID Health Service Delivery will work with administrative and technical staff at all levels: central, health affairs directorate, and facility in order to support the introduction and scale up of effective service delivery improvement activities. USAID Health Service Delivery aims to reach a stage in which Jordanian counterparts assume full ownership of all programs that it helps to introduce and scale up.

USAID Health Service Delivery is expected to contribute to USAID's Development Objective # 3: "Social Sector Quality Improved". In particular it will contribute to IR3.1 "Health Status Improved" through improving access to and quality of services provided to women of reproductive age and children under 5.

Location and Institutional Context

The USAID Health Service Delivery Team has selected Service Delivery Points (SDPs) in Geographic Focus Areas (GFAs) to target women of reproductive age and children under five with improved RMNCH+ services. Selection criteria emphasize women of reproductive age and children under five population density, number of Syrian refugees, and SDP workload. The activities will be implemented in all governorates through all Health Affairs Directorates. Starting FY19, USAID Health Service Delivery will be working with 91 MOH health centers, 19 MOH and RMS hospitals, 31 NGO clinics. The selected 141 SDPs offer their services to more than 70% of women of reproductive age and children under five living in the catchment areas (based on the 2015 Census). Furthermore, USAID Health Service Delivery will work with about 65 private doctors.

In order to accomplish its goals, USAID Health Service Delivery will work at the central MOH, RMS and NGO, health affairs directorate, and SDP levels to improve management and quality of RMNCH+ services delivery. USAID Health Service Delivery will also work to increase community engagement in providing feedback on service quality and steering improvements. To increase awareness of local communities towards RMNCH+ services and to direct those in need for services to the closest facilities, USAID Health Service Delivery started implementing a community outreach program covering all governorates in FY 18.

Theory of Change and Logical Model

Background

Although health status in Jordan has improved greatly since 1980, Jordan's health system still faces many obstacles. New demographic challenges threaten to reverse positive developments with a large and growing youth population and 1.3 million Syrian refugees currently residing in Jordan, increasing the burden on the health system. Jordan's population has grown from 2.1 million to 9.5 million since 1979, and it continues to grow due to high fertility rates and the influx of Syrian refugees.¹ Use of modern contraceptives (42%) has remained unchanged between 2002 and 2012 with high one-year discontinuation rates (48%) and the total fertility rate (TFR) has remained stable during the same period at approximately 3.5.² The most recent Jordan Population and Family Health Survey points to remarkable reduction in TFR (2.7 children per woman) and reduction of one year discontinuation rates (30%). In face of this reduction the prevalence of modern contraceptive use declined to about 37%, which requires coordinated intensive interventions to improve the use of modern contraceptives.

The health status of women of reproductive age and children under five who constitute about 36% of Jordan's population¹ is of particular concern. Though almost all Jordanian women deliver in hospitals, the majority of maternal deaths were preventable.³ Leading causes of maternal deaths were postpartum hemorrhage, pregnancy induced hypertension and sepsis.⁴ By 2016, there has been no national surveillance system to regularly and timely capture maternal deaths and only two incomplete maternal mortality surveys were carried out over the last two decades. USAID Health Service Delivery assisted the health sector in Jordan to establish for the first time a Maternal Mortality Surveillance and Response system and the first national report for 2018 was released pointing to a maternal mortality ratio of about 30 deaths per 100,000 live births.

High prevalence rates of anemia are observed among children under five and women of reproductive age.² Overall, only one-third of children age 6-23 months are fed appropriately based on recommended infant and young child feeding practices. Thirty-two percent of children age 6-59 months and 34% of women age 15-49 are anemic. On the other hand, an alarming 55% of women are overweight or obese.

The MOH and other sectors are providing RMNCH+ services in the primary health care facilities and hospitals. However, the USAID Health Service Delivery baseline results pointed to gaps in the delivery of services concerning availability of and adherence to protocols and

¹ Department of Statistics, 2015 Census

² Department of Statistics and ICF International, "Jordan Population and Family Health Survey 2012."

³ Amarin Z, Khader Y, Okour A, Jaddou H, Al-Qutob R. "National Maternal mortality ratio for Jordan, 2007-2008." International Journal of Gynecology and Obstetrics, 2010; 111(2): 152-156.

⁴ Ibid

guidelines, implementation processes, documentation and management that weaken the expected results from these services.

Moreover, there are many missed opportunities for integrated care, such as embedding routine counseling and screening for anemia and NCDs within each service; support for early initiation and exclusive breastfeeding in antenatal care; continued encouragement to maintain breastfeeding in postnatal and child health care; and referral for family planning counseling in non-family planning visits such as child vaccination.

Summary

USAID Health Service Delivery will help the MOH and the different participating organizations introduce, adapt, scale up and sustain integrated, client-centered RMNCH+ services and establish a national maternal mortality surveillance and response (JMMSR) system to achieve and measure improved health results. USAID Health Service Delivery is designed to stimulate management, clinical, and behavioral changes within Jordan's public and private health service system that will lead to improvements in access and quality of reproductive, maternal, newborn and child health services including nutrition. As a result of improved access and quality, by the end of USAID Health Service Delivery, health status of women of reproductive age and children under five in Jordan will be improved.

USAID Health Service Delivery's theory of change addresses expanded availability and access to integrated RMNCH+ and improving quality of services.

Integrated, efficient, and effective Health Service Delivery will serve as an essential instrument to enhance health status, health protection, and social welfare of women of reproductive age and children under five. USAID Health Service Delivery conceptual basis and activities stem from the following development hypothesis that:

- If women of reproductive age and children under five years of age in Jordan have access to and receive comprehensive, integrated quality health services across a continuum of care, and
- If the quality of services in the public and private sector is improved ;
 - Then, Jordan will realize a demonstrable improvement in health status
 - Modern family planning services will experience a sustained uptake and
 - Neonatal, child and maternal health outcomes will improve

USAID Health Service Delivery developed an integrated service delivery approach that has been implemented using the collaborative approach and will increase community engagement to decrease missed opportunities. USAID Health Service Delivery will strengthen and empower communities through outreach promotion. These stronger communities and partners (including NGOs and champions) will increase access to quality health services. To improve quality of RMNCH+ services USAID Health Service Delivery will address providers' and organization competencies. Increasing access and availability and improving quality of services will lead to early detection of targeted diseases and conditions and will ensure better management of already detected diseases and conditions, thus leading to improved health status of the targeted population.

USAID Health Service Delivery Results Framework

The Theory of Change that underlines the USAID Health Service Delivery is illustrated in the Results Framework in (Figure 1, Figure 3) below.

Result 1: Expanded availability and access to integrated RMNCH+ services

Generally, integration of health services reduces missed opportunities and increases access to healthcare. Integration of maternal and child healthcare services along with enhancement of health workers' competences is critical for effective service delivery that will lead to increased access to services as well as to improved quality of provided services.

Integrated health care delivery is critical in the year after childbirth, when there are numerous opportunities to reach women and their infants with services including postnatal care, immunization, growth monitoring, and family planning. The USAID Health Service Delivery approach recognizes that every service contact presents an opportunity to comprehensively address women's and children's health needs.

To help achieve this result, two sub-results will lead to result 1:

- Sub-Result 1.1: Increased uptake of integrated RMNCH+ services
- Sub-Result 1.2: Increased community involvement to promote and increase demand for quality RMNCH+ services

Sub Result 1.1: Increased uptake of integrated RMNCH+ services

USAID Health Service Delivery will reduce missed opportunities for the provision of RMNCH+ services by developing and effectively implementing an integrated RMNCH+ services delivery package covering premarital, antenatal, perinatal, postnatal, family planning, neonatal and child healthcare. The ISD package will foster health promotion and disease prevention; early detection and treatment of complications and existing diseases; preparation for birth and evidence-based management of complications that may occur.

The USAID Health Service Delivery ISD package will ensure counseling and voluntary adoption of family planning during the postnatal period in both primary and secondary healthcare settings. The USAID Health Service Delivery baseline findings pointed to a low percentage of women being counseled during child healthcare visits and immediately after delivery before discharge from hospitals, leading to missed opportunities for family planning uptake.

To reduce missed opportunities for family planning, USAID Health Service Delivery will focus on introducing the topic during antenatal care and again in the context of routine infant immunization visits, which provide multiple contacts with the health system during the first year of life. These contacts provide timely opportunities to link new mothers with family planning information and services.

Integration of family planning and immunization services has been recognized as a promising high-impact practice for family planning by USAID, the United Nations Population Fund and

other organizations. Compared to other maternal, newborn, and child health contacts, immunization services are highly utilized in Jordan.⁵

Ensuring healthy timing and spacing of pregnancies is critical for both maternal and child health and eventually contributing to improvement of maternal and child health outcomes.

Healthy timing and spacing of pregnancies can dramatically improve the health and chances of survival of both women and children. With appropriate spacing, children are healthier and more likely to survive infancy than those occurring after short birth intervals. The time between pregnancies also allows the mother to provide the benefits of breastfeeding longer.

Furthermore, the implementation of the community outreach program that started in Fiscal Year (FY) 2018 will increase awareness to importance of antenatal care, postnatal care, family planning, anemia and nutrition through house to house visits in GFAs.

Sub Result 1.2: Increased community involvement to promote and increase demand for quality RMNCH+ services

USAID Health Service Delivery will use community-based participatory interventions through a community engagement model and provision of innovation grants to strengthen the RMNCH+ services. Several evaluations of impact of similar programs showed the effectiveness of community-based participatory interventions.^{6 7 8}

USAID Health Service Delivery will establish women's groups and also support home visits by community health workers, both of which have shown positive effects on maternal and newborn health. USAID Health Service Delivery community-based interventions will focus on raising awareness about the importance of antenatal and postnatal visits, recognizing pregnancy danger signs, and preventing unwanted pregnancies to reduce maternal and neonatal morbidity and mortality.

Furthermore, community-based interventions will be designed to improve maternal and child nutrition behaviors and practices, helping community members to understand and increase consumption of appropriate foods to prevent anemia. USAID Health Service Delivery will particularly focus on encouraging early initiation of breastfeeding, exclusive breastfeeding for six months, and age-appropriate introduction of complementary foods. Participation of community members as partners in various RMNCH+ activities will lead to improved demand for and access to services, achieving and sustaining improvement in health status. Furthermore, all community-based interventions will be implemented jointly with healthcare providers, so they can respond to the identified needs of community and improve the quality of care.

⁵ Department of Statistics and ICF International, "Jordan Population and Family Health Survey 2012."

⁶ Tripathy PK, Nair N, Barnett S, Mahapatra R, Borghi J, Rath S, Rath S, Gope R, Mahto D, Sinha R, Lakshminarayana R, Patel V, Pagel C, Prost A, Costello A. Effect of a participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Orissa, India: a cluster-randomized controlled trial. *Lancet*. 2010;375:1182–1192. doi: 10.1016/S0140-6736(09)62042-0]

⁷ Howard-Grabman. Demystifying community mobilization: an effective strategy to improve maternal and newborn health [internet]. 2007. [cited July 2014]. Available from: [HTTP://PDF.USAID.GOV/PDF_DOCS/PNADI338.PDF](http://PDF.USAID.GOV/PDF_DOCS/PNADI338.PDF)

⁸ Nair N, Tripathy P, Prost A, Costello A, Osrin D. Community-based approaches to improve neonatal survival in low-income countries: lessons from South Asia. *PLoS Med*. 2010;7:e1000246. doi: 10.1371/journal.pmed.1000246.

Result 2: Improved quality of integrated RMNCH+ services across the public and private sectors

Through capacity building of health providers and managers as well as strengthening the management of RMNCH+ services through the efficient analysis of data for decision making, USAID Health Service Delivery will improve the quality of services and patient satisfaction across the public and private sectors.

To help achieve this result, two sub-results will lead to result 2:

- Sub-Result 2.1: Improved providers' competency and behavior to deliver evidence-based RMNCH+ services
- Sub-Result 2.2: Strengthened management to support delivery of high quality RMNCH+ services

Sub Result 2.1: Improved providers' competency and behavior to deliver evidence-based RMNCH+ services

Deficiencies in quality of care quite often represent neither the failure of professional compassion nor necessarily a lack of resources.⁹ Rather, they result from gaps in knowledge or lack of consistency in applying acquired knowledge, stressing the importance of capacity building.¹⁰ Health care quality is generally defined in two ways: technical quality and sociocultural quality. Technical quality refers to the impact that the available health services can have on the health conditions of a population.¹¹ Sociocultural quality measures the degree of acceptability of services and the ability to satisfy patients' expectations.¹⁰ Thus building human resource capacity through developing clinical pathways and procedures and training of healthcare providers will affect both the quality of provided service and access to these services. Using a collaborative approach in the training of providers to analyze the current situation, collect necessary data, identify gaps, develop Change Packages and apply fixes in each SDP will improve the capacity of staff to provide better quality care. USAID Health Service Delivery capacity building activities will build a core of trainers at different levels of the health system that will be trained on the evidence-based clinical procedures and pathways to ensure that local counterparts have the capacity to conduct staff trainings independently and sustain service provision improvements.

Sub Result 2.2: Strengthened management to support delivery of high quality RMNCH+ services

Strengthening management of RMNCH+ services will include helping managers measure achievements, probe into reasons for success and failure and make use of the findings in redirecting interventions. Increased use of data for decision-making will contribute to improved quality of these services.

USAID Health Service Delivery support for a facility-based supportive supervision related to individual staff, collection and analysis of data to monitor implementation, development of a

⁹ Institute of Medicine. 2001. *Crossing the Quality Chasm*. Washington, DC: National Academy Press.

¹⁰ Silimperi D. R., Franco L. M., van Zanten T. Veldhuyzen, MacAulay C. A Framework for Institutionalizing Quality Assurance. *International Journal for Quality in Health Care*.2002;14(Suppl. 1):67–73. [\[PUBMED\]](#)

¹¹ Zurn P, Dal Poz MR, Stilwell B, Adams O: Imbalance in the health workforce. *Human Resources for Health*. 2004, 2: 13-10.1186/1478-4491-2-13

Performance Management Support System (PMSS) to track RMNCH+ services and innovative information technology approaches are expected to strengthen management of RMNCH+ services. Design and implementation of a national maternal mortality surveillance and response system will provide not only accurate figures about maternal mortality, but also inform actions aiming at minimizing preventable maternal deaths.

Measuring Results

To capture improved health status, USAID Health Service Delivery will use proximate determinants of women and child health outcomes that will constitute the first level of indicators, corresponding to USAID Health Service Delivery's goal (Figure 2). Access to and availability of services as well as quality of services are measured through a set of second level indicators, corresponding to USAID Health Service Delivery's two intermediate results.

Third level indicators, corresponding with USAID Health Service Delivery's four sub-intermediate results, will capture processes and key outputs for capacity building, community involvement, integration of services and improving management capacity. First and second level indicators will be reported to the Mission, while the third level indicators will be used internally by USAID Health Service Delivery to monitor processes and outputs to ensure timely achievements of targets set for higher level indicators. First and second level indicators are further described below in sections three and four.

USAID Health Service Delivery supports the USAID/Jordan Results Framework contributing to the Mission's IR 3.1 (Health Status Improved). USAID Health Service Delivery contributes to the Mission's Sub-IR 3.1.1.1 (Increased access to quality health services) by expanding access to and availability of integrated RMNCH+ health services in geographic focus areas (USAID Health Service Delivery Result 1) while at the same time improving the quality of RMNCH+ health services in the public and private sectors in geographic areas of focus (USAID Health Service Delivery Result 2). USAID Health Service Delivery contributes to the Mission's Sub-IR 3.1.1.2 (Improved health seeking behaviors and practices) by increasing the engagement of communities in providing feedback on quality of and access to RMNCH+ services (USAID Health Service Delivery Sub R1.2). USAID Health Service Delivery also contributes to Mission Sub-IR 3.1.3 (Impacts of rapid population growth alleviated and/or mitigated) by increasing access to quality family planning services.

USAID Health Service Delivery further posits that USAID Health Service Delivery's interventions, which are mainly supply-side focused, in combination with HRH 2030's interventions and JCAP's demand-generation activities will serve as important inputs for USAID Health Service Delivery activities to increase use of high quality RMNCH+ services and, subsequently, improve the health status of women of reproductive age and children under 5 (Figure 3).

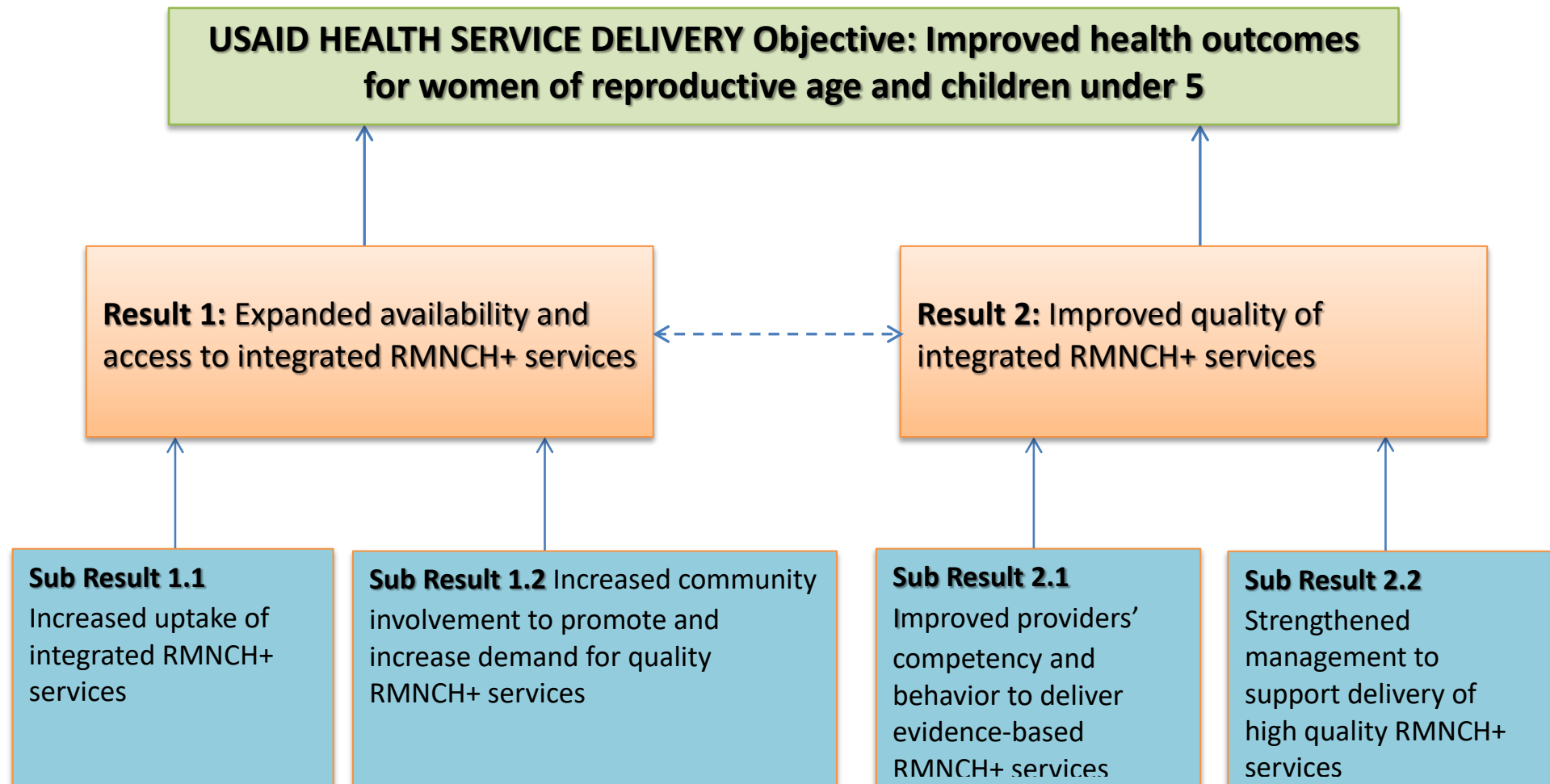


Figure 1: USAID Health Service Delivery Results Framework

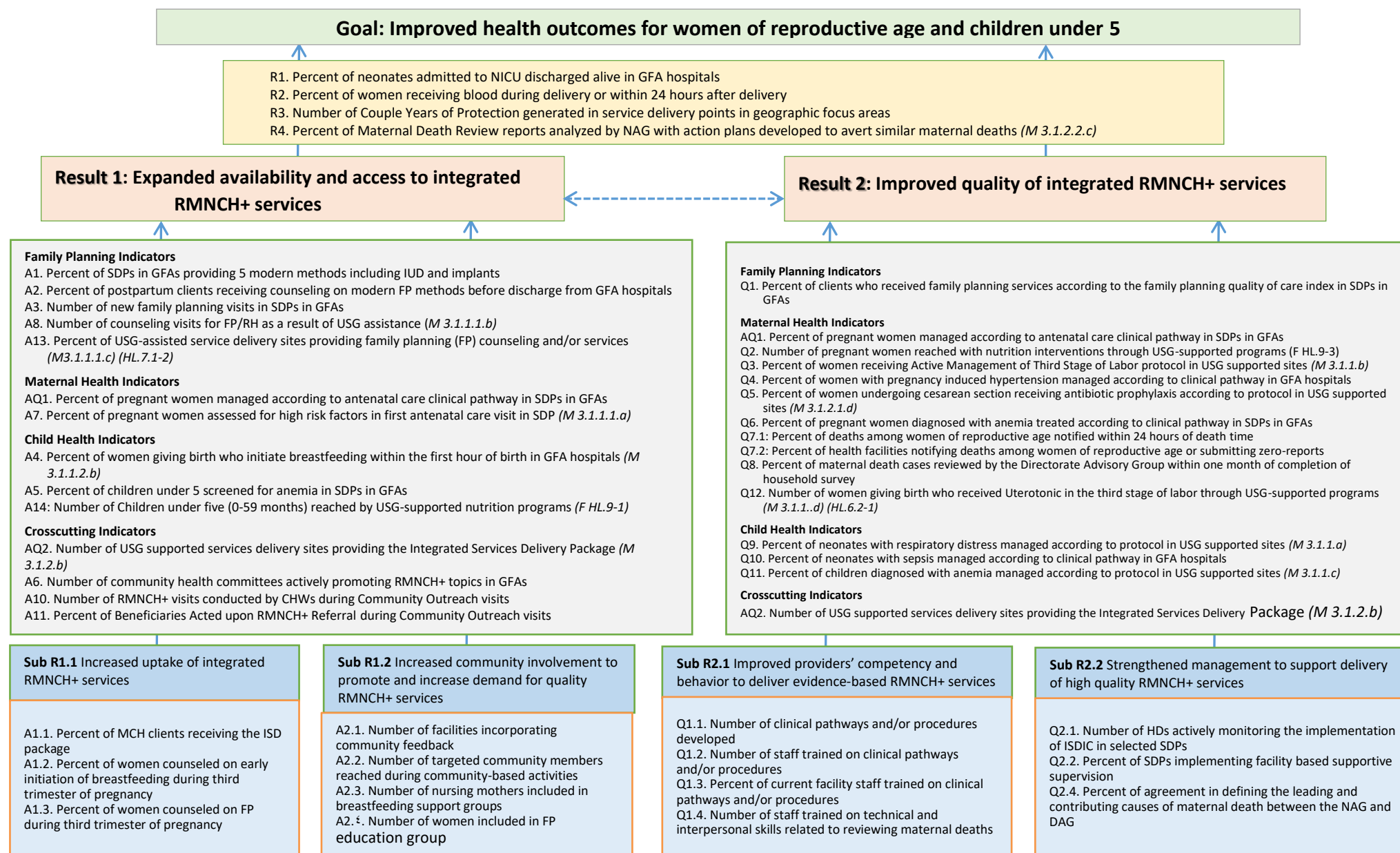


Figure 2: USAID Health Service Delivery Results Framework with Indicators

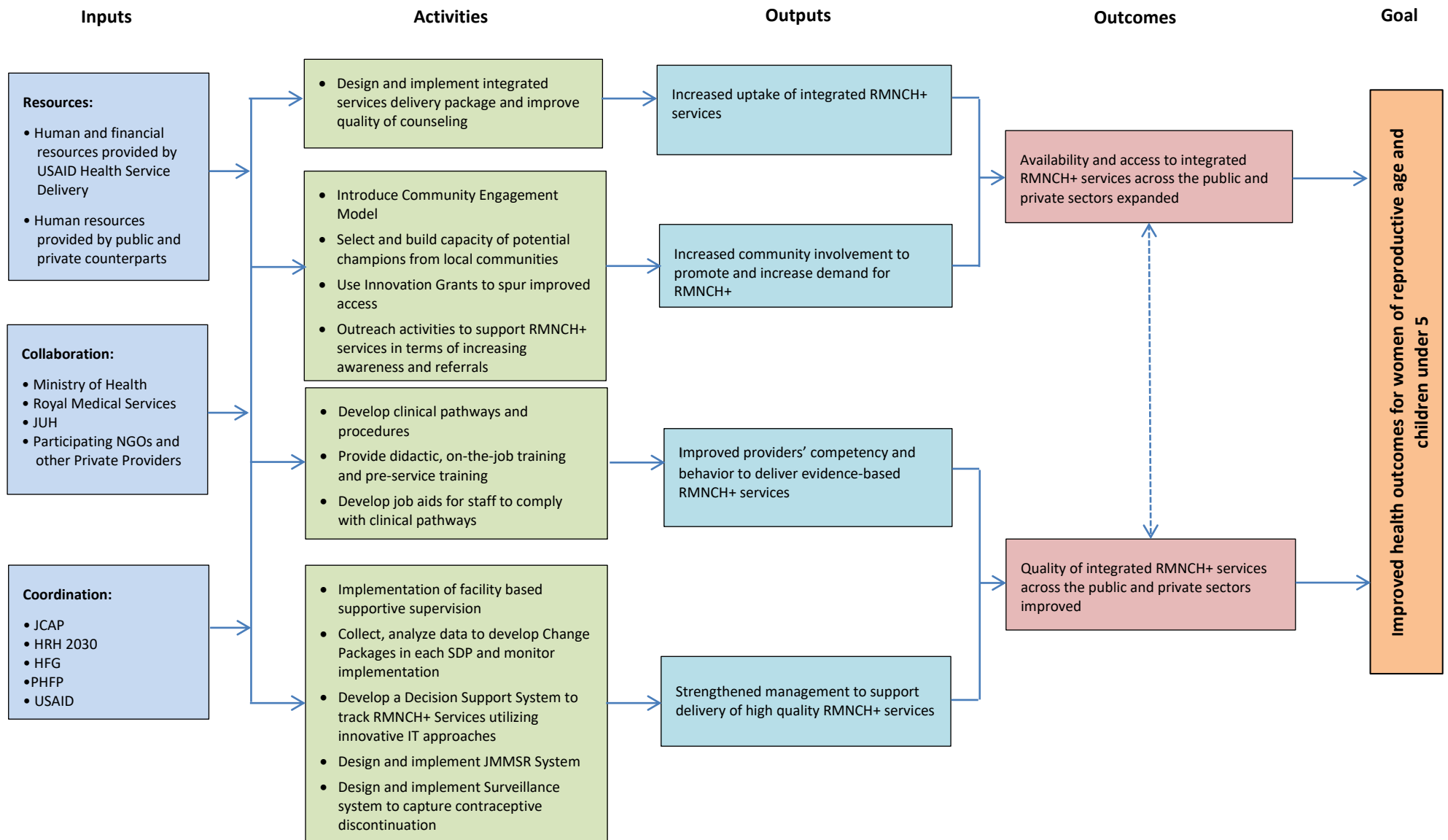


Figure 3: USAID Health Service Delivery Logical Framework

Activity Critical Assumptions

USAID Health Service Delivery's ability to implement interventions and achieve results proposed under its theory of change depends on a number of critical assumptions, related to factors both within and outside of USAID Health Service Delivery's control. Below we outline the assumptions that underpin our theory of change. To the extent possible, USAID Health Service Delivery will anticipate and mitigate risks associated with these assumptions and adjust its work to fit changing circumstances.

Causal Assumptions

Causal assumptions are related to USAID Health Service Delivery's beliefs about the linkages between its activities and results, and how its activities will lead to the results outlined in its theory of change. Below we outline key assumptions that underpin USAID Health Service Delivery's theory of change.

- There will be adequate MOH funding to procure contraceptive methods, which is essential to USAID Health Service Delivery's ability to provide these methods and support improvements in quality of family planning service delivery.
- USAID Health Service Delivery and other actors will be able to improve documentation of service delivery, data aggregation, and analysis systems at the SDP, Health Affaires Directorate (HAD), and central MOH levels to support use of data for decision making.
- Public and private sector counterparts will be held accountable for changing service provision and management in response to new clinical pathways/procedures and performance data at the HAD and SDP levels. The accountability of service providers and administrators will be essential in USAID Health Service Delivery implementation. While USAID Health Service Delivery interventions will clearly outline roles and responsibilities, holding staff accountable for their responsibilities lies within the health sector in which they work.
- Surveillance facilities, including public and private hospitals, and forensic medicine departments, will be mandated by national laws and regulations to report on mortality cases as outlined by the JMMSR model and will be held accountable by national authorities for reporting to the JMMSR system.
- Counterparts will be open to accepting and acting upon both negative and positive results from new and improved data collection systems and USAID Health Service Delivery MEL. As new data are produced through interventions such as the JMMSR system or through research studies, USAID Health Service Delivery will include counterparts in the process of interpreting data and deciding how to use it in management of RMNCH+ services so that counterparts feel ownership of and trust results, even if they are negative.
- Communities and clients are willing to give honest feedback about health services. USAID Health Service Delivery engagement of communities in RMNCH+ services depends on accurate feedback from clients in facilities and from community groups such as Community Health Committees (CHCs). Clients and community leaders may be concerned about the repercussions of providing feedback about health services, especially if their feedback is negative. Therefore USAID Health Service Delivery will, to the extent possible, use data collection and reporting processes and tools that ensure respondent privacy.

Contextual Assumptions

Shifting political and economic circumstances at the national or regional level are outside of USAID Health Service Delivery's control and could affect USAID Health Service Delivery's ability to achieve results. Ongoing regional conflicts, especially in Syria, may change in unpredictable ways that could affect USAID Health Service Delivery's interventions. USAID Health Service Delivery is carefully monitoring these situations, especially as related to the influx of Syrian refugees into Jordan, and coordinates closely with other donor organizations and the MOH. Also, USAID Health Service Delivery's work is contingent upon USAID priorities and funding, both at the global and national levels, which we assume will continue as planned. USAID Health Service Delivery will monitor changes in regional dynamics or USAID priorities and work with USAID to adjust its interventions if needed.

2. THE USAID HEALTH SERVICE DELIVERY MEL PLAN

Collaborating, Learning and Adapting

Monitoring and evaluation will play a central role in USAID Health Service Delivery's commitment to collaboration, learning, adaptation (CLA) and data driven approach for decision making. USAID's framework for ensuring that progress toward development objectives is guided by continuous learning and iterative adaptation of program implementation and strategy. USAID Health Service Delivery will rely on its Activity MEL Plan to continuously assess the causal pathways to desired outcomes and adjust activities as necessary to yield the most effective course of action.

Stakeholder Collaboration

USAID Health Service Delivery will use different mechanisms for collaboration with stakeholders, partners and target groups. These mechanisms include: committees, discussion groups, advisory groups, peer-review for some sectors, and internal and external dialogue. These platforms will serve as a base for knowledge sharing, learning and adapting. Through these mechanisms, USAID Health Service Delivery will deliver feasible innovative solutions based on the knowledge gained.

USAID Health Service Delivery will initiate and support constructive dialogue with its beneficiaries and targeted governmental and regulatory bodies through regular meetings. The purpose of such meetings will be to assess progress to date, identify constraints when targets have not been met, and discuss ways to collaboratively apply lessons learned going forward.

USAID Health Service Delivery invests constant attention in maintaining a close, strong and productive relationship with MOH managers and technical leads at all levels. This collaboration is essential for progress in all aspects of the program. The MOH Secretary General in an USAID Health Service Delivery /MOH Steering Committee meeting considered USAID Health Service Delivery a model of collaboration between a donor-funded projects and the ministry that should be emulated by others. USAID Health Service Delivery has established a relationship with key individuals, technical teams and senior management of the MOH that is characterized by confidence in each other's good intentions and common goals. At the central level of the MOH,

USAID Health Service Delivery's relationship starts with individual meetings with key technical counterparts, culminating in well-organized planning meetings to define the main lines of each year's work plan.

Once the work plan is approved and underway, the USAID Health Service Delivery/MOH Steering Committee is an important opportunity to engage the Secretary General, Primary Health Care and Hospital Administrations, and the Health Affairs Directorates with which USAID Health Service Delivery works most directly, in reviewing progress and identifying and resolving any challenges that emerge.

USAID Health Service Delivery has established and maintained excellent relations with the RMS. The RMS senior leadership regularly meets with USAID Health Service Delivery and actively supports all RMNCH+ interventions in its hospitals.

USAID Health Service Delivery supports a continuous dialogue with the directors and senior management of the three NGOs participating in the RMNCH+ activity that have resulted from their partnership through MOUs with USAID Health Service Delivery. Collaboration with NGOs in introducing the unified medical record developed by USAID Health Service Delivery not only improved the delivery and monitoring of RMNCH+ services but also increased the understanding and collaboration among the three entities.

UNFPA, UNICEF, WHO, UNHCR and JICA are all engaged in one or more of the RMNCH+ technical areas that fall within the USAID Health Service Delivery scope of work. Most of their support is channeled through the MOH or NGOs providing health services in Jordan; the MOH has the lead role in ensuring collaboration among the health donors. As an implementing partner, the USAID Health Service Delivery follows USAID leadership and guidance concerning interactions between the Activity and donor organizations. At the technical level, USAID Health Service Delivery staff participate regularly in UNFPA-led sub-sector working groups on reproductive health, community health, and nutrition. The monthly meetings of these groups give USAID Health Service Delivery opportunities to track and share information concerning health interventions for Syrian refugees, and to offer technical updates and materials on RMNCH+ to be used by other groups.

Collaboration with Other Implementing Partners

The USAID Health Service Delivery is one of several USAID/Jordan health projects, all of which depend on each other for overall success. Therefore, USAID Health Service Delivery plans, implements, and monitors its interventions in coordination, cooperation, and/or collaboration with the other implementing partners.

USAID/Jordan PFH Office fosters a collaborative climate through a series of events and workshops including quarterly meetings among the four current implementing partners for health. USAID Health Service Delivery also directly interacts with the other partners concerning shared challenges, joint activities in specific program elements or potential new areas of collaboration.

USAID Health Service Delivery has identified common interests and initial collaborative efforts in meetings with implementing partners. Details of collaborative activities with other implementing partners are clearly identified in the annual work plans. USAID Health Service Delivery will engage continuously with the other implementing partners, which may result in additional areas of collaboration that has been noted in the quarterly and annual progress reports.

Communicating Results to Stakeholders

The USAID Health Service Delivery team will ensure that the learning and evidence generated through M&E and research are widely disseminated and used at the facility, community, health affairs directorate, and MOH levels, and fed back into USAID Health Service Delivery programming. The USAID Health Service Delivery team will build local demand and interest in using data for decision making for the key Jordanian stakeholders such as MOH, RMS and NGO officials and community health committees members.

Through the M&E process that consists of standardized data collection, analysis and reporting, as well as evaluations and issue-specific studies, USAID Health Service Delivery will continually identify and integrate lessons learned into the implementation of planned activities.

Performance Monitoring System and Approaches

Performance Indicators

The USAID Health Service Delivery team created a list of indicators to measure the effect of interventions, and yielded a total of 32 first and second-level indicators. Four proximate indicators are set at the goal level and are prefixed with letter “R”. Thirteen IR-level indicators mainly measure access to services and are prefixed with letter “A”, while another thirteen IR-level indicators mainly measure quality of services and are prefixed with letter “Q”. Two IR-level indicators measure both access and quality and are prefixed with letters “AQ”. Over one third of USAID Health Service Delivery reportable indicators are either F or Mission indicators. Table A lists the 13 F and Mission indicators.

Table A: USAID Health Service Delivery Performance Indicators corresponding to F and Mission indicators
R4. Percent of Maternal Death Review Reports from maternal mortality surveillance and response (JMMSR) System analyzed by National Advisory Group with action plans developed to avert similar deaths (M 3.1.2.2.c)
Q3. Percent of women receiving Active Management of Third Stage of Labor protocol in USG supported sites (M 3.1.1.b)
Q5. Percent of women undergoing cesarean section receiving antibiotic prophylaxis according to protocol in USG supported sites (M 3.1.2.1.d)
Q9. Percent of neonates with respiratory distress managed according to protocol in USG supported sites (M 3.1.1.a)
Q11. Percent of children diagnosed with anemia managed according to protocol in USG supported sites (M 3.1.1.c)
Q12. Number of women giving birth who received Uterotonic in the third stage of labor (OR immediately after birth) through USG-supported programs (M 3.1.1.d) (HL6.2-1)

Table A: USAID Health Service Delivery Performance Indicators corresponding to F and Mission indicators

Q2. Number of pregnant women reached with nutrition interventions through USG-supported programs (<i>F HL.9-3/</i>)
A7. Percent of pregnant women assessed for high risk factors in first antenatal care visit in SDPs (<i>M 3.1.1.1.a</i>)
A8. Number of counseling visits for FP/RH as a result of USG assistance (<i>M 3.1.1.1.b</i>)
A12. Number of USG assisted community health workers (CHWs) providing family planning (FP), information, referrals and or services during the year (<i>M 3.1.1.2.d</i>) (<i>HL.7.2-2</i>)
A13. Percent of USG-assisted service delivery sites providing family planning (FP) counseling and/or services (<i>M 3.1.1.1.c</i>) (<i>HL.7.1-2</i>)
A14. Number of children under five (0-59 months) reached by USG-supported nutrition programs (<i>F HL.9-1</i>)
AQ2. Number of USG supported services delivery sites providing the Integrated Services Delivery Package (<i>M 3.1.2.b</i>)

Several of USAID Health Service Delivery's performance indicators are designed to measure the sustainability of interventions. Sustainability means that USAID Health Service Delivery's interventions have been institutionalized so that counterparts have the policies, processes, and resources in place to continue supporting improved health services and outcomes for women of reproductive age and children under 5 beyond the life of USAID Health Service Delivery. For instance, indicators related to the JMMSR system will show whether key counterparts are reporting data into the system and then using data from the system to inform improvements in service delivery that will contribute to preventing maternal deaths. The following indicators will help USAID Health Service Delivery to determine whether the JMMSR system is functioning properly and identify gaps in reporting or data use at the facility, HAD, or central MOH levels:

- **R4.** Percent of Maternal Death Review Reports from maternal mortality surveillance and response (JMMSR) System analyzed by National Advisory Group with action plans developed to avert similar deaths (*M 3.1.2.2.c*)
- **Q7.1.** Percent of deaths among women of reproductive age notified within 24 hours of death time
- **Q7.2.** Percent of health facilities notifying deaths among women of reproductive age or submitting zero-reports
- **Q8.** Percent of maternal death cases reviewed by the Directorate Advisory Group within one month of completion of household survey

Many of USAID Health Service Delivery's indicators related to service quality capture whether providers at SDPs in GFAs deliver services according to clinical pathways/procedures also measure sustainability of USAID Health Service Delivery activities. Building human resource capacity through developing clinical pathways and procedures and training of healthcare providers coupled with adequate follow-up through facility based supportive supervision and regular monitoring of achievements will lead to sustainable outcomes.

USAID outlined key expected results for USAID Health Service Delivery and indicators are designed to measure our contributions to these expected results.

It is important to note that several of these are high-level, national results. USAID Health Service Delivery will contribute to improvements in these areas, as will other donor-funded projects and MOH initiatives. However, changes in these results are not fully within USAID Health Service Delivery's control and USAID Health Service Delivery cannot measure its performance over the coming five years through these types of high-level results. Therefore, USAID Health Service Delivery has designed its performance indicators to align with contributions that USAID Health Service Delivery activities will make to achieve these expected results.

For example, under Result 6 "Reduction in newborn deaths throughout geographic focus areas," USAID Health Service Delivery interventions can only reasonably influence certain factors related to newborn deaths at the service delivery level in USAID Health Service Delivery intervention sites. Therefore, USAID Health Service Delivery will not measure national numbers of newborn deaths or the neonatal mortality rate as USAID Health Service Delivery performance indicators. Instead, USAID Health Service Delivery will measure its contributions to reductions in newborn deaths with the following indicators that directly link to its planned interventions:

- **RI.** Percent of neonates admitted to NICU discharged alive in GFA hospitals
- **Q9.** Percent of neonates with respiratory distress managed according to protocol in USG supported sites (M 3.1.1.a)
- **Q10.** Percent of neonates with sepsis managed according to clinical pathway in GFA hospitals

Similarly, Table B below illustrates how USAID Health Service Delivery indicators will measure the contributions to higher level results.

Table B. Distribution of USAID Health Service Delivery Indicators According to Activity Expected Results	
USAID Health Service Delivery Expected Results	Relevant USAID Health Service Delivery Indicators
1. Increase modern contraceptive prevalence rate (mCPR) nationwide	• R3. Number of Couple Years of Protection generated in service delivery points in geographic focus areas • A2. Percent of postpartum clients receiving counseling on modern FP methods before discharge from GFA Hospitals • Q1. Percent of clients who received family planning services according to the family planning quality of care index in SDPs in GFAs
2. Increase uptake of modern family planning methods through community outreach in geographic focus areas	• A3. Number of new family planning visits in in SDPs in GFAs • A6. Number of community health committees actively promoting RMNCH+ topics in GFAs

Table B. Distribution of USAID Health Service Delivery Indicators According to Activity Expected Results	
USAID Health Service Delivery Expected Results	Relevant USAID Health Service Delivery Indicators
	• A8. Number of counseling visits for FP/RH as a result of USG assistance (M 3.1.1.1.b) • A10. Number of RMNCH+ visits conducted by CHWs during Community Outreach visits • A11. Percent of Beneficiaries Acted upon RMNCH+ Referral during Community Outreach visits • A12. Number of USG assisted community health workers (CHWs) providing family planning (FP), information, referrals and or services during the year (M 3.1.1.2.d) (HL.7.2-2) • A13. Percent of USG-assisted service delivery sites providing family planning (FP) counseling and/or services (M 3.1.1.1.c) (HL.7.1-2)
3. Increase percentage of health facilities offering at least five modern contraceptive methods throughout geographic focus areas	• A1. Percent of Service Delivery Points in GFAs providing five modern methods including IUD and implants
4. Maternal mortality surveillance and response (JMMSR) system adopted and implemented nationwide	• R4. Percent of Maternal Death Review Reports from maternal mortality surveillance and response (JMMSR) System analyzed by National Advisory Group with action plans developed to avert similar deaths (M 3.1.2.2.c) • Q7.1. Percent of deaths among women of reproductive age notified within 24 hours of death time • Q7.2. Percent of health facilities notifying deaths among women of reproductive age or submitting zero-reports • Q8: Percent of maternal death cases reviewed by the Directorate Advisory Group within one month of completion of household survey

Table B. Distribution of USAID Health Service Delivery Indicators According to Activity Expected Results	
USAID Health Service Delivery Expected Results	Relevant USAID Health Service Delivery Indicators
5. Reduction in maternal deaths throughout geographic focus areas	• AQ1. Percent of pregnant women managed according to antenatal care clinical pathway in SDPs in GFAs • A7 Percent of pregnant women assessed for high risk factors in first antenatal care visit in SDP (3.1.1.1.a) • R2. Percent of women receiving blood during delivery or within 24 hours after delivery • Q3. Percent of women receiving Active Management of Third Stage of Labor protocol in USG supported sites (M 3.1.1.b) • Q4. Percent of women with pregnancy induced hypertension managed according to clinical pathway in GFA hospitals • Q12. Number of women giving birth who received Uterotonic in the third stage of labor (or immediately after birth) through USG-supported programs (M 3.1.1.d) (HL.6.2-1)
6. Reduction in newborn deaths throughout geographic focus areas	• R1. Percent of neonates admitted to NICU and discharged alive in GFA hospitals • Q9. Percent of neonates with respiratory distress managed according to protocol in USG supported sites (M 3.1.1.a) • Q10. Percent of neonates with sepsis managed according to clinical pathway in GFA hospitals
7. Reduction of maternal anemia throughout geographic focus areas	• AQ1. Percent of pregnant women managed according to antenatal care clinical pathway in SDPs in GFAs • Q2. Number of pregnant women reached with nutrition interventions through USG-supported programs (F HL.9-3/) • Q6. Percent of pregnant women diagnosed with anemia treated according to clinical pathway in SDPs in GFAs • A10. Number of RMNCH+ visits conducted by CHWs during Community Outreach visits • A11. Percent of Beneficiaries Acted upon RMNCH+ Referral during Community Outreach visits
8. Reduction of anemia in children under 5 throughout geographic focus areas	• A5. Percent of children under 5 screened for anemia in SDPs in GFAs

Table B. Distribution of USAID Health Service Delivery Indicators According to Activity Expected Results	
USAID Health Service Delivery Expected Results	Relevant USAID Health Service Delivery Indicators
	• A10. Number of RMNCH+ visits conducted by CHWs during Community Outreach visits • A11. Percent of Beneficiaries Acted upon RMNCH+ Referral during Community Outreach visits • Q11. Percent of children diagnosed with anemia managed according to protocol in USG supported sites (M 3.1.1.c) • A14. Number of Children under five (0-59 months) reached by USG-supported nutrition programs (F HL.9-1)
9. Increase percentage of mothers who initiate breastfeeding within the first hour of delivery throughout geographic focus areas.	• A4. Percent of women giving birth who initiate breastfeeding within the first hour of birth in GFA hospitals (M 3.1.1.2.b)
10. Increase number of SDPs providing preventive and quality integrated model of care services throughout geographic focus areas.	• AQ2. Number of USG supported services delivery sites providing the Integrated Services Delivery Package (M 3.1.2.b) • AQ1. Percent of pregnant women managed according to antenatal care clinical pathway in SDPs in GFAs

Indicator Baselines and Targets

Table 2 under Section 3 (Performance Indicator Tracking) lists the USAID Health Service Delivery indicators according to the agreement results with data sources, frequency of data collection, baseline values for FY16 covering 52 facilities and FY17 covering 76 facilities, actual results of FY17 and FY18 and targets for the Activity implementation.

The USAID Health Service Delivery 32 reportable indicators are described in the PIRS according to USAID requirements, with clear definitions, baseline assessments, and targets. USAID Health Service Delivery started with 52 SDPs in FY17 and baseline values for the indicators were collected in FY16. Based on this baseline, targets were established for FY17 indicators. In FY18 an additional 76 SDPs were added and a baseline for the new facilities was conducted. Starting FY19 USAID Health Service Delivery indicators' targets were revised based on the actual results of FY18 indicators and the baseline of the added SDPs. In FY19, 13 SDPs were added bringing the total to 141. Based on FY19 achievements, FY20 targets for some indicators were revised.

Data Quality Assurance and Data Quality Assessment (DQA) Procedures

USAID Health Service Delivery will manage its data collection, storage, analysis and reporting to ensure that the USAID Jordan Mission and other users have a high level of confidence in the data generated by the Activity.

To accomplish this goal, USAID Health Service Delivery will implement the following data quality assurance measures, consistent with the five USAID data quality standards – validity, reliability, precision, integrity and timeliness.

1. **Standardized Data Collection Processes and Tools:** USAID Health Service Delivery developed standard data collection tools, including templates and checklists, and provides clear, easy-to-follow instructions to counterparts directly involved in documenting and aggregating data. The USAID Health Service Delivery team has developed electronic data collection forms and uses tablets to collect standard indicators and indicator-related data. Electronic data collection tools have built with skips, quality checks and validation rules that minimize the possibility of missing data or data entry errors. The use of electronic data collection forms increases efficiency, as it reduces time needed for data entry, and increase data quality, as it allows for real-time data quality checks.
2. **M&E Systems:** USAID Health Service Delivery has built a web-based Decision Support System to aggregate, store and use data for monitoring. This system is available to all USAID Health Service Delivery staff to ensure that data is used in program management and will standardize the reporting of key indicators. In addition, DSS includes a web-based dashboard containing RMNCH+ key indicator data that is available to USAID Health Service Delivery staff as well as to central MOH, HADs, and SDP staff as appropriate. Furthermore, USAID Health Service Delivery produces real time pdf and excel reports for all indicators with disaggregation up to the SDP level. Moreover, separate reports are auto generated to produce all tables in DevResults format to ensure accurate transcription of data from relevant one way or two way tabulations. JMMSR and outreach electronic web-based systems produce real-time reports as required.
3. **M&E Capacity Building:** USAID Health Service Delivery has been developing and conducting internal M&E workshops and meetings for all technical USAID Health Service Delivery staff. They focus on explaining the Activity MEL Plan, the roles and responsibilities of all technical staff in monitoring and evaluating progress toward achieving targets, assessing and guiding activities, meeting internal and external reporting requirements, and contributing to Collaborating, Learning and Adapting. The Monitoring, Evaluation and Learning (MEL) Lead, and other technical staff, work closely with the USAID-funded MESP Activity to ensure optimal reporting of USAID Health Service Delivery results as well as attendance at technical M&E Community Sessions. Furthermore, M&E staff participate in workshops organized by MESP on regular basis.
4. **Performance Indicator Reference Sheets (PIRS):** The PIRS will be reviewed and updated on an annual basis, or as needed, to ensure that the data collection methods are still appropriate, assumptions about data limitations are still valid, and actions planned to address those limitations are still applicable.

5. Data Quality Assessment (DQA): Initial DQAs will be performed for every first and second-level performance indicator according to the plan as indicated in the PIRS. DQAs for the F and Mission indicators are conducted by the AOR.
6. Secure Data Storage: Soft and hard copies of data are being stored at USAID Health Service Delivery premises. Soft copies are stored on the Activity server with regular back-up, and hard copies are stored in a secure location. JMMSR servers are located at the MOH and outreach servers are located at the implementing partners premises. At close-out, soft copies will be transferred to Abt Associates home office server, and USAID Health Service Delivery will make plans to destroy all hard copies or ship them to the Abt Associates home office as appropriate.
7. Controlled Access to Data: In order to safeguard data, personnel have access to the data according to their technical needs and administrative seniority. The USAID Health Service Delivery Team developed an overarching Data Security Plan (DSP), designed to create effective administrative, technical, and physical safeguards for the protection of data. This DSP will safeguard and protect the information.
8. Ethical Approval: The USAID Health Service Delivery team will comply with ethical approval processes for research involving human subjects through the Abt Institutional Review Board (IRB) and Jordanian authorities, and obtain consent from all assessment and research study participants.

Reporting of Indicator Data

This section describes two categories of reports that USAID Health Service Delivery will produce to communicate M&E information to USAID/Jordan, including implementation progress and results. The first category includes contractually required reports – Quarterly Progress Reports, Annual Progress Reports and a Final Performance Report. The second category includes additional reports that may be requested by USAID/Jordan on an ad-hoc basis, as well as reports for any studies or evaluations.

USAID Health Service Delivery will provide Quarterly Progress Reports for the Mission and enter data on performance indicators into DevResults. At the end of each fiscal year, USAID Health Service Delivery will submit an annual performance report including a compilation of the year's actual achievements against targets for each indicator as well as explanatory narrative. The quarterly reports will provide details about any challenges encountered by USAID Health Service Delivery team that may result in delays in achievement of intended results and solutions proposed to address those challenges where appropriate. All reports are presented as drafts to the AOR before final submission. Once approved, reports for subsequent quarters will be used to document any changes required for results and data reported in previous reports. USAID Health Service Delivery will use standard templates for all reports submitted to USAID/Jordan.

The indicators' values and challenges outlined in the quarterly reports are shared with partners and form the foundation for preparing change packages for the next quarter.

All M&E reports produced by MEL team will be reviewed by the COP, DCOP and HQ prior to submission to ensure the quality of the content, format and adherence to the USAID/Jordan submission requirements.

Contractually required reports will include the following:

- Performance indicators relevant to the reporting period in question, and the status of each indicator against its established annual target, presented in the Outcomes Reporting Table.
- Analysis of key findings and factors that have affected performance (positive and negative).
- Reasons for not meeting established targets, if appropriate.
- Description of planned or taken corrective actions, if necessary.

Furthermore, USAID Health Service Delivery collects data on the annual indicators that are based on review of medical records quarterly to inform the implementation process and not for reporting purposes and they are not part of the annual indicators. The annual indicators are collected during the fourth quarter to reflect the maturity of interventions implemented over the previous several months.

Additional reports will include in depth topic-specific information. They will include a narrative of key findings and recommendations for the design of future programs. The narrative will be accompanied by tables and graphs to visually represent the data. Additional reports will be uploaded to the Development Experience Clearinghouse (DEC), USAID/Jordan's Knowledge Management Portal (KaMP) and, when applicable, de-identified datasets with supporting materials will be uploaded to the Development Data Library (DDL).

Roles and Responsibilities

The MEL Lead will be responsible for implementing all components of the Activity MEL Plan through the Activity interventions. COP, DCOP and Abt Associates home office will provide support to the MEL team as needed. The USAID Health Service Delivery team will ensure that all required data are recorded and reported in a timely manner, and that indicators are effectively capturing progress towards intervention goals.

Information Management

With reference to “ADS 203.3.3.1 g” USAID Health Service Delivery supports the Mission's efforts to maintain a performance monitoring information system that holds performance indicator data including data collected by this Activity MEL plan. The USAID Health Service Delivery MEL team will ensure timely and accurate reporting of data through the Mission's Management Information System (MIS) as required in the contract/agreement. In addition to the use of appropriate notes fields in the MIS, quarterly reports will also be used to track the details of reported indicator data and will also describe modifications to reported data in the MIS to data previously reported in the MIS and approved in quarterly reports in previous quarters. Where required, a designated staff member will regularly provide participant training-related information to TraiNet.

Reporting

The MEL Lead is in charge of producing the M&E reports on time, and in a technically valid, high-quality, and policy-relevant manner, with the purpose of providing firm grounds for management decisions. He is responsible for developing the electronic data collection tools to ensure that data is gathered in a technically sound manner, is consistent and can be compared throughout the years. He must make judgments with respect to whether or not data meets quality standards.

M&E Oversight

The MEL Lead is responsible for overseeing M&E activities, assuring that the work meets overall project needs and responds to Mission requests for information. Missions in high-visibility locations such as Jordan have frequent “data calls” and information requests, so assuring that our responses are policy- and decision-relevant is an important role.

Home Office Support

USAID Health Service Delivery receives technical support from the Home Office (HO) M&E staff. The essential services or responsibilities of the HO are to ensure that high standards are maintained and activities are consistent with best practices in the field. From start-up, the HO provides specialized assistance in finalizing the Activity MEL Plan, supporting evaluations, and offering specialized training to the USAID Health Service Delivery team, when needed.

Data Collection Methodologies

Overview of Data Collection Methods

In FY20, USAID Health Service Delivery will report on 32 indicators (Table 2) measuring access to and quality of RMNCH+ services:

- Three quarterly reported indicators that are based on all data collected monthly as aggregate data from each SDP (R3, A1 and A3). These indicators are primarily coming from primary healthcare facilities.
- Three quarterly reported indicators that are collected monthly based on all data from the web-based JMMSR system (Q7.1, Q7.2 and Q8)
- One annually reported indicator that is collected quarterly based on all data from the web-based JMMSR system (R4)
- Two semiannual indicators that are also based on all data and collected monthly as aggregate data from hospital logbooks (R1 and A2).
- Seven annual hospital-based indicators that are collected based on review of samples of medical records during quarter four (A4, Q3, Q4, Q5, Q9, Q10 and Q12).
- One annually reported hospital-based indicator that is based on all data and collected monthly as aggregate data from hospital and blood bank logbooks (R2).

- Seven primary healthcare-based annual indicators that are collected through reviewing samples of medical records during quarter four (AQ1, A5, A7, Q1, Q2, Q6 and Q11).
- Five annually reported indicators that are collected monthly based on all data coming from the outreach web-based information system (A8, A10, A11, A12 and A14)
- Three annual indicators that are collected based on documentation of activities that are required to meet the indicators (AQ2, A6 and A13).

USAID Health Service Delivery collects data electronically using tablets for all indicators except for three annual indicators (AQ2, A6, A13). Upon reviewing medical records, USAID Health Service Delivery does not collect any personally identifiable information.

USAID Health Service Delivery used Census and Survey Processing System (CSPro) software to design and revise the data collection tools except for JMMSR and outreach data. These tools have all necessary quality checks, skips, validation rules in order to minimize the possibility of data entry errors and nullify user missing data. CSPro has been developed and supported by the U.S. Census Bureau and ICF MACRO, the organization that implements the Demographic and Health Surveys (DHS). Funding for the development and maintenance of CSPro is primarily provided by USAID.

USAID Health Service Delivery field officers perform the data collection under supervision of immediate supervisors and the M&E team. Collected data is synced to a secure server on daily basis.

The USAID Health Service Delivery team has created a system that automatically aggregates data from all data collectors, creates data files in Stata software format. Since there are quality checks embedded in USAID Health Service Delivery's electronic data collection tools, few cases require additional cleaning by the M&E team. Cleaning is usually related to extreme values that require explanation. The M&E team developed customized programs using Stata software to automatically produce indicator reports with all necessary disaggregation up to SDP level in both PDF and Excel formats. In addition, the M&E team developed a separate Stata program to produce all tables in DevResults format to ensure accurate transcription of data from one way and two-way tabulations.

USAID Health Service Delivery collects data on JMMSR indicators (R4, Q7.1, Q7.2 and Q8) and outreach indicators (A8-A12, and A14) using web-based applications with centralized databases hosted on secure servers. USAID Health Service Delivery has built the applications using ASP.net with SQL databases. The applications are programmed to produce various types of reports including indicators with relevant disaggregation. The JMMSR data is collected from all hospitals and forensic medicine departments across Jordan and not limited to USAID Health Service Delivery geographic focus areas. Outreach workers collect data related to the outreach program during their house-to-house visits in all targeted districts having covering women of reproductive age and children under five.

Recording of data at time of occurrence has been utilized to collect data pertaining to some of the indicators. This type of data is collected during or immediately following implementation by and carried out either by USAID Health Service Delivery staff or by its beneficiary counterparts.

Such activities have definitive timeframes and include Integrated Service Delivery Improvement Collaborative (ISDIC) sessions, workshops, professional events, among others.

During FY17, USAID Health Service Delivery has improved documentation processes for many indicators through continuous coaching and by introducing new logbooks to capture the indicators' related data. During FY18 and FY19, USAID Health Service Delivery used the same approach for the added 89 SDPs.

Sampling for Annual Indicators Based on Review of Medical Records

USAID Health Service Delivery collects all data related to JMMSR system, outreach program and other quarterly and semiannual indicators using complete census data from all SDPs and these indicators do not require sampling at the SDP level. All annual indicators that are based on review of medical records require representative samples.

A more convenient and less time consuming cluster sampling is not suitable for collection of data from a sample of SDPs as primary sampling units. The data need to be collected from every single SDP in order to be used for planning purposes at each SDP during Integrated Services Delivery Improvement Collaborative (ISDIC) sessions. Therefore, within each SDP, USAID Health Service Delivery uses systematic random sampling of medical records based on the three months prior to data collection from the relevant logbook. In cases of conditions that are relatively rare, such as pregnancy induced hypertension and neonatal respiratory distress, USAID Health Service Delivery reviews records from all cases from the six months prior to data collection. The minimum sample size of medical records to be reviewed for each indicator was set at about 400. This sample size encompassed an alpha error of 0.05, a prevalence of 0.5 (assuming maximum variability) and a precision level of 0.05. Because of large number of SDPs at the primary healthcare level the sample size will be inflated by 2-4 times for better representation.

Starting FY18, the overall sample of medical records for each indicator was allocated in advance to individual SDPs depending on the size of the SDP related to individual indicators. To avoid small numbers allocated to SDPs with small size, USAID Health Service Delivery will does not use allocation proportionate to size. Instead, USAID Health Service Delivery uses allocation proportionate to square root or the allocation proposed by Kish(1988). Kish formula is based on an allocation proportional to $n = \sqrt{(W_h^2 + H^2)}$, where n is the overall sample size, W_h is the proportion of the size in SDP h and H is the number of SDPs. For every small SDP the second term dominates the first, thereby preventing allocations that are too small.

Gender and Other Vulnerable Groups M&E Section

The USAID/Jordan Country Development Cooperation Strategy (2013-2017) emphasizes the importance of gender and youth, and the Mission has adopted a development objective to address gender (DO4). USAID Health Service Delivery will mainstream gender throughout its work.

Whenever applicable and feasible, USAID Health Service Delivery will disaggregate indicators by sex, age groups, and nationality so that USAID Health Service Delivery can assess the extent to which its activities reach women, male and female youth, men (male engagement), and other target groups.

USAID Health Service Delivery target populations are women of reproductive age and children under 5, and interventions will rigorously monitor and evaluate the contributions to the well-being of these target groups. In addition, as USAID Health Service Delivery develops its work plans, it will assess the feasibility of conducting research and evaluations related to men's engagement in RMNCH+ services.

Evaluation, Assessment, Special Study and Other Learning Questions

USAID Health Service Delivery will cooperate with any planned Mission-led evaluation specific to USAID Health Service Delivery or the mission's larger health portfolio. In FY19, a midterm evaluation of USAID Health Service Delivery found no issues with current M&E system. Below is a description of completed and planned assessments.

Baseline Assessments

USAID Health Service Delivery designed and conducted two baseline assessments that covered intervention hospitals and primary healthcare clinics in three sectors (MOH, RMS and NGO). In FY16, USAID Health Service Delivery completed and reported the baseline results for 54 SDPs (Later two SDPs were dropped). This baseline was used to set the targets for USAID Health Service Delivery reportable indicators and to better understand the provision of RMNCH+ services in different facilities. The findings of the absence of a standardized approach for provision of services and reluctance of providers to document procedures was mitigated through the design and implementation of clinical pathways, procedures, logbooks and medical records in FY17.

A second baseline assessment was conducted during the third quarter of FY17 for a total of 76 new SDPs (Two SDPs were added after the baseline was conducted) to pinpoint facility-specific issues related to provision of RMNCH+ services and provide baseline values for various indicators to be used in the ISDIC sessions in FY18. The findings of the second baseline assessment along with the actual results of FY17 indicators were used to reset the targets starting FY18 for all of the 128 SDPs.

A third baseline assessment was conducted during Q1 of FY19 for an additional 13 SDPS bringing the total to 141 facilities.

Community Resource Mapping

USAID Health Service Delivery conducted a mapping of community resources available at SDPs and in their catchment areas in GFAs. This mapping used two tools, 1) the Community Resource Mapping tool, and 2) the Community Health Committee Assessment. This mapping informed the design of USAID Health Service Delivery's community engagement interventions.

Discontinuation of Modern Contraceptive Methods Study

In FY17, the USAID Health Service Delivery team worked with the MOH and NGOs to design and start implementation of a study to track discontinuation of modern family planning methods among about 2,500 FP clients in selected 32 health centers and NGO clinics. Enrollment of women was completed in mid-August, 2017. In close collaboration with the USAID Health Service Delivery, the MOH team followed the new acceptors of modern methods in selected

SDPs who agree to participate in the study every two months for one year. By the end of FY18, the USAID Health Service Delivery team completed the study and prepared a report on 12-month discontinuation rates for five modern contraceptive methods.

The results were disaggregated by type of method; interval (e.g. discontinuation by month, six months and one year); and reasons of programmatic importance for discontinuation including pattern of switching methods. Results of the study will be used by HADs, WCHD and NGOs to track their performance in providing quality counseling and to determine possible corrective measures. This study is expected to be repeated after three years of implementation of activities related to study recommendations.

Community Scorecard

USAID Health Service Delivery has worked with the Health Communications and Awareness Directorate (HCAD) and WCHD to design and implement a community scorecard as a tool to collect, channel client feedback and improve service quality. The community scorecards generated through community group interactions provided valuable feedback to service providers that was used for joint decision-making. This approach allowed communities to give systematic and constructive feedback to service providers about their performance. USAID Health Service Delivery assisted SDPs to incorporate feedback within their quarterly change packages.

Calendar of MEL Events

Table I. Calendar of MAIN MEL Events for FY 2020

Event	Date/Duration	Comments
Revision of Activity Monitoring, Evaluation, and Learning Plan including PIRs	October and November, 2019 with two M&E persons for three days and the time spent by the technical teams during discussions. (LOE of 10 person-days)	All PIRS were revised based on the actual results of FY19. Any change in the FY19 approved AMEL will be recorded in the change log annex.
Prepare the annual FY19 M&E report	October, 2019 with two people for 10 days (LOE of 20 person-days)	The report included an overview of Q4 results and annual achievements for all the FY19 reportable indicators.
DQA visits	Quarterly starting January, 2020 / one person, 2 one-day visits per quarter. (LOE of 8 person-days)	M&E staff will conduct these visits to ensure the quality of collected data and give feedback to technical teams.
Quarterly Reports Preparation	January 2020, April 2020, July 2020 with two persons for 10 days (Average LOE of 60 person-days)	M&E team, leads, and specialists with COP review.
Quarterly meetings with the technical teams and senior management	Every quarter for two days with participation of two MEL staff	To discuss the findings for each quarter, identify the challenges and ways to mitigate them.

Resources Required for MEL Plan Implementation

Following are the steps of MEL plan implementation:

- Technical teams prepare data collection forms that capture indicators and other important data related to the implementation of clinical pathways and procedures.
- Tools are discussed and finalized with MEL team, COP and DCOP.
- MEL team design the data collection forms in electronic format using CSPro software. Data related to JMMSR system and outreach program are designed with ASP.net using SQL databases by USAID Health Service Delivery management information system team.
- Electronic tools are loaded in tablets and pilot tested in the field after training of data collection staff.
- Electronic tools are revised and finalized based on the pilot testing.
- Some changes to the tools still happen during data collection based on the experience from the field.
- Data collected from the field is synced to a secure server. JMMSR and outreach are web-based applications.
- Data is aggregated from all data collectors and converted to Stata software format.
- Stata software is used to clean and analyze the data.
- All tabulations of indicators and related variable with disaggregation up to SDP level are produced automatically through special programing in Stata.
- MEL team receives reports from the JMMSR and outreach databases on monthly basis.
- MEL team regularly holds meetings with technical teams to discuss generated reports, issues, mitigation of issues and lessons learned.
- MEL team along with relevant supervisors monitor data collection in the field and conducts DQA for all indicators with immediate feedback.
- Targets are established and modified based on conducted baseline assessments and with participation of the senior leadership of the project including the COP and DCOP.
- MEL team timely produces and submits the quarterly and annual MEL reports to USAID as per the Agreement.
- Indicators and related information are shared with partners quarterly.
- MEL team participates in most of the training workshops organized by MESP project.

The MEL team is composed of three staff, the lead and two specialists. The team is responsible for building and revision of the electronic tools used for data collection using CSPro software except for data related to JMMSR and outreach systems that are web-based. The monitoring data on all indicators is collected using tablets that are synced on daily basis to a secure USAID Health Service Delivery server. Collected data is not restricted to indicators, but also include other variables related to implementation of clinical pathways. Data is collected from the field USAID Health Service Delivery and partners staff members who are supervised by their immediate

supervisors. USAID Health Service Delivery data collectors are mainly physicians nurses and pharmacists. All data collectors have enough clinical experience and participate in collaborative sessions and day to day coaching of providers.

All data collectors are subjected to training and pilot testing before the start of actual data collection. Furthermore, the electronic tools have a special section explaining the provided options for each question. Immediately, after syncing the collected data, the MEL team produces automatic reports that checks for the data quality focusing on extreme values.

When the data is considered cleaned, final reports on collected data is placed on a USAID Health Service Delivery public drive and becomes accessible to all relevant staff. Stata software is used in data analysis and automatic production of reports.

MEL team holds meetings with each group of data collectors and supervisors to discuss the findings of the reports. MEL team holds quarterly meetings with senior management staff and technical leads to present the findings of the previous quarter, identify issues and agree on mitigation plans.

Baseline data was collected for FY17, FY18 and FY19 SDPs prior to implementation. The same tools were used to collect indicator's' data throughout the lifetime of USAID Health Service Delivery. Quarterly MEL reports are prepared during the first two weeks after the end of the quarter and communicated to USAID as an Annex to the USAID Health Service Delivery quarterly report. Annual MEL reports are prepared during the first month following the end of the fiscal year and communicated to USAID as an attachment to the Annual report within three months after the end of Q4. Indicators are timely inputted in the DevResults on quarterly basis. All required DevResults data is auto generated in excel format to avoid errors during transcription of different tabulations. Indicators and related information are shared with partners (MOH, RMS and NGOs) on quarterly basis during ISDIC sessions and used to inform the change packages at each SDP.

Data quality checks are conducted in the field by the MEL team with immediate feedback to data collectors and their supervisors. USAID, PFH team leads the DQAs for Mission and F indicators. Electronic tools have built in skips, quality checks, validation rules with no probability of user missing fields in any tool.

3. PERFORMANCE INDICATOR TRACKING TABLE

Table 2. Indicators with basic definitions and targets

FY20 is the last complete year of implementation for USAID Health Service Delivery and accordingly, targets for FY21 are not provided.

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
USAID Health Service Delivery Goal: Improved Health Outcomes for Women of Reproductive Age and Children Under 5											
R1	Percent of neonates admitted to NICU discharged alive in GFA hospitals	This is a quantitative indicator that measures the percent of neonates with sepsis and respiratory distress who were discharged alive based on a sample of reviewed medical records.	Percent	Semiannual	Neonatal medical records of sepsis and neonatal respiratory distress	92.6% (N/A) (N/A)	88.5%	91.2%	95.3%	95%	FY20 target was set in FY19 AMEL and was not changed.
R2	Percent of women receiving blood during delivery or within 24 hours after delivery	This is a quantitative indicator that measures the percent of clients receiving blood transfusion or any blood components during vaginal delivery or within 24 hours after delivery.	Percent	Annual	Logbooks in the blood bank and the obstetric department	N/A (N/A) (N/A)	1.8%	2.4%	2.1%	Less than 2.5%	FY20 target was set in FY19 AMEL and was not changed. Based on literature about 3% of women with active management of the third stage of labor still develop postpartum hemorrhage that would require blood transfusion**.

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
R3	Number of Couple Years of Protection generated in service delivery points in geographic focus areas	This is a quantitative indicator that measures the number of CYP calculated from the modern contraceptive methods dispensed in SDPs in USAID Health Service Delivery GFAs. This is an internationally recognized quantitative indicator used by USAID to calculate the overall population effect of contraceptives dispensed through programs it supports.	Number	Quarterly	SDP monthly logistics reports	42,970 (66,304) (N/A)	49,540	125,506	141,655	145,000	FY20 target was revised taking into consideration the actual FY19 result (141,655).
R4	Percent of Maternal Death Review Reports from maternal mortality surveillance and response (JMMSR) system analyzed by National Advisory Group with action plans developed to avert similar deaths (M 3.1.2.2.c)	This is a quantitative indicator that measures the percent of all of Maternal Death Review reports analyzed by the NAG with recommendations to inform action plans developed to avert similar maternal deaths. The MDR reports are produced by health affairs directorates	Percent	Annual	Newly developed JMMSR documentation and review forms	N/A	N/A	62.5%	61.4%	100%	FY20 target was set in FY19 AMEL and was not changed.

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
		and reported to the MOH NCDD.									
RI: Expanded Availability and Access to Integrated RMNCH+ Services											
A1	Percent of Service Delivery Points in GFAs providing five modern methods including IUD and implants	This is a quantitative indicator that measures the percent of SDPs in USAID Health Service Delivery GFAs that provide five modern contraceptive methods at a given point in time. Modern contraceptive methods calculated within this indicator are: IUD, hormonal implants, hormonal injectables, oral contraceptive pills and male condoms.	Percent	Quarterly	SDP monthly logistics reports and MOH HMIS	0% (27.7%) (N/A)	41.2%	83.2%	87.2%	90%	FY20 target was set in FY19 AMEL and was not changed.
A2	Percent of postpartum clients receiving counseling on modern FP methods before discharge from GFA Hospitals	This is a quantitative indicator that measures the percent of postpartum clients who received family planning counseling before discharge from a hospital in a GFA, as registered in logbooks in the postpartum wards and reported to the MOH Women and	Percent	Semiannual	Postpartum ward monthly reports	26% (59%) (N/A)	75.8%	75.4%	85.1%	90%	FY20 target was set in FY19 AMEL and was not changed.

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
		Child Health Directorate.									
A3	Number of new family planning visits in SDPs in GFAs	This is a quantitative indicator that measures the number of new clients seeking family planning information or services from MOH and NGO clinics.	Number	Quarterly	MCH logbooks and equivalent registers or forms in NGOs or other clinics	18,204 (29,911) (N/A)	22,936	55,317	55,923	60,000	FY20 target was revised taking into consideration the actual result of FY19 (55,923).
A4	Percent of women giving birth who initiate breastfeeding within the first hour of birth in GFA hospitals (M 3.1.1.2.b)	This is a quantitative indicator that measures the percent of clients giving birth through vaginal delivery in hospitals in USAID Health Service Delivery GFAs who apply skin to skin contact and initiate breastfeeding within the first hour of birth.	Percent	Annual	A sample of patient medical records	20% (7%) (41.7%)	87.9%	88.9%	99.2%	98%	FY20 target was revised taking into consideration the actual FY19 result (99%).
A5	Percent of children under 5 screened for anemia in SDPs in GFAs	This is a quantitative indicator that measures the percent of children under 5 years of age at MOH and NGO clinics in USAID Health Service Delivery GFAs screened for anemia.	Percent	Annual	Child health medical records at MOH and NGO clinics in GFAs	42% (47%) (0%)	89.4%	87.1%	95.2%	95%	FY20 target was set in FY19 AMEL and was not changed.

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
A6	Number of community health committees actively promoting RMNCH+ topics in GFAs	This is a quantitative indicator that measures the number of community health committees within USAID Health Service Delivery GFAs promoting the ISD package of reproductive, maternal, neonatal and child health (RMNCH+) services provided at SDPs. A community health committee is considered active in promoting RMNCH+ topics if it meets the following criteria: • Develop annual action plan covering at least three topics in the RMNCH+ package. • Implement at least 60% of annual planned activities as defined in its annual plan. • Participate in ISDIC technical sessions with SDPs.	Number	Annual	The annual plans and reports generated by the community health committees within USAID Health Service Delivery GFAs	0	28	60	80	80	FY20 target was set in FY19 AMEL and was not changed.

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
A7	Percent of pregnant women assessed for high risk factors in first antenatal care visit in SDP (M 3.1.1.1.a)	Percent of pregnant women assessed for high risk factors during their 1st antenatal care visit of pregnancy in primary healthcare service delivery points in USAID Health Service Delivery GFAs. Currently, the Copeland Score is used to assess high risk factors for pregnant women. A client is considered assessed for high risk if she is registered at the Maternal Child Health (MCH) center, her pregnancy is assessed for risk during her first antenatal visit to the health center, and the assessment result is documented in the clinic's daily antenatal care logbook.	Percent	Annual	Medical records of pregnant clients in SDPs in the USAID Health Service Delivery GFA	86% (60%) (21.6%)	93.3%	97.1%	99.4%	100%	FY20 target was set in FY19 AMEL and was not changed.
A8	Number of counseling visits for FP/RH as a result of USG assistance (M 3.1.1.1.b).	This indicator aggregates the number of household visits of Women of Reproductive Age made by community health workers (CHWs) where FP	Number	Annual	Daily entered data uploaded to the secured USAID Health Service Delivery server	N/A	N/A	153,055	212,632	150,000	FY20 target was revised taking into consideration the following: • The actual FY19 result (212,632) with three implementing partners

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
		awareness messages are delivered during the RMNCH+ Community Outreach program with USAID Health Service Delivery support. The outreach program is conducted by implementing partners in assigned USAID Health Service Delivery districts. Household visit target all women of reproductive age..									operating for 12 months. • In FY20, one implementing partner will be in place for three months and the remaining two implementers will be operating for 10 months.
A10	Number of RMNCH+ visits conducted by CHWs during the RMNCH+ Community Outreach Program.	This is a quantitative indicator that measures the number of visits conducted by community health workers (CHWs) during the RMNCH+ Community Outreach program, where a visit is defined as an RMNCH+ awareness session for each beneficiary. Beneficiaries are classified according to the RMNCH+ health service that they might need.	Number	Annual	Daily entered data uploaded to the secured USAID Health Service Delivery server	N/A	N/A	259,569	404,716	290,000	FY20 target was revised taking into consideration the following: • The actual FY19 result (404,716) with three implementing partners operating for 12 months; • In FY20, one implementing partner will be in place for three months and the remaining two implementers will be operating for 10 months.

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
A11	Percent of Beneficiaries Acted upon RMNCH+ Referral during RMNCH+ Community Outreach Program.	This is a quantitative indicator that measures the percent of beneficiaries visited by CHWs during the RMNCH+ Community Outreach Program household visits who were referred and acted upon the referral to seek service for RMNCH+ at MOH or private providers (for profit/NGO) who are participating in USAID Health Service Delivery activities. Referral in the context of this indicator is defined as a verbal directing of clients in need for certain services to the health facilities in the catchment area.	Percent	Annual	Daily entered data uploaded to the secured USAID Health Service Delivery server	N/A	N/A	44.4%	66.9%	65%	FY20 target was revised taking into consideration the actual FY19 result (67%).
A12	Number of USG assisted community health workers (CHWs) providing family planning (FP), information, referrals and or services during	This is a quantitative indicator that aggregates the number of community health workers who will conduct the household visits during the RMNCH+	Number	Annual	Subcontract agreement with implementing partners	N/A	N/A	106	168	163	FY20 target was revised taking into consideration the number of CHWs that will be in place by the end of period of performance.

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
	the year (M 3.1.1.2.d) (HL.7.2-2).	Community Outreach Program.									
A13	Percent of USG-assisted service delivery sites providing family planning (FP) counseling and/or services (M 3.1.1.1.c) (HL.7.1-2)	This is a quantitative indicator that measures the number of USG supported service delivery points (SDPs) within USAID Health Service Delivery Geographic Focus Areas (GFAs) provided family planning (FP) counseling and/or services.	Percent	Annual	MOH and NGO logbooks	N/A	N/A	100%	100%	100%	FY20 target was set in FY19 AMEL and was not changed.
A14	Number of Children under five (0-59 months) reached by USG-supported nutrition programs (F HL.9-1)	This is a quantitative indicator that measures the number of children reached through USG supported nutrition programs within USAID Health Service Delivery GFAs. A child will be counted as reached if s/he receives one of the following behavior change communication interventions that promote essential infant and young child feeding behaviors including nutrition-specific interventions	Number	Annual	The compiled data files of the community outreach program which are stored on secure servers	N/A	N/A	57,181	64,135	45,000	FY20 target was revised taking into consideration the following: • The actual FY19 result (64,135) with three implementing partners operating for 12 months. • In FY20, one implementing partner will be in place for three months and the remaining two implementers will be operating for 10 months.

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
		through the mother/caretaker: • Immediate, exclusive, and continued breastfeeding • Appropriate, adequate and safe complementary foods from 6 to 24 months of age									
R2: Improved Quality of Integrated RMNCH+ Services											
Q1	The percent of clients who received family planning services according to the family planning quality of care index in SDPs in GFAs.	This is a composite quantitative indicator that measures key dimensions of the quality of family planning care as documented in maternal medical records at MOH and NGO clinics. This composite indicator includes the following criteria, each of which is assigned a percent value. The values add up to a total of 100%. If the record shows 100% compliance, it will be considered as meeting quality of care standards.	Percent	Annual	Family planning medical records at SDPs in GFAs	0% (16%) (20.2%)	96.6%	95.1%	98.4%	99%	FY20 target was set in FY19 AMEL and was not changed.

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
Q2	Number of pregnant women reached with nutrition interventions through USG-supported programs (F HL.9-3/)	This is a quantitative indicator that measures the projected number of pregnant woman if she receives one or more of the following interventions: 1. Iron and folic acid supplementation 2. Counseling on maternal and/or child nutrition	Number	Annual	The aggregated data file from all participating facilities which is stored on a secure server.	N/A	N/A	26,685	30,134	32,000	FY20 target was set in FY19 AMEL and was not changed.
Q3	Percent of women receiving Active Management of Third Stage of Labor protocol in USG supported sites (M 3.1.1.b)	This is a quantitative indicator that measures the percent of clients delivering in GFA hospitals who receive active management of the third stage of labor (AMTSL) according to clinical pathway (protocol). A client is managed according to the AMTSL clinical pathway if she receives 10 international units of oxytocin.	Percent	Annual	Hospital medical records	29% (55%) (88%)	97.4%	97.6%	100%	99%	FY20 target was set in FY19 AMEL and was not changed.
Q4	Percent of women with pregnancy induced hypertension managed	This is a quantitative indicator that measures the percent of pregnancy induced hypertension (PIH)	Percent	Annual	Hospital medical records of clients with PIH	57% (76%) (N/A)	98.7%	99.2%	99.7%	99%	FY20 target was set in FY19 AMEL and was not changed.

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
	according to clinical pathway in GFA hospitals	clients managed with loading and maintenance dose of magnesium sulfate according to clinical pathway (protocol).									
Q5	Percent of women undergoing cesarean section receiving antibiotic prophylaxis according to protocol in USG supported sites (M 3.1.2.1.d)	This is a quantitative indicator that measures the percent of clients undergoing cesarean section receiving antibiotic prophylaxis according to clinical pathway (protocol) in GFA hospitals. Adherence to clinical pathway requires that all the following criteria are met: • Administration of correct antibiotic at the correct time: within 60 minutes of incision. • Lack of administration of any additional antibiotics for prophylaxis.	Percent	Annual	Hospital medical records/ Medication administration records or anesthesia templates	19.9% (5%) (5.6%)	60.6%	64.7%	82.6%	80%	FY20 target was revised taking into consideration the actual FY19 result (83%).
Q6	Percent of pregnant women diagnosed with anemia treated according to clinical pathway in SDPs in GFAs	This is a quantitative indicator that measures the percent of pregnant clients diagnosed with anemia in MOH and NGO clinics receiving treatment	Percent	Annual	Medical records of pregnant clients in MOH and NGO clinics	0% (0%) (3.5%)	78.4%	58.6%	78.1%	80%	FY20 target was revised taking into consideration the actual FY19 result (78%).

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
		for anemia according to a clinical pathway with the following criteria met: • Treatment documented • Follow-up hemoglobin test documented • Client is referred to specialist if hemoglobin is less than or equal to 7 g/dL • The correct dose of iron treatment documented • Counseling on nutrition and iron intake documented									
Q7.1	Percent of deaths among women of reproductive age notified within 24 hours of death time	Bylaw 10 of the Public Health Law mandates that health facilities notify their respective health affairs directorates of deaths among women of reproductive age (15 – 49 years of age) within 24 hours of the time of death. Health facilities include all hospitals and forensic medicine department from all health sectors nationwide.	Percent	Quarterly	Newly developed JMMSR documentation and review forms	0%	N/A	43.7%	47.8%	60%	FY20 target was revised taking into consideration the actual FY19 result (51%).

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
		This indicator aims to measure the percent of health facilities successfully performing the notification step in JMMSR system implementation.									
Q7.2	Percent of health facilities notifying deaths among women of reproductive age or submitting zero-reports	This indicator aims to measure the active surveillance. Active surveillance requires zero-reporting in addition to the reporting of any death of women of reproductive age or reporting no death (zero reporting), for that health facility staff report "zero" for days in which no death of a women of reproductive age occurred or was received at their facility. Health facilities include all hospitals and forensic medicine department from all health sectors nationwide.	Percent	Quarterly	Newly developed JMMSR documentation and review forms	0%	N/A	82.1%	91%	95%	FY20 target was set in FY19 AMEL and was not changed.
Q8	Percent of maternal death cases reviewed by the	All maternal deaths identified must be reviewed by the Directorate Advisory	Percent	Quarterly	Newly developed JMMSR documentatio	0%	N/A	66.7%	88.9%	100%	FY20 target was set in FY19 AMEL and was not changed.

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
	Directorate Advisory Group within one month of completion of household survey	Group (DAG) after completion of Maternal Death Review Forms (Facilities/Households) and within one month of completion of household survey.			n and review forms						
Q9	Percent of neonates with respiratory distress managed according to protocol in USG supported sites (M 3.1.1.a)	This is a quantitative indicator that measures the percent of neonates with respiratory distress in NICU wards in GFAs hospitals who received non-invasive ventilator support according to clinical pathway (protocol) and fulfilling the following criteria: • Neonate initially assessed for sign of respiratory distress • Any neonate with mild to moderate respiratory distress initiated on non-invasive ventilator support according to clinical pathway. • Neonate placed on non-invasive ventilator support and is monitored	Percent	Annual	USAID Health Service Delivery GFA Hospital NICU medical records including forms to measure compliance with this clinical pathway	0% (1.4%) (0%)	75.8%	92.2%	94.8%	95%	FY20 target was set in FY19 AMEL and was not changed.

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
		regularly every 30 minutes for first two hours according to clinical pathway									
Q10	Percent of neonates with sepsis managed according to clinical pathway in GFA hospitals	This is a quantitative indicator that measures the percent of neonates with sepsis in NICU wards in USAID Health Service Delivery Focus Geographical Area (GFA) hospitals that received care according to clinical pathway and fulfilling the following criteria: • Cultures are ordered for suspected cases • Antibiotic of choice administered immediately after culture samples are collected • Antibiotic modified according to culture result • Completing antibiotic course appropriately	Percent	Annual	USAID Health Service Delivery GFA Hospital NICU medical records including forms to measure compliance with this protocol	84% (75%) (26.1%)	92.5%	94.8%	98.4%	99%	FY20 target was revised taking into consideration the actual result of FY19 (98%)
Q11	Percent of children diagnosed with anemia managed	This is a quantitative indicator that measures the percent of children	Percent	Annual	Medical records of children in SDPs in the	0% (5%) (0%)	68.7%	78.1%	83.2%	90%	FY20 target was set in FY19 AMEL and was not changed.

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
	according to protocol in USG supported sites (M 3.1.1.c)	under 5 who are diagnosed with anemia in primary health care SDPs in USAID Health Service Delivery GFAs who received treatment for anemia according to the clinical pathway (protocol) with all of the following criteria met: • Treatment documented • Follow-up hemoglobin test documented • Child is referred to specialist if hemoglobin is less than or equal 7 g/dL			USAID Health Service Delivery GFA						
Q12	Number of women giving birth who received Uterotonic in the third stage of labor (OR immediately after birth) through USG-supported programs (M 3.1.1.d) (HL.6.2-1)	This is a quantitative indicator that measures the number of women who gave birth in the last year who received an Uterotonic in the third stage of labor (or immediately after birth). Oxytocin is the only Uterotonic used in Jordan while misoprostol is not available.	Number	Annual	Hospital medical records.	N/A	N/A	53,509	58,011	62,000	FY20 target was revised taking into consideration the actual FY19 result (58,011).

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
AQ1	Percent of pregnant women managed according to antenatal care clinical pathway in SDPs in GFAs	This is a composite indicator that measures multiple dimensions of the quality of antenatal care. From review of a sample of medical records, the percent of pregnant clients in MOH and NGO clinics managed according to the antenatal clinical pathway with evidence of all the following criteria met: • Screened for anemia • Screened for high risk pregnancy • Blood pressure monitored • Supplemental iron and folic acid provided • Weight gain monitored Client counseled on family planning, nutrition, and breastfeeding	Percent	Annual	Medical records of pregnant clients in SDPs in the USAID Health Service Delivery GFA	6% (0.2%) (1.4%)	62.2%	76.3%	90.1%	90%	FY20 target was revised taking into consideration the actual FY19 result (90%).
AQ2	Number of USG supported services delivery sites providing the Integrated Services Delivery	This is a quantitative indicator that measures the number of USG supported SDPs within USAID Health	Number	Annual	The change packages developed by SDPs, quarterly meeting	0	52	128	141	141	FY20 target was revised taking into consideration the actual number in FY19, given that no new SDPs will be added in FY20.

#	Indicator	Definition	Unit of Measure	Reporting Frequency	Data Source	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Actual FY17	Actual FY18	Actual FY19	Target FY20	Target Justification
	Package (M 3.1.2.b)	Service Delivery GFAs enrolled in the USAID Health Service Delivery ISDIC. An SDP will be considered providing the ISD Package if it is: • Participating in the quarterly technical collaborative sessions • Developing Change Packages to address gaps • Generating data to report on progress on quarterly basis			reports/minutes, and data reports						

* 2016 Baseline was conducted for 52 FY17 SDPs. 2017 baseline was conducted for the additional 76 FY18 facilities and 2018 baseline was conducted for the additional 13 FY19.

** Janice M. Anderson and Duncan Etches, Prevention and Management of Postpartum Hemorrhage, American Academy of Family Physician 2007;75:875-82 ([HTTP://WWW.AAFP.ORG/AFP/2007/0315/P875.HTML](http://www.aafp.org/afp/2007/0315/p875.html))

Table 3. Performance Data Table with baselines and targets and results

#	Indicator	Disaggregation	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Value for Q4 FY 19	Q4 FY19 Comments	FY19 Target	FY19 Actual	FY20 Target	Actual to Date
R1	Percent of neonates admitted to NICU discharged alive in GFA hospitals	- Geographic location - Governorate - Nationality - Jordanian - Syrian - Other - Facility Sector - MOH - RMS - Other - Numerator - Denominator	92.6% (N/A) (N/A)	96.7%	Indicator's value was within $\pm 10\%$ of the target.	94%	95.3%	95%	95.3%
R2	Percent of women receiving blood during delivery or within 24 hours after delivery	- Geographic location - Governorate - Cause for transfusion - Postpartum hemorrhage - Anemia on admission - Other causes - Facility Sector - MOH - RMS - Other - Numerator - Denominator	N/A (N/A) (N/A)	Annual Indicator		Less than 2.5%	2.1%	Less than 2.5%	2.1%
R3	Number of Couple Years of Protection generated in service delivery points in geographic focus areas	- Geographic location - Governorate - Facility Sector - MOH - RMS - NGOs - Private - Other - Facility Type - Hospital - Health Center	42,970 (66,304) (N/A)	39,993	Indicator's value was above 10% of the target.	130,000	141,655	145,000	141,655

#	Indicator	Disaggregation	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Value for Q4 FY 19	Q4 FY19 Comments	FY19 Target	FY19 Actual	FY20 Target	Actual to Date
R4	Percent of Maternal Death Review Reports from maternal mortality surveillance and response (JMMSR) system analyzed by National Advisory Group with action plans developed to avert similar deaths (M 3.1.2.2.c)	- Geographic location - Governorate - Facility Type - Hospital - Forensic Medicine Department - Facility Sector - MOH - RMS - NGO - Private - Other - Numerator - Denominator	0%	Annual Indicator		100%	61.4%	100%	61.4%
A1	Percent of Service Delivery Points in GFAs providing five modern methods including IUD and implants	- Geographic location - Governorate - Facility Sector - MOH - NGOs - Other - Numerator - Denominator	0% (27.7%) (N/A)	86.6%	Indicator's value was within $\pm 10\%$ of the target.	85%	87.2%	90%	87.2%
A2	Percent of postpartum clients receiving counseling on modern FP methods before discharge from GFA Hospitals	- Geographic location - Governorate - Facility Sector - MOH - RMS - Other - Numerator - Denominator	26% (59%) (N/A)	85.7%	Indicator's value was within $\pm 10\%$ of the target.	80%	85.1%	90%	85.1%
A3	Number of new family planning visits in SDPs in GFAs	- Geographic location - Governorate - Facility Sector - MOH - NGOs - Other	18,204 (29,911) (N/A)	14,811	Indicator's value was within $\pm 10\%$ of the target.	65,000	55,923	60,000	55,923

#	Indicator	Disaggregation	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Value for Q4 FY 19	Q4 FY19 Comments	FY19 Target	FY19 Actual	FY20 Target	Actual to Date
A4	Percent of women giving birth who initiate breastfeeding within the first hour of birth in GFA hospitals (M 3.1.1.2.b)	- Geographic location - Governorate - Nationality - Jordanian - Syrian - Other - Facility Sector - MOH - RMS - Other - Numerator - Denominator	20% (7%) (41.7%)	Annual Indicator		93%	99.2%	98%	99.2%
A5	Percent of children under 5 screened for anemia in SDPs in GFAs	- Geographic location - Governorate - Facility Sector - MOH - NGOs - Other - Nationality - Jordanian - Syrian - Other - Numerator - Denominator	42% (47%) (0%)	Annual Indicator		90%	95.2%	95%	95.2%
A6	Number of community health committees actively promoting RMNCH+ topics in GFAs	- Geographic location - Governorate	0	Annual Indicator		80	80	80	80

#	Indicator	Disaggregation	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Value for Q4 FY 19	Q4 FY19 Comments	FY19 Target	FY19 Actual	FY20 Target	Actual to Date
A7	Percent of pregnant women assessed for high risk factors in first antenatal care visit in SDP (M 3.1.1.1.a)	- Geographic location - Governorate - Facility Sector - MOH - NGOs - Other - Nationality - Jordanian - Syrian - Other - Age Group - Youth 10-17 - Youth 18-29 - Adult 30-49 - Adult 50 and above - Numerator - Denominator	86% (60%) (21.6%)	Annual Indicator		95%	99.4%	100%	99.4%
A8	Number of counseling visits for FP/RH as a result of USG assistance (M 3.1.1.1.b).	- Geographic location - Governorate - Nationality - Jordanian - Syrian - Other - Age Group - Youth 10-17 - Youth 18-29 - Adult 30-49 - Adult 50 and above	N/A	Annual Indicator		247,000	212,632	150,000	212,632

#	Indicator	Disaggregation	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Value for Q4 FY 19	Q4 FY19 Comments	FY19 Target	FY19 Actual	FY20 Target	Actual to Date
A10	Number of RMNCH+ visits conducted by CHWs during the RMNCH+ Community Outreach Program.	- Geographic location - Governorate - Nationality - Jordanian - Syrian - Other - Age Group - Infant <1 year - Child 1-5 years - Youth 10-17 - Youth 18-29 - Adult 30-49 - Adult 50 and above - Beneficiary Profile - ANC - PNC - Married women of reproductive age - Unmarried Women of reproductive age - Children under 5	N/A	Annual Indicator		420,000	404,716	290,000	404,716
A11	Percent of Beneficiaries Acted upon RMNCH+ Referral during RMNCH+ Community Outreach Program.	- Geographic location - Governorate - Nationality - Jordanian - Syrian - Other - Age Group - Infant <1 year - Child 1-5 years - Youth 10-17 - Youth 18-29 - Adult 30-49 - Adult 50 and above - Numerator - Denominator	N/A	Annual Indicator		45%	66.9%	65%	66.9%

#	Indicator	Disaggregation	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Value for Q4 FY 19	Q4 FY19 Comments	FY19 Target	FY19 Actual	FY20 Target	Actual to Date
A12	Number of USG assisted community health workers (CHWs) providing family planning (FP), information, referrals and or services during the year (M 3.1.1.2.d) (HL.7.2-2)	- Sex - Male - Female	N/A	Annual Indicator		181	168	163	168
A13	Percent of USG-assisted service delivery sites providing family planning (FP) counseling and/or services (M 3.1.1.1.c) (HL.7.1-2)	- Geographic location - Governorate - Facility Sector - MOH - RMS - NGOs - Other - Facility Type - Hospital - Health Center - Numerator - Denominator	N/A	Annual Indicator		100%	100%	100%	100%
A14	Number of Children under five (0-59 months) reached by USG-supported nutrition programs (F HL.9-1)	- Geographic location - Governorate - Sex - Male - Female	N/A	Annual Indicator		75,000	64,135	45,000	64,135
Q1	The percent of clients who received family planning services according to the family planning quality of care index in SDPs in GFAs.	- Geographic location - Governorate - Facility Sector - MOH - NGOs - Other - Nationality - Jordanian - Syrian - Other - Numerator - Denominator	0% (16%) (20.2%)	Annual Indicator		95%	98.4%	99%	98.4%

#	Indicator	Disaggregation	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Value for Q4 FY 19	Q4 FY19 Comments	FY19 Target	FY19 Actual	FY20 Target	Actual to Date
Q2	Number of pregnant women reached with nutrition interventions through USG-supported programs (F HL.9-3/)	- Geographic location - Governorate	N/A	Annual Indicator		29,000	30,134	32,000	30,134
Q3	Percent of women receiving Active Management of Third Stage of Labor protocol in USG supported sites (M 3.1.1.b)	- Geographic location - Governorate - Facility Sector - MOH - RMS - Other - Nationality - Jordanian - Syrian - Other - Age Group - Youth 10-17 - Youth 18-29 - Adult 30-49 - Adult 50 and above - Numerator - Denominator	29% (55%) (88%)	Annual Indicator		99%	100%	99%	100%
Q4	Percent of women with pregnancy induced hypertension managed according to clinical pathway in GFA hospitals	- Geographic location - Governorate - Facility Sector - MOH - RMS - Other - Nationality - Jordanian - Syrian - Other - Numerator - Denominator	57% (76%) (N/A)	Annual Indicator		98%	99.7%	99%	99.7%

#	Indicator	Disaggregation	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Value for Q4 FY 19	Q4 FY19 Comments	FY19 Target	FY19 Actual	FY20 Target	Actual to Date
Q5	Percent of women undergoing cesarean section receiving antibiotic prophylaxis according to protocol in USG supported sites (M 3.1.2.1.d)	- Geographic location - Governorate - Facility Sector - MOH - RMS - Other - Nationality - Jordanian - Syrian - Other - Age Group - Youth 10-17 - Youth 18-29 - Adult 30-49 - Adult 50 and above - Numerator - Denominator	19.9% (5%) (5.6%)	Annual Indicator		68%	82.6%	80%	82.6%
Q6	Percent of pregnant women diagnosed with anemia treated according to clinical pathway in SDPs in GFAs	- Geographic location - Governorate - Facility Sector - MOH - NGOs - Other - Nationality - Jordanian - Syrian - Other - Numerator - Denominator	0% (0%) (3.5%)	Annual Indicator		64%	78.1%	80%	78.1%

#	Indicator	Disaggregation	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Value for Q4 FY 19	Q4 FY19 Comments	FY19 Target	FY19 Actual	FY20 Target	Actual to Date
Q7.1	Percent of deaths among women of reproductive age notified within 24 hours of death time	- Geographic location - Governorate - Facility Type - Hospital - Forensic Medicine Department - Numerator - Denominator	0%	51.1%	Indicator's value was more than 10% below of the target. Deaths taking place over weekends and holidays cannot be notified within 24 hours due to shortages in human resources.	65%	47.8%	60%	47.8%
Q7.2	Percent of health facilities notifying deaths among women of reproductive age or submitting zero-reports	- Geographic location - Governorate - Facility Type - Hospital - Forensic Medicine Department - Numerator - Denominator	0%	96.9%	Indicator's value was within $\pm 10\%$ of the target.	90%	91%	95%	91%
Q8	Percent of maternal death cases reviewed by the Directorate Advisory Group within one month of completion of household survey	- Geographic location - Governorate - Numerator - Denominator	0%	87.5%	Indicator's value was more than 10% below of the target. The DAGs managed to review seven out of eight cases within one month of completion of the household surveys.	100%	88.9%	100%	88.9%

#	Indicator	Disaggregation	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Value for Q4 FY 19	Q4 FY19 Comments	FY19 Target	FY19 Actual	FY20 Target	Actual to Date
Q9	Percent of neonates with respiratory distress managed according to protocol in USG supported sites (M 3.1.1.a)	- Geographic location - Governorate - Facility Sector - MOH - RMS - Other - Nationality - Jordanian - Syrian - Other - Numerator - Denominator	0% (1.4%) (0%)	Annual Indicator		95%	94.8%	95%	94.8%
Q10	Percent of neonates with sepsis managed according to clinical pathway in GFA hospitals	- Geographic location - Governorate - Facility Sector - MOH - RMS - Other - Nationality - Jordanian - Syrian - Other - Numerator - Denominator	84% (75%) (26.1%)	Annual Indicator		95%	98.4%	99%	98.4%
Q11	Percent of children diagnosed with anemia managed according to protocol in USG supported sites (M 3.1.1.c)	- Geographic location - Governorate - Facility Sector - MOH - NGOs - Other - Nationality - Jordanian - Syrian - Other - Age Group - Infant <1 year - Child 1-5 years - Numerator - Denominator	0% (5%) (0%)	Annual Indicator		84%	83.2%	90%	83.2%

#	Indicator	Disaggregation	Baseline FY16 Baseline (FY17) Baseline (FY18)*	Value for Q4 FY 19	Q4 FY19 Comments	FY19 Target	FY19 Actual	FY20 Target	Actual to Date
Q12	Number of women giving birth who received Uterotonic in the third stage of labor (OR immediately after birth) through USG-supported programs (M 3.1.1.d)(HL.6.2-1)	- Geographic location - Governorate - Facility Sector - MOH - RMS - Other - Numerator - Denominator	N/A	Annual Indicator		60,000	58,011	62,000	58,011
AQ1	Percent of pregnant women managed according to antenatal care clinical pathway in SDPs in GFAs	- Geographic location - Governorate - Facility Sector - MOH - NGOs - Other - Nationality - Jordanian - Syrian - Other - Numerator - Denominator	6% (0.2%) (1.4%)	Annual Indicator		77%	90.1%	90%	90.1%
AQ2	Number of USG supported services delivery sites providing the Integrated Services Delivery Package (M 3.1.2.b)	- Geographic location - Governorate - Facility Sector - MOH - RMS - NGOs - Other - Facility Type - Hospital - Health Center	0	Annual Indicator		143	141	141	141

ANNEX A: DATA QUALITY ASSESSMENT FORM

Percent of neonates with respiratory distress managed according to protocol in USG supported sites (PMP 3.1.1.a)

USAID Mission or Operating Unit Name: USAID/Jordan	
Title of Performance Indicator: <i>Percent of neonates with respiratory distress managed according to protocol in USG supported sites (PMP 3.1.1.a)</i>	
Linkage to Foreign Assistance Standardized Program Structure, if applicable (i.e. Program Area, Element, etc.): N/A	
Result This Indicator Measures (i.e., Specify the Development Objective, Intermediate Result, or Project Purpose, etc.): Development Objective 3: Social Sector Quality Improved / IR 3.1 Health Status Improved / Sub-IR: 3.1.1 Increase Use of Quality Health Services	
Data Source(s): Hospital Records, paper-based and electronic (Hakeem)	
Name of Activity and Partner/Contractor Who Provided the Data: Health Service Delivery (HSD) Activity	
Period for Which the Data Are Being Reported: FY 2017	
Is This Indicator a Standard or Custom Indicator?	☐ Standard Foreign Assistance Indicator ☒ Custom (created by the OU; not standard)
Where is this indicator reported?	☒ Mission PMP ☒ Mission PPR ☐ Other (specify)
Is this indicator being reported under other activity(ies)?	☐ Yes ☒ No
If yes, list the activity(ies)	
If yes, confirm the definition and data collection methodology is uniform amongst all activities?	☐ Yes ☐ No

Data Quality Assessment methodology: One day was dedicated to verifying data reported under several indicators by the HSD Activity. An interview guide was developed by the Mission's M&E Team to identify needed information and documentation. The assessment team joined the HSD Primary Health Care Service Delivery Improvement lead and field officers to visit two Maternal and Child Health (MCH) Units at Primary Health Care (PHC) centers, one in Amman Comprehensive Center which had electronic medical records using "Hakeem" and the other PHC in Sweileh which was still working on a paper base filing system. Following the visits to the Health Centers, the team went to HSD's offices in order to understand the overall M&E system of the activity, and discuss specifics for each of the relevant indicators. Three indicators were discussed at HSD's Office since raw data was retrieved from Hospitals in the same consistent methodology that was conducted at PHC. Relevant M&E documents were reviewed (e.g. Mission PMP, IP AMEPs, Mission and IP PIRS, DevResults data), and HSD's database (CS PRO) was displayed on a projector so that the M&E Team and the AOR could view the dynamics of the system and review data collection procedures and documentation. Samples were shared with the team. Meeting was attended by: USAID: Nagham Abu Shaqra (AOR), Philmon Haile (Development Assistant) and Anna Karmandarian (Monitoring & Evaluation Specialist). MESP: Nikki Zimmerman HSD: Dr. Ali Arbaji (MEL Research Lead), Dr. Oraib Smadi (PHC SDI lead) , Dr. Rajaa Khater (Hospital SDI Lead), Nour Mansour(M&E Specialist), Adla Hamlan (Hospital SDI Specialist), Nisreen Qamouh Amman Comprehensive Health Center: Dr. Tityana, Nurse Shadia Hizajeen Sweileh Health Center: Nurse Amal
Date(s) of Assessment: October 2, 2017
Assessment Team Members: Dr. Nagham Abu Shaqra (AOR), Anna Karmandarian (PRO M&E Specialist), Nikki Zimmerman (Senior M&E Specialist, MESP)
<i>USAID Mission/OU Verification of DQA</i> Team Leader Officer approval X_____
Jordan/PRO Clearance X_____

Category	Y	N	Not Applicable/ Insufficient information	Comments
DQA Methodology				
Was the DQA based on an assessment of actual reported data? If no, please explain why actual data were not utilized.	X			Data was available to view in HSD's database at their offices.
Was reviewed supporting documentation selected through a random sampling methodology specified or approved by the USAID assessor? If yes, please describe the sampling methodology. If no, please describe the methodology used for selecting supporting documentation for review.	X			Yes the data was reviewed on the HSD database and the field officers showed us how they upload the data on their tablets.
Are there important gaps or limitations in the DQA methodologies used for this assessment? If yes, please describe in the comments.		X		
Validity				
Does the indicator reflect the intended results of the activity – i.e. is it a useful indicator for activity management?	X			Yes it is a useful indicator as it captures the percentage of neonates who are born with respiratory distress and are treated according to protocol in GFA hospitals according to clinical pathways offered by HSD. Respiratory distress is one of the leading causes of death among neonates. If NICU personnel follow a clinical pathway drawn from evidence-based guidelines that includes key steps in correct management of respiratory distress among neonates, this should directly contribute to reduced mortality of neonates and contribute to the DO level indicator.
Do the data being collected and reported match the intent or language of the indicator?	X			Yes, all newborn cases connected to the noninvasive respiratory support as documented in the hospital are selected due to limited number of infants connected

Category	Y	N	Not Applicable/ Insufficient information	Comments
				to noninvasive respiratory support. Data is collected by the HSD team during their visits each quarter. This process takes two weeks each quarter.
Are the data collection methods (interviews, observation, etc.) appropriate to produce good data?	X			The field officers first look at the log books/registry books to identify cases with respiratory distress and then they look at their files whether paper or electronic medical records (Hakeem). The neonates are identified by their mother's National ID and Syrians by a special identification number.
Are the data collection procedures and/or sources relatively free of bias?	X			
Are the people collecting the data qualified and/or adequately experienced?	X			Yes the field officers are all qualified health practitioners who are either Pharmacists, Nurses or have a health background.
Are the people collecting the data properly supervised?	X			The field officer is supervised by the team lead who joins them in the visits. The data is entered using tablets and the MEL Research Lead retrieves the data and prepares relevant reports for USAID. The MEL Research Lead reports directly to the COP who reviews the data prior to submitting to USAID.
Reliability				
Are the definitions and procedures for data collection, calculation and reporting clear and well understood by all relevant staff?	X			Yes the field officers have been introduced to the indicator, its definition and data collection methodology on tablet format.

Category	Y	N	Not Applicable/ Insufficient information	Comments
Do the definitions and procedures for collecting and calculating the data match the Mission PIRS if applicable?	X			
If not, please describe the differences.				
Are data collection and analysis methods documented in writing in a PIRS?	X			
Is a consistent data collection process used from (describe any changes/differences observed if N): Year to year?	X			
In all activity locations/sites?	X			
By all activity partners/sub-contractors?			X	
Are there procedures in place for periodic review of data collection, maintenance, and processing that can detect data quality issues?	X			
Has the partner identified significant data quality limitations in the past?		X		
Were these communicated to USAID? If yes, describe how.			X	
Have these data quality limitations been addressed by the partner? If yes, explain how.			X	
Has the partner identified significant data quality limitations in current data? If yes, please describe.		X		
Are these limitations described in the indicator PIRS or written data collection and analysis procedures? If yes, please describe.			X	
Are these limitations described in reporting to USAID? If yes, please describe.			X	
Timeliness				
Are the data for this indicator reported to USAID by the method (ex. Quarterly Performance Data Table) and frequency required?	X			

Category	Y	N	Not Applicable/ Insufficient information	Comments
Is this format and schedule appropriate for project/activity management? If no, describe how it should be changed,	X			
Precision				
Is there a method for detecting duplicate data? If yes, please describe.	X			Yes, each patient is identified by their mother's National ID and data collection happens once a quarter so the probability of double counting is minimal as a once a neonates is released from the hospital that means they have been treated and discharged from the hospital.
If there is duplication of data, is the level of duplication acceptable for this indicator? Describe why or why not.			X	
If there is unacceptable duplication of data, is it identified in the PIRS under data limitations or another section?			X	
If there is unacceptable duplication of data, has information on duplication been shared with USAID? Describe how.			X	
Is there a method for detecting missing data? If yes, please describe.	X			
If there are missing data, is the level acceptable for this indicator? Describe why or why not.			X	
If there are unacceptable amounts of missing data, is this identified in the PIRS under data limitations or another section?			X	
If there are unacceptable amounts of missing data, has information on missing data been shared with USAID? Describe how.			X	
Are the reported data disaggregated according to USAID guidance?	X			
Integrity				

Category	Y	N	Not Applicable/ Insufficient information	Comments
Are there procedures in place to check for transcription errors at all levels of the data collection and reporting system?	X			
Are there proper safeguards in place to prevent unauthorized changes to the data?	X			Yes only HSD MEL Lead has access to the databases and authority to change the data.
Are there procedures in place to ensure unbiased analysis of data and subsequent reporting?	X			
Are their safeguards in place to ensure that all relevant tools, tracking sheets and data are backed up and protected from data loss?	X			The server is in house and backed-up twice a day. At the hospitals the data is saved as electronic records on the Hakeem servers.

IF NO DATA ARE AVAILABLE FOR THE INDICATOR	COMMENTS
If no recent relevant data are available for this indicator, why not?	
What concrete actions are now being taken to collect and report these data as soon as possible or on schedule?	
When will data be reported?	

SUMMARY (where multiple items are listed by the assessor in each row, they should be numbered so that it is clear what recommendations apply to which limitations)
Based on the assessment above, what is the overall conclusion regarding the quality of the data? Overall, the data is of good quality and the methodology followed to collect the data is sound and follows certain guidelines in a systematic manner.
What limitations, if any, were observed and what actions should be taken to address these limitations?

Partner responses to DQA findings above:

Final agreed upon actions and timeframe needed to address limitations prior to the next DQA (given level of USG control over data):

AOR will do follow up visit to the Hospitals in the next few months.

Percent of women receiving Active Management of Third Stage of Labor protocol in USG supported sites (PMP 3.1.1.b)

USAID Mission or Operating Unit Name: USAID/Jordan	
Title of Performance Indicator: Percent of women receiving Active Management of Third Stage of Labor protocol in USG supported sites (PMP 3.1.1.b)	
Linkage to Foreign Assistance Standardized Program Structure, if applicable (i.e. Program Area, Element, etc.): N/A	
Result This Indicator Measures (i.e., Specify the Development Objective, Intermediate Result, or Project Purpose, etc.): Development Objective 3: Social Sector Quality Improved / IR 3.1 Health Status Improved / Sub-IR: 3.1.1 Increase Use of Quality Health Services	
Data Source(s): Hospital Records, paper-based and electronic (Hakeem)	
Name of Activity and Partner/Contractor Who Provided the Data: Health Service Delivery (HSD) Activity	
Period for Which the Data Are Being Reported: FY 2017	
Is This Indicator a Standard or Custom Indicator?	☐ Standard Foreign Assistance Indicator ☒ Custom (created by the OU; not standard)
Where is this indicator reported?	☒ Mission PMP ☒ Mission PPR ☐ Other (specify)
Is this indicator being reported under other activity(ies)?	☐ Yes ☒ No
If yes, list the activity(ies)	
If yes, confirm the definition and data collection methodology is uniform amongst all activities?	☐ Yes ☐ No
Data Quality Assessment methodology: One day was dedicated to verifying data reported under several indicators by the HSD Activity. An interview guide was developed by the Mission's M&E Team to identify needed information and documentation. The assessment team joined the HSD Primary Health Care Service Delivery Improvement lead and field officers to visit two Maternal and Child Health (MCH) Units at Primary	

Health Care (PHC) centers, one in Amman Comprehensive Center which had electronic medical records using “Hakeem” and the other PHC in Sweileh which was still working on a paper base filing system. Following the visits to the Health Centers, the team went to HSD’s offices in order to understand the overall M&E system of the activity, and discuss specifics for each of the relevant indicators. Three indicators were discussed at HSD’s Office since raw data was retrieved from Hospitals in the same consistent methodology that was conducted at PHC. Relevant M&E documents were reviewed (e.g. Mission PMP, IP AMEPs, Mission and IP PIRS, DevResults data), and HSD’s database (CS PRO) was displayed on a projector so that the M&E Team and the AOR could view the dynamics of the system and review data collection procedures and documentation. Samples were shared with the team. Meeting was attended by: USAID: Nagham Abu Shaqra (AOR), Philmon Haile (Development Assistant) and Anna Karmandarian (Monitoring & Evaluation Specialist). MESP: Nikki Zimmerman HSD: Dr. Ali Arbaji (MEL Research Lead), Dr. Oraib Smadi (PHC SDI lead) , Dr. Rajaa Khater (Hospital SDI Lead), Nour Mansour(M&E Specialist), Adla Hamlan (Hospital SDI Specialist), Nisreen Qamouh Amman Comprehensive Health Center: Dr. Tityana, Nurse Shadia Hizajeen Sweileh Health Center: Nurse Amal
Date(s) of Assessment: October 2, 2017
Assessment Team Members: Dr. Nagham Abu Shaqra (AOR), Anna Karmandarian (PRO M&E Specialist), Nikki Zimmerman (Senior M&E Specialist, MESP)
<i>USAID Mission/OU Verification of DQA</i> Team Leader Officer approval X_____
Jordan/PRO Clearance X_____

Category	Y	N	Not Applicable/ Insufficient information	Comments
DQA Methodology				
Was the DQA based on an assessment of actual reported data? If no, please explain why actual data were not utilized.	X			Data was available to view in HSD's database at their offices.
Was reviewed supporting documentation selected through a random sampling methodology specified or approved by the USAID assessor? If yes, please describe the sampling methodology. If no, please describe the methodology used for selecting supporting documentation for review.	X			Yes the data of women who receive AMSTL were selected randomly to verify the data that HSD is collecting on their tablets.
Are there important gaps or limitations in the DQA methodologies used for this assessment? If yes, please describe in the comments.		X		
Validity				
Does the indicator reflect the intended results of the activity – i.e. is it a useful indicator for activity management?	X			Yes it is a useful indicator as it captures the percentage of women receiving AMSTL in GFA hospitals according to clinical pathways offered by HSD. Postpartum hemorrhage (PPH) is the most common cause of maternal death in Jordan. The WHO recommendations support AMTSL as a critical intervention for PPH prevention. The HSD Team will assist the GFA Hospitals to systematically implement AMTSL according to a clinical pathway with appropriate documentation. This is linked to reduction in the percent of women receiving blood transfusion (Indicator R2) since the use of AMTSL reduces the incidence of PPH.
Do the data being collected and reported match the intent or language of the indicator?	X			Yes, a selected sample size of 100-120 cases per hospital is verified by the HSD team

Category	Y	N	Not Applicable/ Insufficient information	Comments
				during their visit in Q4 to collect the annual indicator. This process took 4 weeks. Furthermore, data is collected from the hospitals each quarter to inform the implementation process with about 20-30 cases per hospital in each quarter. Systematic Randomization is used throughout the process of selection of medical records for review.
Are the data collection methods (interviews, observation, etc.) appropriate to produce good data?	X			The field officers first look at the electronic medical records (Hakeem) and identify the women received AMSTL during labor. The women are identified by their National ID and Syrians by a special identification number.
Are the data collection procedures and/or sources relatively free of bias?	X			
Are the people collecting the data qualified and/or adequately experienced?	X			Yes the field officers are all qualified health practitioners who are either Pharmacists, Nurses or have a health background.
Are the people collecting the data properly supervised?	X			The field officer is supervised by the team lead who joins them in the visits. The data is entered using tablets and the MEL Research Lead retrieves the data and prepares relevant reports for USAID. The MEL Research Lead reports directly to the COP who reviews the data prior to submitting to USAID.

Category	Y	N	Not Applicable/ Insufficient information	Comments
Reliability				
Are the definitions and procedures for data collection, calculation and reporting clear and well understood by all relevant staff?	X			Yes the field officers have been introduced to the indicator, its definition and data collection methodology on tablet format.
Do the definitions and procedures for collecting and calculating the data match the Mission PIRS if applicable?	X			
If not, please describe the differences.				
Are data collection and analysis methods documented in writing in a PIRS?	X			
Is a consistent data collection process used from (describe any changes/differences observed if N): Year to year?	X			
In all activity locations/sites?	X			
By all activity partners/sub-contractors?			X	
Are there procedures in place for periodic review of data collection, maintenance, and processing that can detect data quality issues?	X			
Has the partner identified significant data quality limitations in the past?		X		
Were these communicated to USAID? If yes, describe how.			X	
Have these data quality limitations been addressed by the partner? If yes, explain how.			X	
Has the partner identified significant data quality limitations in current data? If yes, please describe.		X		
Are these limitations described in the indicator PIRS or written data collection and analysis procedures? If yes, please describe.			X	

Category	Y	N	Not Applicable/ Insufficient information	Comments
Are these limitations described in reporting to USAID? If yes, please describe.			X	
Timeliness				
Are the data for this indicator reported to USAID by the method (ex. Quarterly Performance Data Table) and frequency required?	X			
Is this format and schedule appropriate for project/activity management? If no, describe how it should be changed,	X			
Precision				
Is there a method for detecting duplicate data? If yes, please describe.	X			Yes, each patient is identified by their National ID and data collection happens once a quarter so the probability of double counting is minimal as a woman in labor won't repeat that again in less than 9 months.
If there is duplication of data, is the level of duplication acceptable for this indicator? Describe why or why not.			X	
If there is unacceptable duplication of data, is it identified in the PIRS under data limitations or another section?			X	
If there is unacceptable duplication of data, has information on duplication been shared with USAID? Describe how.			X	
Is there a method for detecting missing data? If yes, please describe.	X			
If there are missing data, is the level acceptable for this indicator? Describe why or why not.			X	
If there are unacceptable amounts of missing data, is this identified in the PIRS under data limitations or another section?			X	

Category	Y	N	Not Applicable/ Insufficient information	Comments
If there are unacceptable amounts of missing data, has information on missing data been shared with USAID? Describe how.			X	
Are the reported data disaggregated according to USAID guidance?	X			
Integrity				
Are there procedures in place to check for transcription errors at all levels of the data collection and reporting system?	X			
Are there proper safeguards in place to prevent unauthorized changes to the data?	X			Yes only HSD MEL Lead has access to the databases and authority to change the data.
Are there procedures in place to ensure unbiased analysis of data and subsequent reporting?	X			
Are their safeguards in place to ensure that all relevant tools, tracking sheets and data are backed up and protected from data loss?	X			The server is in house and backed-up twice a day. At the hospitals the data is saved as electronic records on the Hakeem servers.

IF NO DATA ARE AVAILABLE FOR THE INDICATOR	COMMENTS
If no recent relevant data are available for this indicator, why not?	
What concrete actions are now being taken to collect and report these data as soon as possible or on schedule?	
When will data be reported?	

SUMMARY (where multiple items are listed by the assessor in each row, they should be numbered so that it is clear what recommendations apply to which limitations)

Based on the assessment above, what is the overall conclusion regarding the quality of the data? Overall, the data is of good quality and the methodology followed to collect the data is sound and follows certain guidelines in a systematic manner.
What limitations, if any, were observed and what actions should be taken to address these limitations?
Partner responses to DQA findings above:
Final agreed upon actions and timeframe needed to address limitations prior to the next DQA (given level of USG control over data):

Percent of children diagnosed with anemia managed according to protocol in USG supported sites (PMP 3.1.1.c)

USAID Mission or Operating Unit Name: USAID/Jordan	
Title of Performance Indicator: Percent of children diagnosed with anemia managed according to protocol in USG supported sites (PMP 3.1.1.c)	
Linkage to Foreign Assistance Standardized Program Structure, if applicable (i.e. Program Area, Element, etc.): N/A	
Result This Indicator Measures (i.e., Specify the Development Objective, Intermediate Result, or Project Purpose, etc.): Development Objective 3: Social Sector Quality Improved / IR 3.1 Health Status Improved / Sub-IR: 3.1.1 Increase Use of Quality Health Services	
Data Source(s): Primary Health Care Records, paper-based and electronic (Hakeem)	
Name of Activity and Partner/Contractor Who Provided the Data: Health Service Delivery (HSD) Activity	
Period for Which the Data Are Being Reported: FY 2017	
Is This Indicator a Standard or Custom Indicator?	☐ Standard Foreign Assistance Indicator ☒ Custom (created by the OU; not standard)
Where is this indicator reported?	☒ Mission PMP ☒ Mission PPR ☐ Other (specify)
Is this indicator being reported under other activity(ies)?	☐ Yes ☒ No
If yes, list the activity(ies)	
If yes, confirm the definition and data collection methodology is uniform amongst all activities?	☐ Yes ☐ No
Data Quality Assessment methodology: One day was dedicated to verifying data reported under several indicators by the HSD Activity. An interview guide was developed by the Mission's M&E Team to identify needed information and documentation. The assessment team joined the HSD Primary Health Care Service Delivery Improvement lead and field officers to visit two Maternal and Child Health (MCH) Units at Primary Health Care (PHC) centers, one in Amman Comprehensive Center which had electronic medical	

records using “Hakeem” and the other PHC in Sweileh which was still working on a paper base filing system. Following the visits to the Health Centers, the team went to HSD’s offices in order to understand the overall M&E system of the activity, and discuss specifics for each of the relevant indicators. Three indicators were discussed at HSD’s Office since raw data was retrieved from Hospitals in the same consistent methodology that was conducted at PHC. Relevant M&E documents were reviewed (e.g. Mission PMP, IP AMEPs, Mission and IP PIRS, DevResults data), and HSD’s database (CS PRO) was displayed on a projector so that the M&E Team and the AOR could view the dynamics of the system and review data collection procedures and documentation. Samples were shared with the team. Meeting was attended by: USAID: Nagham Abu Shaqra (AOR), Philmon Haile (Development Assistant) and Anna Karmandarian (Monitoring & Evaluation Specialist). MESP: Nikki Zimmerman, Senior M&E Specialist HSD: Dr. Ali Arbaji (MEL Research Lead), Dr. Oraib Smadi (PHC SDI lead) , Dr. Rajaa Khater (Hospital SDI Lead), Nour Mansour(M&E Specialist), Adla Hamlan (Hospital SDI specialist), Nisreen Qamouh Amman Comprehensive Health Center: Dr. Tityana, Nurse Shadia Hizajeen Sweilh Health Center: Nurse Amal
Date(s) of Assessment: October 2, 2017
Assessment Team Members: Dr. Nagham Abu Shaqra (AOR), Anna Karmandarian (PRO M&E Specialist), Nikki Zimmerman (Senior M&E Specialist, MESP)
<i>USAID Mission/OU Verification of DQA</i> Team Leader Officer approval X_____
Jordan/PRO Clearance X_____

Category	Y	N	Not Applicable/ Insufficient information	Comments
DQA Methodology				
Was the DQA based on an assessment of actual reported data? If no, please explain why actual data were not utilized.	X			Data was available to view in log books, medical records and paper files in Sweileh and then on Hakeem system in Amman Comprehensive Center. The data for this indicator was then inputted into HSD's tablets and uploaded to the main office.
Was reviewed supporting documentation selected through a random sampling methodology specified or approved by the USAID assessor? If yes, please describe the sampling methodology. If no, please describe the methodology used for selecting supporting documentation for review.	X			Yes names of anemic patients were selected randomly to verify the data that HSD is collecting on their tablets.
Are there important gaps or limitations in the DQA methodologies used for this assessment? If yes, please describe in the comments.		X		
Validity				
Does the indicator reflect the intended results of the activity – i.e. is it a useful indicator for activity management?	X			Yes it is a useful indicator as it captures the results of the interventions that HSD offers through TA at the Maternal and Child Health Units at Primary Health Centers. Anemia is an underlying cause of child morbidity and delayed development. The early detection of anemia and proper treatment improves a child's health and nutritional status, and reduces child morbidity and mortality rates that the HSD Activity strives towards.
Do the data being collected and reported match the intent or language of the indicator?	X			Yes, a selected sample size of 30 cases is verified by the

Category	Y	N	Not Applicable/ Insufficient information	Comments
				HSD team during their visits- Systematic Randomization
Are the data collection methods (interviews, observation, etc.) appropriate to produce good data?	X			The field officer first look at the registry log book that has the names of children and the hemoglobin results. Once the field Officer identifies anemia cases for a certain period, she writes down the names of patients and review their files on the computer. When checking the file she ensures that the anemic child received the right dose of medication and that the follow up hemoglobin level improved. She then enters all the data using her tablet. Although the field officers are writing names of patients manually but are identifying them on the tablet by their date of birth to avoid double counting. However, with paper medical records, there is always a slight possibility of human error when writing down information of each case. If there is doubt about patients with the same birth date, the team verifies the name of the health center and the date of the visit to avoid duplication.
Are the data collection procedures and/or sources relatively free of bias?	X			
Are the people collecting the data qualified and/or adequately experienced?	X			Yes the field officers are all qualified health practitioners who are either Pharmacists, Nurses or have a health background.
Are the people collecting the data properly supervised?	X			The field officer is supervised by team lead who join the in the visits on regular basis.

Category	Y	N	Not Applicable/ Insufficient information	Comments
				The data is entered using tablets and the MEL Research Lead retrieves the data and prepares relevant reports for USAID. The MEL Research Lead reports directly to the COP who reviews the data prior to submitting to USAID.
Reliability				
Are the definitions and procedures for data collection, calculation and reporting clear and well understood by all relevant staff?	X			Yes the field officers have been introduced to the indicator, its definition and data collection methodology on tablet format.
Do the definitions and procedures for collecting and calculating the data match the Mission PIRS if applicable?	X			
If not, please describe the differences.				
Are data collection and analysis methods documented in writing in a PIRS?	X			
Is a consistent data collection process used from (describe any changes/differences observed if N): Year to year?	X			
In all activity locations/sites?	X			
By all activity partners/sub-contractors?			X	
Are there procedures in place for periodic review of data collection, maintenance, and processing that can detect data quality issues?	X			
Has the partner identified significant data quality limitations in the past?		X		
Were these communicated to USAID? If yes, describe how.			X	
Have these data quality limitations been addressed by the partner? If yes, explain how.			X	

Category	Y	N	Not Applicable/ Insufficient information	Comments
Has the partner identified significant data quality limitations in current data? If yes, please describe.		X		
Are these limitations described in the indicator PIRS or written data collection and analysis procedures? If yes, please describe.			X	
Are these limitations described in reporting to USAID? If yes, please describe.			X	
Timeliness				
Are the data for this indicator reported to USAID by the method (ex. Quarterly Performance Data Table) and frequency required?	X			
Is this format and schedule appropriate for project/activity management? If no, describe how it should be changed,	X			
Precision				
Is there a method for detecting duplicate data? If yes, please describe.	X			Yes, each patient is identified by three things, date of birth, PHC and initial Hb value. So if those three things are the same then that data is a duplicate and is then deleted by the MEL Lead.
If there is duplication of data, is the level of duplication acceptable for this indicator? Describe why or why not.			X	
If there is unacceptable duplication of data, is it identified in the PIRS under data limitations or another section?			X	
If there is unacceptable duplication of data, has information on duplication been shared with USAID? Describe how.			X	
Is there a method for detecting missing data? If yes, please describe.	X			

Category	Y	N	Not Applicable/ Insufficient information	Comments
If there are missing data, is the level acceptable for this indicator? Describe why or why not.			X	
If there are unacceptable amounts of missing data, is this identified in the PIRS under data limitations or another section?			X	
If there are unacceptable amounts of missing data, has information on missing data been shared with USAID? Describe how.			X	
Are the reported data disaggregated according to USAID guidance?	X			
Integrity				
Are there procedures in place to check for transcription errors at all levels of the data collection and reporting system?	X			
Are there proper safeguards in place to prevent unauthorized changes to the data?	X			Yes only HSD MEL Lead has access to the databases and authority to change the data.
Are there procedures in place to ensure unbiased analysis of data and subsequent reporting?	X			
Are their safeguards in place to ensure that all relevant tools, tracking sheets and data are backed up and protected from data loss?	X			The server is in house and backed-up twice a day. At the health centers the logbooks are paper records and are kept up to five years in a secure room and electronic records are backed up too on Hakeem servers.

IF NO DATA ARE AVAILABLE FOR THE INDICATOR	COMMENTS
If no recent relevant data are available for this indicator, why not?	

What concrete actions are now being taken to collect and report these data as soon as possible or on schedule?	
When will data be reported?	

SUMMARY (where multiple items are listed by the assessor in each row, they should be numbered so that it is clear what recommendations apply to which limitations)	
Based on the assessment above, what is the overall conclusion regarding the quality of the data?	
Overall, the data is of good quality and the methodology followed to collect the data is sound and follows certain guidelines in a systematic manner.	
What limitations, if any, were observed and what actions should be taken to address these limitations?	
No limitations but just a general observation. Not all centers are using Hemoglobin test to diagnose anemia, some are still using the packed cell volume (PCV) which measures the percentage volume of red blood cells in the blood. Hemoglobin is a part of hematocrit because hematocrit is a measure of total red blood cells where hemoglobin is only a component. Both tests can be used to diagnose anemia, however the hemoglobin test is more accurate and the diagnosis method should be consistent. In addition, although the field officers check the dose of iron given they do not check the frequency and this is something that HSD will start doing.	
Partner responses to DQA findings above:	
Final agreed upon actions and timeframe needed to address limitations prior to the next DQA (given level of USG control over data):	

Number of USG supported service delivery sites providing the Integrated Service Delivery Package (PMP 3.1.2.b)

USAID Mission or Operating Unit Name: USAID/Jordan	
Title of Performance Indicator: Number of USG supported service delivery sites providing the Integrated Service Delivery Package (PMP 3.1.2.b)	
Linkage to Foreign Assistance Standardized Program Structure, if applicable (i.e. Program Area, Element, etc.): N/A	
Result This Indicator Measures (i.e., Specify the Development Objective, Intermediate Result, or Project Purpose, etc.): Development Objective 3: Social Sector Quality Improved / IR 3.1 Health Status Improved / Sub-IR: 3.1.2 Improved Health Sector Sustainability & Resilience	
Data Source(s): Health Service Delivery (HSD) Activity data reports and change packages, Primary Health Care and Hospital records	
Name of Activity and Partner/Contractor Who Provided the Data: Health Service Delivery (HSD) Activity	
Period for Which the Data Are Being Reported: FY 2017	
Is This Indicator a Standard or Custom Indicator?	☐ Standard Foreign Assistance Indicator ☒ Custom (created by the OU; not standard)
Where is this indicator reported?	☒ Mission PMP ☒ Mission PPR ☐ Other (specify)
Is this indicator being reported under other activity(ies)?	☐ Yes ☒ No
If yes, list the activity(ies)	
If yes, confirm the definition and data collection methodology is uniform amongst all activities?	☐ Yes ☐ No
Data Quality Assessment methodology: One day was dedicated to verifying data reported under several indicators by the HSD Activity. An interview guide was developed by the Mission's M&E Team to identify needed information and documentation. The assessment team joined the HSD field officers to visit two Maternal and Child Health (MCH) Units at Primary Health Care (PHC) centers, one in Amman Comprehensive Center	

which had electronic medical records using “Hakeem” and the other PHC in Sweileh which was still working on a paper base filing system. Following the visits to the Health Centers, the team went to HSD’s offices in order to understand the overall M&E system of the activity, and discuss specifics for each of the relevant indicators. Three indicators were discussed at HSD’s Office since raw data was retrieved from Hospitals in the same consistent methodology that was conducted at PHC. Relevant M&E documents were reviewed (e.g. Mission PMP, IP AMEPs, Mission and IP PIRS, DevResults data), and HSD’s database (CS PRO) was displayed on a projector so that the M&E Team and the AOR could view the dynamics of the system and review data collection procedures and documentation. Samples were shared with the team. Meeting was attended by: USAID: Nagham Abu Shaqra (AOR), Philmon Haile (Development Assistant), Anna Karmandarian (Monitoring & Evaluation Specialist) MESP: Nikki Zimmerman (Senior M&E Specialist) HSD: Dr. Ali Arbaji (MEL Research Lead), Dr. Oraib Smadi (PHC SDI lead) , Dr. Rajaa Khater (Hospital SDI Lead), Nour Mansour(M&E Specialist), Adla Hamlan (Hospital SDI specialist) Amman Comprehensive Health Center: Dr. Tityana, Nurse Shadia Hizajeen Sweileh Health Center: Nurse Amal
Date(s) of Assessment: October 2, 2017
Assessment Team Members: Dr. Nagham Abu Shaqra (AOR), Anna Karmandarian (PRO M&E Specialist), Nikki Zimmerman (Senior M&E Specialist, MESP) and Philmon Haile (Development Assistant).
<i>USAID Mission/OU Verification of DQA</i> Team Leader Officer approval X_____
Jordan/PRO Clearance X_____

Category	Y	N	Not Applicable/ Insufficient information	Comments
DQA Methodology				
Was the DQA based on an assessment of actual reported data? If no, please explain why actual data were not utilized.	X			Data was available to view in the Dr. Oraib Smadi files as she explained the ISDP in depth.
Was reviewed supporting documentation selected through a random sampling methodology specified or approved by the USAID assessor? If yes, please describe the sampling methodology. If no, please describe the methodology used for selecting supporting documentation for review.	X			
Are there important gaps or limitations in the DQA methodologies used for this assessment? If yes, please describe in the comments.		X		
Validity				
Does the indicator reflect the intended results of the activity – i.e. is it a useful indicator for activity management?	X			Yes it is a useful indicator as it captures the number of service delivery sites that provides the ISD package of RMNCH+ services. The ISD package is designed to improve access to a consistent set of high quality preventive and curative interventions for reproductive, maternal, newborn and child health. Participation of these SDPs in this process is expected to improve health outcomes among WRA and CU5. The ISD package is implemented by developing change packages customized based on the gaps identified at the SDPs taking into account the community feedback and rolled out through quarterly collaborative sessions to analyze, measure gaps, plan, modify the change package, monitor and generate data as well as to provide high quality integrated preventive and curative services. For non-governmental organizations (NGOs), the ISD

Category	Y	N	Not Applicable/ Insufficient information	Comments
				package is tailored according to the mandate of each participating NGO.
Do the data being collected and reported match the intent or language of the indicator?	X			
Are the data collection methods (interviews, observation, etc.) appropriate to produce good data?	X			The collaborative session records including name of health facilities and name of staff trained on INSDP in addition to facility record of the change packages and progress reports.
Are the data collection procedures and/or sources relatively free of bias?	X			
Are the people collecting the data qualified and/or adequately experienced?	X			Yes Dr. Oraib Smadi leads this component. The field officers are highly qualified and are well trained.
Are the people collecting the data properly supervised?	X			The field officers are supervised by the team lead who joins the visits on a regular basis. The data is entered using tablets and the MEL Research Lead retrieves the data and prepares relevant reports for USAID. The MEL Research Lead reports directly to the COP who reviews the data prior to submitting to USAID.
Reliability				
Are the definitions and procedures for data collection, calculation and reporting clear and well understood by all relevant staff?	X			
Do the definitions and procedures for collecting and calculating the data match the Mission PIRS if applicable?	X			
If not, please describe the differences.				
Are data collection and analysis methods documented in writing in a PIRS?	X			

Category	Y	N	Not Applicable/ Insufficient information	Comments
Is a consistent data collection process used from (describe any changes/differences observed if N): Year to year?	X			
In all activity locations/sites?	X			
By all activity partners/sub-contractors?			X	
Are there procedures in place for periodic review of data collection, maintenance, and processing that can detect data quality issues?	X			
Has the partner identified significant data quality limitations in the past?		X		
Were these communicated to USAID? If yes, describe how.			X	
Have these data quality limitations been addressed by the partner? If yes, explain how.			X	
Has the partner identified significant data quality limitations in current data? If yes, please describe.		X		
Are these limitations described in the indicator PIRS or written data collection and analysis procedures? If yes, please describe.			X	
Are these limitations described in reporting to USAID? If yes, please describe.			X	
Timeliness				
Are the data for this indicator reported to USAID by the method (ex. Quarterly Performance Data Table) and frequency required?	X			
Is this format and schedule appropriate for project/activity management? If no, describe how it should be changed,	X			
Precision				
Is there a method for detecting duplicate data? If yes, please describe.	X			Data is collected quarterly and reported annually. There is no chance of duplication as the

Category	Y	N	Not Applicable/ Insufficient information	Comments
				number reflects the number of the health facilities that were selected and underwent a baseline assessment. The facilities are described by name and numbers.
If there is duplication of data, is the level of duplication acceptable for this indicator? Describe why or why not.			X	
If there is unacceptable duplication of data, is it identified in the PIRS under data limitations or another section?			X	
If there is unacceptable duplication of data, has information on duplication been shared with USAID? Describe how.			X	
Is there a method for detecting missing data? If yes, please describe.	X			As mentioned above the number of USG supported service delivery sites providing the Integrated Service Delivery Package should match the approved selected sites that HSD plan to work with.
If there are missing data, is the level acceptable for this indicator? Describe why or why not.			X	
If there are unacceptable amounts of missing data, is this identified in the PIRS under data limitations or another section?			X	
If there are unacceptable amounts of missing data, has information on missing data been shared with USAID? Describe how.			X	
Are the reported data disaggregated according to USAID guidance?	X			
Integrity				
Are there procedures in place to check for transcription errors at all levels of the data collection and reporting system?	X			

Category	Y	N	Not Applicable/ Insufficient information	Comments
Are there proper safeguards in place to prevent unauthorized changes to the data?	X			Yes only the MEL lead has access to the databases and authority to change the data.
Are there procedures in place to ensure unbiased analysis of data and subsequent reporting?	X			
Are their safeguards in place to ensure that all relevant tools, tracking sheets and data are backed up and protected from data loss?	X			The server is in house and backed-up twice a day. Copies are kept at the facilities.

IF NO DATA ARE AVAILABLE FOR THE INDICATOR	COMMENTS
If no recent relevant data are available for this indicator, why not?	
What concrete actions are now being taken to collect and report these data as soon as possible or on schedule?	
When will data be reported?	

SUMMARY (where multiple items are listed by the assessor in each row, they should be numbered so that it is clear what recommendations apply to which limitations)
Based on the assessment above, what is the overall conclusion regarding the quality of the data? Overall, the data is of good quality and the methodology followed to collect the data is sound and follows certain guidelines in a systematic manner.
What limitations, if any, were observed and what actions should be taken to address these limitations? No limitations were observed for this indicator.
Partner responses to DQA findings above:
Final agreed upon actions and timeframe needed to address limitations prior to the next DQA (given level of USG control over data): N/A

Number of women giving birth who received Uterotonic in the third stage of labor (OR immediately after birth) through USG-supported programs (HL.6.2-1)

USAID Mission or Operating Unit Name:	
Title of Performance Indicator: Number of women giving birth who received Uterotonic in the third stage of labor (OR immediately after birth) through USG-supported programs (HL.6.2-1)	
Linkage to Foreign Assistance Standardized Program Structure, if applicable (i.e. Program Area, Element, etc.):	
Result This Indicator Measures (i.e., Specify the Development Objective, Intermediate Result, or Project Purpose, etc.): Development Objective 3: Social Sector Quality Improved/ IR3.1 Health Status Improved/ Sub-IR: 3.1.1 Increase Use of Quality Health Services	
Data Source(s): Hospital medical records (paper and electronic) and aggregate monthly data on number of vaginal deliveries	
Name of Activity and Partner/Contractor Who Provided the Data: USAID Health Service Delivery	
Period for Which the Data Are Being Reported: FY 2018	
Is This Indicator a Standard or Custom Indicator?	☒ Standard Foreign Assistance Indicator ☐ Custom (created by the OU; not standard)
Where is this indicator reported?	☒ Mission PMP ☐ Mission PPR ☐ Other (specify)
Is this indicator being reported under other activity (ies)?	☐ Yes ☒ No
If yes, list the activity(ies)	
If yes, confirm the definition and data collection methodology is uniform amongst all activities?	☐ Yes ☐ No
Data Quality Assessment methodology: - Visit to Al-Bashir hospital to observe the process of data collection for vaginal deliveries and women who received 10 IU of oxytocin immediately after delivery (within one minute). - The number of vaginal deliveries are collected on monthly basis from each hospital, while percent of women receiving oxytocin are collected quarterly based on review of samples of medical records at the delivery ward of each hospital. - Visit to USAID Health Service Delivery office to discuss with the M&E team the sampling process, allocation of the sample to individual hospitals, data concatenation and analysis. Visit attended by: USAID Health Service Delivery: Noor Al-Mansour(M&E Specialist), Suheil Abu-Ata (Hospital SDI Specialist), Huda Abu-Hatab (Hospital SDI officer)	
Date(s) of Assessment: May 28, 2018	
Assessment Team Members: Noor Al-Mansour(M&E Specialist)	
<i>USAID Mission/OU Verification of DQA</i> Team Leader Officer approval _____	
Jordan/PRO Clearance _____	

Category	Y	N	Not Applicable/ Insufficient information	Comments
DQA Methodology				
Was the DQA based on an assessment of actual reported data? If no, please explain why actual data were not utilized.	X			Collected data was available for review at USAID Health Service Delivery offices.
Was reviewed supporting documentation selected through a random sampling methodology specified or approved by the USAID assessor? If yes, please describe the sampling methodology. If no, please describe the methodology used for selecting supporting documentation for review.	X			• Data collection for number of vaginal deliveries is complete census data that is collected monthly for each hospital. • Data on percent of women receiving oxytocin are collected quarterly based on review of samples of medical records at the delivery ward of each hospital. • Systematic random sample from the logbook of vaginal deliveries over the intended quarter is obtained, followed by retrieval of medical records, review of medical records and transcription of data on administration of oxytocin using tablets. Total number of vaginal deliveries is also entered into the tablets. • The minimum sample size is calculated based on 95% confidence level, 5% error level, while assuming maximum variability. • The sample is allocated to individual hospitals applying Kish formula "$n = \sqrt{(W^2h + H - 2)}$", where n is the overall sample size, Wh is the proportion of the size of the hospital based on annual number of vaginal deliveries, and H is the number of hospitals. Alternatively, allocation proportionate to size will result in very small

Category	Y	N	Not Applicable/ Insufficient information	Comments
				numbers in hospitals with small client load.
Are there important gaps or limitations in the DQA methodologies used for this assessment? If yes, please describe in the comments.		X		
Validity				
Does the indicator reflect the intended results of the activity – i.e. is it a useful indicator for activity management?	X			Yes, as it captures the percentage of women receiving AMSTL in USAID supported hospitals according to clinical pathways. Postpartum hemorrhage (PPH) is the most common cause of maternal death in Jordan. The WHO recommendations support AMTSL as a critical intervention for PPH prevention. The USAID Health Service Delivery Team assists the target Hospitals to systematically implement AMTSL according to a clinical pathway with appropriate documentation.
Do the data being collected and reported match the intent or language of the indicator?	X			The indicator is calculated by multiplying the total number of vaginal deliveries by the proportion of receiving oxytocin based on samples for each quarter, thus projecting the total number of women receiving uterotonic drug.
Are the data collection methods (interviews, observation, etc.) appropriate to produce good data?	X			The data collection officer first reviewed the logbook and applied systematic random sampling to select the medical records for review. As far as this hospital uses electronic medical record system, the officer reviewed all of the selected medical records and entered the required data into the respective data tool using tablet. Electronic data collection tools have all necessary validation rules and

Category	Y	N	Not Applicable/ Insufficient information	Comments
				skips which brings data collection to the minimum while not permitting any user missing values.
Are the data collection procedures and/or sources relatively free of bias?	X			
Are the people collecting the data qualified and/or adequately experienced?	X			Yes the field officer is a qualified nurse with over 10 years of experience, Moreover, she received training on use of data collection tools that were developed by M&E team using CSPro software.
Are the people collecting the data properly supervised?	X			The data collection officer was supervised by an Ob&Gyn physician. The officer entered the data into the tablet and then uploaded it. After uploading, the M&E team checked and analyzed the data, that is used later to develop quarterly and annual reports. Finally, the COP reviews the reports prior to submitting to USAID.
Reliability				
Are the definitions and procedures for data collection, calculation and reporting clear and well understood by all relevant staff?	X			Yes the officer was familiar with indicator definition, data source, data collection methodology.
Do the definitions and procedures for collecting and calculating the data match the Mission PIRS if applicable?	X			
If not, please describe the differences.				
Are data collection and analysis methods documented in writing in a PIRS?	X			Yes the indicator has specific PIRS in the AMEL plan.
Is a consistent data collection process used from (describe any changes/differences observed if N): Year to year?	X			The data collection tools were built at the beginning of implementation of activities and no changes were made over the last two years.
In all activity locations/sites?	X			

Category	Y	N	Not Applicable/ Insufficient information	Comments
By all activity partners/sub-contractors?			X	
Are there procedures in place for periodic review of data collection, maintenance, and processing that can detect data quality issues?	X			Electronic data collection tools have built in skips, quality checks and validation rules that minimize the possibility of data entry errors and prevents any user missing values. Moreover, the collected data is subject to further quality checks by the USAID Health Service Delivery teams. Collected data is stored on a secure server at USAID Health Service Delivery offices.
Has the partner identified significant data quality limitations in the past?		X		
Were these communicated to USAID? If yes, describe how.			X	
Have these data quality limitations been addressed by the partner? If yes, explain how.			X	
Has the partner identified significant data quality limitations in current data? If yes, please describe.			X	
Are these limitations described in the indicator PIRS or written data collection and analysis procedures? If yes, please describe.			X	
Are these limitations described in reporting to USAID? If yes, please describe.			X	
Timeliness				
Are the data for this indicator reported to USAID by the method (ex. Quarterly Performance Data Table) and frequency required?	X			Reporting frequency for this indicator is annual. USAID Health Service Delivery report the results on quarterly basis to inform day-to-day implementation of interventions.
Is this format and schedule appropriate for project/activity management? If no, describe how it should be changed,	X			
Precision				
Is there a method for detecting duplicate data? If yes, please describe.	X			Yes, each patient is identified by their National ID and data collection happens once at the

Category	Y	N	Not Applicable/ Insufficient information	Comments
				end of each quarter so the probability of double counting is minimal as a woman in labor won't repeat that again in less than 9 months.
If there is duplication of data, is the level of duplication acceptable for this indicator? Describe why or why not.			X	
If there is unacceptable duplication of data, is it identified in the PIRS under data limitations or another section?			X	
If there is unacceptable duplication of data, has information on duplication been shared with USAID? Describe how.			X	
Is there a method for detecting missing data? If yes, please describe.	X			Electronic data collection tools have built in skips, quality checks and validation rules that completely prevents user missing values.
If there are missing data, is the level acceptable for this indicator? Describe why or why not.			X	
If there are unacceptable amounts of missing data, is this identified in the PIRS under data limitations or another section?			X	
If there are unacceptable amounts of missing data, has information on missing data been shared with USAID? Describe how.			X	
Are the reported data disaggregated according to USAID guidance?	X			This indicator is disaggregated by governorate and facility sector.
Integrity				
Are there procedures in place to check for transcription errors at all levels of the data collection and reporting system?	X			
Are there proper safeguards in place to prevent unauthorized changes to the data?	X			Yes only MEL team has access to the databases and authority to change the data.
Are there procedures in place to ensure unbiased analysis of data and subsequent reporting?	X			All quarterly and annual data analysis and production of tables are programmed using Stata

Category	Y	N	Not Applicable/ Insufficient information	Comments
				software. When data is concatenated and cleaned, all tables based on collected data are auto generated with no possibility for biased analysis.
Are their safeguards in place to ensure that all relevant tools, tracking sheets and data are backed up and protected from data loss?	X			The server is in house and backed-up twice a day. At the hospitals the data is saved as electronic records on the Hakeem servers.

IF NO DATA ARE AVAILABLE FOR THE INDICATOR	COMMENTS
If no recent relevant data are available for this indicator, why not?	
What concrete actions are now being taken to collect and report these data as soon as possible or on schedule?	
When will data be reported?	

SUMMARY (where multiple items are listed by the assessor in each row, they should be numbered so that it is clear what recommendations apply to which limitations)
Based on the assessment above, what is the overall conclusion regarding the quality of the data? Overall, the data is of good quality.
What limitations, if any, were observed and what actions should be taken to address these limitations?
Partner responses to DQA findings above:
Final agreed upon actions and timeframe needed to address limitations prior to the next DQA (given level of USG control over data):

ANNEX B: DATA COLLECTION TOOLS

There are over 30 data collection tools that are built in electronic format with data vetting procedures programmed in CPro and the web-based applications. Knowing that only one JMMSR survey form is over 20 pages, it would be impossible to include all these tools as an annex. USAID Health Service Delivery already demonstrated samples of the tools to USAID in different occasions. Samples of the tools were also demonstrated to USAID and MESP team during the conduction of data quality checks for the Mission Indicators. USAID Health Service Delivery is open to further demonstration of the tools to any interested individuals at any time.

ANNEX C: CHANGE LOG

Type of change	Change Date	Source documentation/ date of version	Page	Detailed Description: Before Change based on the approved FY19 AMEL	Detailed Description: After Change	Justification
Indicator Target	Nov 2019	Oct 2018 version	69	Indicator R3: Number of Couple Years of Protection generated in service delivery points in geographic focus areas. Target FY20: 135,000	Indicator R3: Number of Couple Years of Protection generated in service delivery points in geographic focus areas. Target FY20: 145,000	FY20 target was revised taking into consideration the actual FY19 results (141,655).
Indicator Target	Nov 2019	Oct 2018 version	77	Indicator A3: Number of new family planning visits in service delivery points in geographic focus areas Target FY20: 68,000	Indicator A3 : Number of new family planning visits in service delivery points in geographic focus areas Target FY20: 60,000	FY20 target was revised taking into consideration the actual FY19 results (55,923).
Indicator Target	Nov 2019	Oct 2018 version	79	Indicator A4: Percent of women giving birth who initiate breastfeeding within the first hour of birth in GFA hospitals (M 3.1.1.2.b) Target FY20: 95%	Indicator A4: Percent of women giving birth who initiate breastfeeding within the first hour of birth in GFA hospitals (M 3.1.1.2.b) Target FY20: 98%	FY20 target was revised taking into consideration the actual FY19 results (99.2%).
Indicator Target	Nov 2019	Oct 2018 version	87	Indicator A8: Number of counseling visits for FP/RH as a result of USG assistance (M 3.1.1.1.b). Target FY20: 177,000	Indicator A8: Number of counseling visits for FP/RH as a result of USG assistance (M 3.1.1.1.b). Target FY20: 150,000	FY20 target was revised taking into consideration the actual FY19 results (212,632) with three implementing partners operating for 12 months, the fact that in FY20 one implementer will be in place for only three months and the remaining two implementers will be in place for only 10 months.
Deleted Indicator	Nov 2019	Oct 2018 version	89	Indicator A9: Percent of children under 5 who redeemed anemia screening vouchers distributed through outreach program at selected private sector facilities. Target FY20: 60%	Indicator Dropped	The indicator depends on screening children for anemia using HemoCue with all anemic children subjected to confirmatory testing using CBC machines. Due to major discrepancies between HemoCue and CBC testing for anemia, USAID asked USAID Health Service Delivery to stop the voucher program and accordingly to drop this indicator.
Indicator Target	Nov 2019	Oct 2018 version	91	Indicator A10: Number of RMNCH+ visits conducted by CHWs during the RMNCH+ Community Outreach Program. Target FY20: 300,000	Indicator A10: Number of RMNCH+ visits conducted by CHWs during the RMNCH+ Community Outreach Program. Target FY20: 290,000	FY20 target was revised taking into consideration the actual FY19 results (404,716) with three implementing partners operating for 12 months, the fact that in FY20 one implementer will be in place for only three months and the remaining two implementers will be in place for only 10 months.
Indicator Target	Nov 2019	Oct 2018 version	93	Indicator A11: Percent of Beneficiaries Acted upon RMNCH+ Referral during RMNCH+ Community Outreach Program. Target FY20: 50%	Indicator A11: Percent of Beneficiaries Acted upon RMNCH+ Referral during RMNCH+ Community Outreach Program. Target FY20: 65%	FY20 target was revised taking into consideration the actual FY19 results (66.9%).
Indicator Target	Nov 2019	Oct 2018 version	95	Indicator A12: Number of USG assisted community health workers (CHWs) providing family planning (FP), information, referrals and or services during the year (M 3.1.1.2.d) (HL.7.2-2). Target FY20: 121	Indicator A12: Number of USG assisted community health workers (CHWs) providing family planning (FP), information, referrals and or services during the year (M 3.1.1.2.d) (HL.7.2-2). Target FY20: 163	FY20 target was revised taking into consideration the number of CHWs at the end of period of performance for each implementing partners.
Indicator Target	Nov 2019	Oct 2018 version	99	Indicator A14: Number of Children under five (0-59 months) reached by USG-supported nutrition programs (F HL.9-1) Target FY20: 80,000	Indicator A14: Number of Children under five (0-59 months) reached by USG-supported nutrition programs (F HL.9-1) Target FY20: 45,000	FY20 target was revised taking into consideration the actual FY19 results (64,135) with three implementing partners, with three implementing partners operating for 12 months, the fact that in FY20 one implementer will be in place for only three months and the remaining two implementers will be in place for only 10 months.
Indicator Target	Nov 2019	Oct 2018 version	111	Indicator Q5: Percent of women undergoing cesarean section receiving antibiotic prophylaxis according to protocol in USG supported sites (M 3.1.2.1.d) Target FY20: 75%	Indicator Q5: Percent of women undergoing cesarean section receiving antibiotic prophylaxis according to protocol in USG supported sites (M 3.1.2.1.d) Target FY20: 80%	FY20 target was revised taking into consideration the actual FY19 results (82.6%).
Indicator Target	Nov 2019	Oct 2018 version	113	Indicator Q6 : Percent of pregnant women diagnosed with anemia treated according to clinical pathway in SDPs in GFAs Target FY20: 70%	Indicator Q6 : Percent of pregnant women diagnosed with anemia treated according to clinical pathway in SDPs in GFAs Target FY20: 80%	FY20 target was revised taking into consideration the actual FY19 results (78.1%).

Type of change	Change Date	Source documentation/ date of version	Page	Detailed Description: Before Change based on the approved FY19 AMEL	Detailed Description: After Change	Justification
Indicator Denominator / Target	Nov 2019	Oct 2018 version	115	Indicator Q7.1: Percent of deaths among women of reproductive age notified within 24 hours of death time Denominator: The total number of deaths among women of reproductive age in the same period of time. Target FY20: 75%	Indicator Q7.1: Percent of deaths among women of reproductive age notified within 24 hours of death time Denominator: The total number of notified deaths among women of reproductive age in the same period of time Target FY20: 60%	- Denominator language was changed for more clarification - FY20 target was revised taking into consideration the actual FY19 results (47.8%) and the fact that staff shortages prevents death notifications within 24 hours during weekends and holidays.
Indicator Numerator/ Denominator	Nov 2019	Oct 2018 version	117	Indicator Q7.2: Percent of health facilities notifying deaths among women of reproductive age or submitting zero-reports Numerator: The number of health facilities in all health affairs directorates submitting maternal death notification or zero-reports on weekly basis during a specified duration of time. Denominator: The total number of health facilities in all health affairs directorates in the same period of time.	Indicator Q7.2: Percent of health facilities notifying deaths among women of reproductive age or submitting zero-reports Numerator: The number of health facility/weeks where facilities submit death notification among women of reproductive age or zero-reports on weekly basis during a specified duration of time. Denominator: The total number of health facility/weeks in all health affairs directorates in the same period of time	- Numerator language was changed for more clarification - Denominator language was changed for more clarification
Indicator Numerator/ Denominator	Nov 2019	Oct 2018 version	119	Indicator Q8 Numerator: The number of maternal deaths for which the DAGs completed Maternal Death Review within one month of completion of household survey. Indicator Q8 Denominator: The total number of identified maternal deaths in the same period of time.	Indicator Q8 Numerator: The number of maternal deaths for which the DAGs completed Maternal Death Review within one month of completion of household survey during specified period. Indicator Q8 Denominator: The total number of maternal deaths for which the household survey was completed during the same period of time.	- Numerator language was changed for more clarification - Denominator language was changed for more clarification
Indicator Target	Nov 2019	Oct 2018 version	123	Indicator Q10 : Percent of neonates with sepsis managed according to clinical pathway in GFA hospitals Target FY20: 95%	Indicator Q10 : Percent of neonates with sepsis managed according to clinical pathway in GFA hospitals Target FY20: 99%	FY20 target was revised taking into consideration the actual FY19 results (98.4%).
Indicator Target	Nov 2019	Oct 2018 version	128	Indicator Q12: Number of women giving birth who received Uterotonic in the third stage of labor (OR immediately after birth) through USG-supported programs (M 3.1.1.d)(HL.6.2-1) Target FY20: 65,000	Indicator Q12: Number of women giving birth who received Uterotonic in the third stage of labor (OR immediately after birth) through USG-supported programs (M 3.1.1.d)(HL.6.2-1) Target FY20: 62,000	FY20 target was revised taking into consideration the actual FY19 results (58,011).
Indicator Target	Nov 2019	Oct 2018 version	130	Indicator AQ1: Percent of pregnant women managed according to antenatal care clinical pathway in SDPs in GFAs Target FY20: 80%	Indicator AQ1: Percent of pregnant women managed according to antenatal care clinical pathway in SDPs in GFAs Target FY20: 90%	FY20 target was revised taking into consideration the actual FY19 results (90.1%).
Indicator Target	Nov 2019	Oct 2018 version	132	Indicator AQ2 : Number of USG supported services delivery sites providing the Integrated Services Delivery Package (M 3.1.2.b) Target FY20: 143	Indicator AQ2 : Number of USG supported services delivery sites providing the Integrated Services Delivery Package (M 3.1.2.b) Target FY20: 141	FY20 target was revised taking into consideration the actual number of SDPs in FY19 that is not going change in FY20.

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