

Statement of Work

SECTION I: BACKGROUND

“GATEWAY TO THE FUTURE” -- THE DEVELOPMENT CHALLENGE IN THE JORDANIAN CONTEXT:

Under USAID/Jordan’s *“Improved Health Status for All Jordanians”* Intermediate Result, the Mission, in cooperation with the GOJ and other international and local partner organizations working in population and health, will broadly support an integrated program leading to improved quality of and access to health care services and information; improved health policies, strategies and systems; and improved practice of healthy lifestyles.

Jordan has one of the fastest growing populations in the world. Between the two censuses in 1979 and 1994, the population grew from 2.1 to 5.1 million people, an average increase of 2.7 percent annually. At this rate, the population of Jordan will double in 25 years. The Government of Jordan (GOJ) has recognized that this is a prospect it can ill afford, given Jordan's natural resource base, current and envisioned potential.

In partnership with the Ministry of Health (MOH), USAID achieved major accomplishments in family planning, reproductive health and primary health care (FP/RH/PHC) over the last strategy period (1997-2003). The interventions, and their commensurate accomplishments, at the clinic level were focused on improved quality of services through clinical training of service providers, establishing performance improvement review systems, improving the management information system, conducting applied research, using communication for behavior change approaches and upgrading the primary health centers/clinics (PHC) through renovation and provision of furniture and specialized medical equipment. Special emphasis was put on FP/RH as Jordan still faces rapid population growth that counteracts advances made in the socio-economic sectors and Jordan’s very limited natural resources.

USAID/Jordan and the MOH are interested in sustaining the gains achieved to date by further expanding these interventions to achieve increased modern method CPR, more rapid reductions in the fertility rate (currently high at 3.6), continuing reductions in maternal and child mortality and morbidity, safe motherhood interventions and overall improvements in primary health care indicators such as the prevention and control of infectious (including HIV/AIDS) and chronic diseases¹ improved life expectancy and improved burden of disease. To achieve these goals, special focus will be placed on expanding and strengthening FP/RH/PHC information, services and systems at the PHC and central levels. Safe motherhood initiatives at public sector hospitals and improving FP/PHC services at the public hospitals’ outpatient clinics will be a new activity.

¹ Chronic diseases are showing a sharp increase as Jordan is entering a demographic and epidemiological transition similar to developed countries

Accordingly, Jordan's focus has been on developing its human potential, essentially by advancing the well-being of its citizens. While overall health conditions in Jordan -- low infant mortality rates and high life expectancy -- are among the best in the region, the population growth rate continues to be a major development constraint for Jordan -- especially when analyzed in light of the quantity and quality of services to be provided to accommodate this rapid increase in population. The landmark passage of the National Population Strategy (NPS) in March 1996 and the passage of the Reproductive Health Action Plan, a sub-strategy of the NPS, in April 2004 made clear that Jordan was serious about family planning and recognized that a population growth rate of 3.7 was a major constraint to Jordan's development prospects. One of the principal elements of the Strategy is the reinforcement of the "right of families to produce an appropriate number of children and to have access to information and family planning methods in order to make their decisions freely, albeit in line with religious and cultural values."

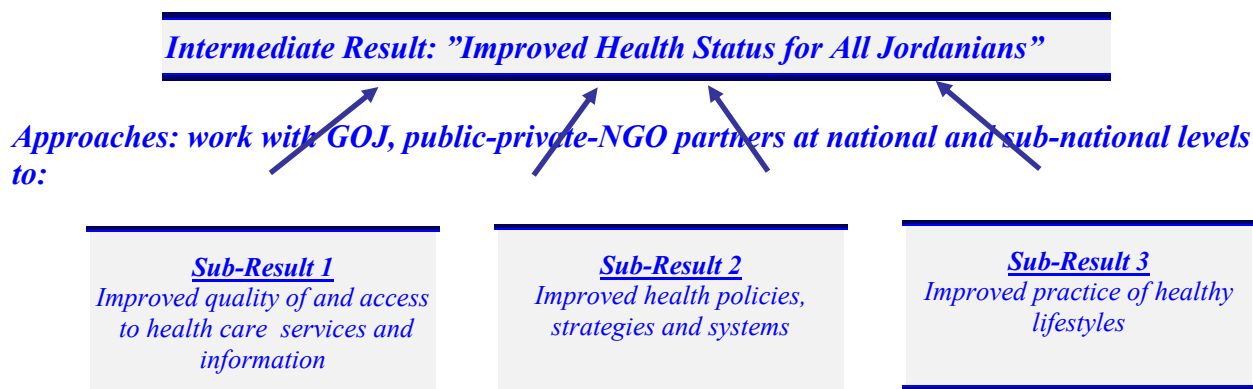
The Total Fertility Rate (TFR) has declined from 5.6 children in 1990 to 3.7 in 2002, resulting in a decrease of two births per woman over the last 12 years, and nearly one birth per woman since 1997. Seventy percent of the decline in fertility resulted from changes in marital fertility, while 30 percent resulted from a delayed age of marriage. The rate of increase in the modern CPR seems to be slowing down in the last five years. However, the continuing decline in fertility rates from 5.6 in 1990 to 3.7 in 2002, and the decline in the rate of natural increase from 2.6 in 1990 to 2.3 in 2001 are encouraging. The seeming contradiction between the slowing of CPR annual increases and the continuing decline in the total fertility rate is likely the result of further counseling and expanded availability, resulting in more effective use of contraceptives. The later age of marriage is also a factor.

Given the situation above, Jordan faces several key constraints, which include large family sizes, less than fully functional public health systems, a significant unmet demand for high quality maternal child health care information and services, and a significant increase in the prevalence of chronic diseases. Importantly, Jordan's high fertility rate -- although on the decline due to sustained family planning efforts by the public, private and non-governmental sectors with USAID assistance -- threatens to outstrip Jordan's economic and natural resource bases at a quicker pace than most other countries in the region.

SECTION II: STRATEGIC FRAMEWORK AND APPROACHES

The Strategic Framework was developed by USAID, the MOH and its many local organizational partners working in population and health at the consensus-building workshop held in October 2003 in Amman, Jordan. Under the Intermediate Result *Improved Health Status for all Jordanians*, USAID/Jordan in cooperation with the GOJ will over the five-year period (2004 -- 2009) broadly support public-private-NGO sector activities that will contribute to the intermediate result and its three sub-results:

USAID/Jordan's strategic framework for population and health for the five-year period 2004 to 2009 is:



It is expected that the majority of this IR's resources will be allocated for programs that directly improve the health and social status of women, children and youth.

Between 2004 – 2009, USAID/Jordan, in partnership with the Ministry of Health (MOH), will continue to support programs that improve the health care system in Jordan with a strong emphasis on family planning and maternal and child health services. By the end of 2009, it is expected that USAID programs will have contributed significantly to a 20 percent decrease in Jordan's fertility rate (from the current 3.7 to a projected 2.9 children per family). In tandem with activities that strengthen the delivery of maternal and child health services, USAID will work to improve important health indicators such as life expectancy, infant mortality, and morbidity – working at all levels of the health system, but especially at the local level where health care workers interact the most with citizens. USAID will also begin to work closely with the GOJ to better integrate on-going primary health services strategies and programs that prevent and treat chronic diseases.

More specifically, over the next five years, USAID will work in the following three sub-areas to improve the health of all Jordanians:

<p style="text-align: center;"><u>Sub-Result 9.1.1:</u> <i>Improved quality of and access to health care services and information</i></p>	<p>In partnership with the MOH, USAID achieved major accomplishments in family planning, reproductive health and primary health care (FP/RH/PHC) over the last strategy period (1997-2003). The interventions, and their commensurate accomplishments, at the clinic level were focused on improved quality of services through clinical training of service providers, establishing performance improvement review systems, improving the management information system, conducting applied research, using communication for behavior change approaches and upgrading the PHC centers through renovation and provision of furniture and specialized medical equipment. Special emphasis was put on FP/RH as Jordan still faces rapid population growth that counteracts advances made in the socio-economic sectors and Jordan's very limited natural resources.</p>
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Over the next five years (2004 – 2009), USAID/Jordan and the MOH will work to sustain the gains achieved to date by further expanding these interventions to achieve increased modern method contraceptive prevalence (CPR), more rapid reductions in the fertility rate (currently high at 3.7), continuing reductions in maternal and child mortality and morbidity, and overall improvements in primary health care indicators such as the prevention and control of infectious (including HIV/AIDS) and chronic diseases², improved life expectancy and improved burden of disease. To achieve these goals, special focus will be placed on expanding and strengthening FP/RH/PHC services, information and systems at the primary health center/clinic and central levels, primarily in the public and NGO sectors. USAID will continue support to the Jordan Association for Family Planning and Protection (JAFPP) in improving its services at all of its clinics and in its cost recovery and sustainability. Safe motherhood initiatives at public sector hospitals (MOH and RMS) and improving FP/PHC services at the public hospitals' outpatient clinics will be a new activity.

The goal of Sub-result 9.1.1 is to expand and institutionalize high quality health care services and information at national and sub-national levels.

Illustrative Approaches/Activities:

- Expand and improve the quality and access to FP/RH/PHC services and information at public sector PHC clinics and hospital outpatient clinics;
- Reduce fertility rate and improve mother and child health indicators through expansion of birth spacing initiatives, reduction in discontinuation of family planning and establishing safe motherhood practices at obstetric wards at public sector hospitals;
- Improve prevention and control of chronic and infectious diseases, including HIV/AIDS, leading to a better quality of life for the poor and disadvantaged;
- Improve child health through the introduction of “integrated management of childhood illness (IMCI)” approach;
- Strengthen service delivery and related public health systems resulting in sustained improvements in the quality of service;
- Physically upgrade the obstetric wards and selected outpatient clinics at public sector hospitals resulting in perceived and actual improved quality of care;
- Reduce disparity in provision of PHC through improving PHC services on the national level thus reaching the poor and disadvantaged;
- Assist the GOJ in reaching the planned national FP/RH/PHC improvements as required by Jordan Socio Economic Transformation Plan (SETP) and the National Population Strategy and its sub-strategy the Reproductive Health Action Plan (RHAP);
- Improve and expand public-private-NGO sector collaboration.

These national and sub-national interventions will be designed to reach every Jordanian. The public sector services are still highly subsidized; therefore, the poor and disadvantaged will be special beneficiaries of this program as MOH services are geographically accessible all over the country. If the life stages approach is applied, mothers, children and young people will be the

² Chronic diseases are showing a sharp increase as Jordan is entering a demographic and epidemiological transition similar to developed countries

most direct beneficiaries of the FP/RH/PHC interventions. Male involvement will be expanded and older people will benefit from the broad spectrum of improved PHC services which will include standardized management of chronic diseases. Finally, the interface between communities and health facilities will be enhanced so that individuals and communities are best served. A special group of beneficiaries will be women in labor and post partum as they have special needs for clinical care and FP counseling.

Activities implemented under this Sub-result will directly contribute to the long-term goal of “Improved Health Status for All Jordanians.” These activities will most directly impact activities related to improved quality of and access to health care services and information. But it will also impact activities related to improved health policies, strategies and systems since emphasis will be placed on building and sustaining health policies, strategies and systems. Activities will primarily focus on the public sector while building relationships with private sector FP/RH improvements and providing synergies to all three sub results.

Sub-Result 9.1.2: Improved health policies, strategies and systems

The Jordanian health sector is generally characterized as being inefficient and lacking in robust administrative and regulatory conditions required for a modern health system. Between 2004 – 2009, USAID will assist the GOJ/MOH to adopt a more competitive legal and regulatory framework for the health sector with an end to improving important national and sub-national level management systems. The GOJ/MOH, although open to the idea of reform in this sector, does not have the resources or expertise to undertake the changes needed to improve the health status of Jordanians. USAID assistance will complement the GOJ/MOH’s public commitment and on-going efforts toward policy reform by assisting it to better assess and implement new policies and reforms. In this connection, USAID may focus on a variety of policies, reforms and national standards to help assure a more competitive legal and regulatory environment. Much of the work that USAID will undertake in this sector will be coordinated with the public, private and NGO sectors to promote transparency, increase civic participation, improve governance and ensure a more integrated approach.

The goal of Sub-result 9.1.2 is to expand and improve essential health sector policies, reforms and public health systems. Such reforms will lead to improved quality and efficiency of information and services and reducing disparity in accessing health care for all Jordanians.

Illustrative Approaches/Activities:

- Expand and improve essential health sector policies, reforms and public health systems;
- Build human capacity leading to established public health systems and dynamic health reform;
- Expand GOJ/MOH priority work in health insurance for the poor and uninsured and establish effective contractual links with the private sector;
- Expand reforms in hospital decentralization resulting in improved quality and access;
- Institutionalize systems for: monitoring quality of care and provider compliance; certification and accreditation of health facilities and health providers; improve non-

- monetary incentives for service providers; institutionalize continued medical education; referral and appointments; and routine maintenance and cleaning of health facilities;
- Improve selected health indicators;
- Reduce disparity in health care services and costs across socio-economic groups by cost containment and the provision of high quality information and services, especially for the poor and disadvantaged;
- Human resource development/manpower planning;
- Improve and expand public-private-NGO sector collaboration.

Activities will primarily focus on the public sector but will include public-private-NGO sector partnerships and the establishment of national policy, regulatory and system reforms appropriate for all sectors. USAID assistance is expected to assist the GOJ/MOH achieve several health reforms with emphasis on health insurance, decentralization of hospitals, and systems for continuous medical education and relevant health provider incentives. One important intervention will be partnering with the private sector through more efficient “contracting out” mechanisms by the MOH that will reduce the load on public sector hospitals by obtaining high quality services from the private sector at an affordable cost to the MOH. Hospital decentralization will be expanded from the current four hospitals to other hospitals including the biggest hospital in the country, thus improving better access and quality of care to the poor and disadvantaged. Non-monetary incentives for service providers will be revisited and improved. Certification and accreditation of health facilities and providers through recognized standards for the public-private-NGO sector will be institutionalized. All such reforms will be in accordance with the GOJ’s Socio-economic Transformation Plan that the GOJ/MOH is eager to implement but lacks the technical resources to accomplish alone. This activity will build on the successes and lessons learned from the current partnership for health reform activity (PHR plus).

These national and sub-national interventions will be designed to reach every Jordanian. All family members could benefit from the improved quality of information and services throughout the health system. The poor, disadvantaged and the uninsured will be special beneficiaries as they are the prime users of MOH facilities. MOH service providers will benefit from the improved incentive schemes. The overall health system will benefit from the certification and accreditation process as it will improve efficiency and reduce redundancy and waste.

Activities implemented under this Sub-result will directly contribute to the long-term goal of “Improved Health Care for All Jordanians.” These activities will most directly impact activities related to improved health policies, strategies and systems since emphasis will be placed on improvements related to strengthening and sustaining them. The primary emphasis will be on the public sector but with a focus on developing and institutionalizing national policy, strategy and system reforms and standards. As with all activities in the PFH portfolio, this activity will help improvement services and information and provide synergies across all three sub-results.

USAID will support the development of a national health communication strategy with activities that help improve the practice of healthy lifestyles. Activities will be designed to assist the MOH and other local partners develop and implement a five-year national health communication strategy and related health communications activities. The ultimate goal of the

Sub-Result 9.1.3:
*Improved practice of
healthy lifestyles*

health communication strategy is to achieve a health competent Jordan in which communication empowers individuals, families, communities, and institutions with the knowledge, skills, and resources needed to work together to improve and sustain health. The partners will work together to create a health competent Jordan in which communication is used to:

Illustrative Approaches/Activities:

- Help households understand and work to produce good health at every stage of life;
- Create universal access to accurate and consistent health information;
- Create demand for services that are integrated, client-centered, and oriented toward continuity of care;
- Help community partnerships advocate for and create local environments that support healthy behavior;
- Help private and public sector organizations work together to support health lifestyles;
- Coordinate health-related programs so that they are mutually reinforcing;
- Advocate for policies that remove barriers to and motivate concerted efforts toward health improvement;
- Institutionalize and sustain dynamic mechanisms and systems of health communication;
- Create a role for everyone to play in achieving good health.

The national health communication strategy for behavior change will frame health competence communication around life-stage segmentation. Under this integrated program, information needs and communication programs will be designed to respond to the unique needs associated with key life-stages within the Jordanian population. As such, life-stage will be used as the primary segmentation variable, defining the demographic and epidemiological characteristics and particular combination of health information needs by segment. Audiences would include, but not necessarily limited to, the following life-stages: (1) early childhood; (2) youth and adolescents; (3) peri-marital young adults; (4) older married couples (limiters); and (5) special emphasis audiences – the underserved and hard-to-reach. This integrated health issues/communication strategy will cut across public-NGO-Private/commercial sectors and will be framed around life-stage segmentation and issues related to chronic diseases and the promotion of healthy lifestyles.

Activities implemented under this Sub-result will directly contribute to the long-term goal of “Improved Health Care for All Jordanians.” More directly, this activity will impact all three sub-results since it seeks to improve information within the health services context, is strategy and health system in its own right, and it seeks to promote healthier lifestyles. Additionally, this activity will forge strong synergies and linkages across health, education and governance (civic participation) on programs that maximize impact and promote greater citizen participation in decision-making and access to quality information and services.

SECTION III: POPULATION AND HEALTH SECTOR IN JORDAN

This section describes the type and scope of activities to be undertaken, and the results to be achieved with the funds under this Task Order as USAID focuses on the national and sub-national level expansion of successful population and health interventions, combined with

strengthening of health systems in selected areas to meet family planning, reproductive, maternal and child health, safe motherhood and related needs in Jordan.

The future of a country is in the hands of its people. Jordan has the opportunity to access a demographic dividend that could double its economic growth over the next 25 years, but this requires policy-makers to understand the demographic trends and create a policy environment that takes maximal advantage of demographic potential. Over the next 50 years, Jordan's demographics will change dramatically – a change that has the potential to translate into dividend or disaster for the country. The country's population is growing rapidly, doubling over the last 20 years and likely to almost double again by 2035. More important, however, is the demographic transition the country is undergoing, as it moves from high fertility and mortality, to low fertility and mortality.³

USAID has been a leading donor in the health sector for many years, working closely with the GOJ and other donors to improve the delivery of health care services in the Kingdom. Nonetheless, Jordan still faces daunting challenges to maintaining past gains and improving future service delivery. Jordan's stubbornly high fertility rate and high maternal/child mortality and morbidity rates threaten to counteract advances made in other economic and social sectors. Fortunately, due to the GOJ's existing policy on HIV/AIDS prevention coupled with conservative social norms, the AIDS epidemic is not expected to pose a significant threat to Jordanians during the next five years. Although the GOJ has committed to a sustained emphasis on improving the quality and availability of family planning and other maternal child health and primary care services, other, more "modern," challenges to ensuring the health and productivity of the Jordanian population have begun to emerge. These challenges include the significant increase in the rate of chronic diseases such as diabetes, hypertension, high cholesterol, obesity, and smoking. These are disturbing findings for a modernizing country with a population of only 5.2 million. These chronic or 'lifestyle' diseases have begun to take the place of infectious diseases as the leading causes of morbidity and mortality in Jordan today – threatening to dramatically increase the amount of resources Jordan invests in curative services in the future. Within the 2004 – 2009 timeframe, USAID will supplement its maternal and child health focus with selected initiatives to improve the capacity of the Jordanian health system to treat and prevent chronic diseases.

Given the situation above, Jordan faces several key constraints, which include large family sizes, less than fully functional public health systems, a significant unmet demand for high quality maternal child health care services and information, and a significant increase in the prevalence of chronic diseases. Importantly, Jordan's high fertility rate – although on the decline due to sustained family planning efforts by the public, private and non-governmental sectors with USAID assistance – threatens to outstrip Jordan's economic and natural resource bases at a quicker pace than most other countries in the region.

As a continuance of its assistance, USAID/Jordan and its implementing agencies and their local partners will work together with the Government of Jordan and its development partners to ***“improve the health status for all Jordanians”*** over the next phase of assistance from 2004-

3 Bloom, David E., et. al. “Demographic Transition and Economic Opportunity: the Case of Jordan,” (April 2001)

2009. Approaches and activities undertaken to achieve this intermediate result will ensure the achievement of the following three sub-results:

- Improved quality of and access to health care services and information
- Improved health policies, strategies and systems
- Improved practice of healthy lifestyles

Working in collaboration with government (GOJ), USAID-funded cooperating agencies/contractors, local non-governmental (NGOs), private commercial sector partners and other donors, USAID assistance will continue to support critical elements of the primary health care service delivery and information system, an expanded referral and appointment system with selected hospitals, selected interventions in hospital obgyn and outpatient MCH wards. These interventions will help strengthen the overall health system. USAID assistance will ensure that access to quality information and the utilization of essential services (including the development of an Essential Service Package including, but not limited to: safe motherhood; reproductive health; maternal and child health; primary health) will continue. USAID assistance will also improve and strengthen the existing health system and its requisite systems (administrative, management, health information, quality assurance, supervision and monitoring, logistics/reporting and service delivery systems). It will continue to support the Government's nascent decentralization efforts by strengthening the institutional, management, and technical capabilities of governorate level health directorates, clinic/center facilities and selected hospitals. Finally, USAID assistance will strengthen the management and technical capabilities of local community organizations in order to improve and expand community and civic participation in the delivery of quality health services and information at the community level and in concert with the government's priorities.

The Future:

Under the new PFH strategy for FY 2004-2009, the strengths of the current health (PFH) program will be supported as resources permit. Activities will be streamlined to reduce organizational and programmatic redundancies, make better use of inherent synergies and opportunities, and provide a strategic geographical focus on priority national and sub-national areas. Overall, the PFH program will maintain a strong information/service delivery focus, bolstered by a dynamic health systems strengthening component that will effectively maximize the impact of USG investments.

The strategy and funding parameters fully reflect Jordan's health situation and status as an emerging developing country.

However, the health sector in Jordan still faces enormous and persistent challenges:

Service delivery challenges (Safe motherhood) challenges: An overwhelming majority of births (97%) in the five years before the 2002 DHS were delivered in a medical facility, an increase of four percentage points from the previous survey. Eighty-one percent of births took place in a public health facility in the North region compared with 54% in the Central region. More women (44%) in the Central region went to a private health facility than women from the North or South regions.

There is also a strong association between the level of education of mothers and the place of delivery. The proportion of births delivered in a public health facility is higher (78%) for uneducated mothers, compared with 50% of births to mothers with higher education.

At Al-Bashir Hospital, the busiest maternity hospital in the country, approximately 45 women are delivered daily. Because of maternity bed shortages, typically an additional 15 laboring women are redirected to other hospitals after arriving at Al-Bashir Hospital. This problem is not unique to Al-Bashir. Optimal quality of care for mothers and neonates cannot be achieved given this situation.

Throughout the world, there is major maternal mortality and morbidity from miscarriage and other complications of pregnancy in the first trimester. In Jordan, in the tiny sample conducted by an evaluation team, post-miscarriage clients occupied a significant caseload in the two hospitals in which inquiries were made. Al-Bashir reportedly admits about 200 patients per month for treatment. Jamil Tutunji reported that 5–6 of the 30 beds in the ward are usually held for women being treated for post-miscarriage complications. Furthermore, the obstetrician/gynecologist reported that there had been two maternal deaths in the hospital within the past two years; one of the two was of a woman who arrived and died from complications of a septic miscarriage.

In light of international maternal morbidity and mortality due to miscarriage complications, USAID/Washington developed a program for the emergency treatment of miscarriage, hemorrhage, and other complications of pregnancy that has four elements:

- emergency clinical treatment of complications,
- post-treatment family planning counseling and services,
- linkages between emergency care and other reproductive health services, and
- community participation to support women's prompt receipt of care.

Such emergency treatment has been supported by USAID since 1994; as of 2001, there were post-miscarriage care programs in more than 40 countries. As noted in a 2001 global evaluation of USAID's program, such "care is a high priority for USAID."

Jordan is not among those 40 countries. At Al-Bashir, the largest maternity hospital in the country where 25 percent of women in childbirth are referred for lack of beds to another hospital, women with incomplete miscarriages are treated with dilation and curettage (D&C), usually under general anesthesia, entailing a 24-hour or longer hospital stay, and receive little or no FP counseling. Hospital stays for miscarriage are generally longer than they are for childbirth, although they do not need to be with the new treatment protocols facilitated by USAID throughout the world. Post-miscarriage care, as promoted by USAID, improves health outcomes for women because less invasive treatment procedures are used; that care also results in financial savings for the health system because women have shorter hospital stays and general anesthesia is not necessary. Post-miscarriage care, moreover, is an excellent time to immediately reach out to women with FP counseling. Al-Bashir Hospital is not unique in these challenges. Thus, it is USAID's intention under the new strategy to help rectify this situation in selected hospitals throughout Jordan. Attachment 1 provides further details on other hospitals in Jordan.

Infant and child health challenges: Challenges remain, however. Jordan's neonatal rate is estimated to be about double that of developed countries. According to the *Study of Neonatal and Perinatal Mortality in Jordan*, "About 30 percent (of neonatal deaths) were judged to be preventable, using available resources." Neonatal mortality (NNM) will not likely be significantly reduced until focused efforts are directed to improving key aspects of in-hospital obstetrical and neonatal care. Declines in neonatal mortality have not kept pace with other declines. The proportion of neonatal mortality (16 percent) relative to infant mortality (22 percent) has increased over time. In 1997, NNM accounted for 62 percent of overall infant mortality; by 2002, the proportion of NNM to IMR has increased to 70 percent as the latter has declined at a faster rate than NNM. At the current rate of decline, the IMR will eventually plateau as the proportion of NNM continues to grow.

The JPFHS 2002 shows that infant and child mortality rates are directly correlated with education; however, for neonatal mortality, the hardest challenge, the difference is far less than that for infant and child mortality.

Infant and child health has not been a focus of PHCI. UNICEF, however, will introduce the integrated management of childhood illness program (IMCI) to Jordan during the next five years. This offers USAID-funded organizations the opportunity to continue to strengthen primary care for children at the health center and to ensure that important reproductive health messages/referral are included in the child health visit. By meeting with UNICEF and the ministry now, during the planning stages, PHCI can help ensure that IMCI interventions will be effectively incorporated into the child health training curricula and build on PHCI work with the MOH.

Birth spacing challenges: Exciting findings, derived from the JPFHS 2002 data, are the changes in Jordanian birth intervals. The percentage of birth intervals of less than 24 months decreased from 44 percent in 1997 to 34 percent in 2002. Correspondingly, the percentage of birth intervals more than 36 months increased during the same timeframe from 26 to 38 percent. The increase in birth intervals is important because of its correlation with reductions in child mortality and maternal morbidity and mortality.

According to the *Population Reports*⁴ children who are born three to four years after a previous birth, compared with children born less than two years after a birth, are 1.5 times more likely to survive the first week of life, 2.2 times more likely to survive the first 28 days of life, 2.3 times more likely to survive the first year of life, and 2.4 times more likely to survive to age 5. As for mothers who have their babies at 27–32 month intervals, compared with a 9–14 month interval, they are 1.3 times more likely to avoid anemia, 1.7 times more likely to avoid third trimester bleeding, and 2.6 times more likely to survive childbirth.

4 "Birth Spacing: Three to Five Saves Lives," *Population Reports*, Population Information Program, Center for Communication Programs, The Johns Hopkins University Series L, No. 13, Volume XXX, Number 3, *Issues in World Health*, Summer 2002.

Given these statistics, the lengthening of birth intervals achieved over the past five years should be viewed as probably having contributed significantly to the health of women and children in Jordan. This conclusion is consistent with reductions in childhood mortality noted during the four years preceding the 2002 DHS versus the prior five-year period. Neonatal mortality fell from 19 to 16 deaths per 1,000 live births; infant mortality dropped from 27 to 22 deaths per 1,000 live births, and under-5 mortality was reduced from 31 to 27 deaths per 1,000 live births. Continuing analysis of the causes of neonatal mortality, disaggregated by region, urban/rural, and income quintile are needed to address this challenge. The analysis should also determine the relationship between the stagnating neonatal mortality trend and the low utilization of postpartum care (31 percent) and low tetanus toxoid coverage (33 percent) among pregnant women. The analysis could also identify interventions that might be undertaken, specifically looking at issues of quality assurance.

Family planning/reproductive health challenges: There is high desire on the part of Jordanian couples to plan the number and spacing of their children. Their ability to do so *effectively* improves individual family outcomes; it also facilitates Jordan's reaching replacement level fertility by 2020, a goal of the national population strategy. USAID was correct in focusing on family planning and should continue to work with the government of Jordan to achieve its goal and to move the kingdom beyond the current apparent plateau in contraceptive prevalence. The JPFHS 2002 presents ever use of contraception at 81 percent of married women of reproductive age (MWRA); modern method ever use is 69 percent. Over 75 percent of all MWRA over 30 years have used a modern method. However, 42 percent of women discontinue within 12 months of using a method. Jordan is a country of high discontinuation and repeat acceptance of contraception. One can say in 2003 after reviewing the JPFHS 2002 data, as John Ross wrote in 2001, looking at the JPFHS 1997 data,

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

Jordan has made progress in reproductive health and family planning over the last five years, as data indicate. There is widespread acceptance of family planning; knowledge of contraceptive methods is no longer an issue. However, contraceptive prevalence has reached a plateau; unmet need is significant; rates of less effective traditional methods are high among youth; a large cohort of well-educated young women are using less effective methods of FP and experiencing high rates of method failure with them; and there are indications that the national program has a high discontinuation and repeat acceptance rate.

Women's Health challenges: The Comprehensive Postpartum Project (CPP) spanned the years from mid-1996 to mid-2000. Its twenty-one participating centers included hospitals in the MOH, Royal Medical Service (RMS), Red Crescent, and Jordan University. These hospitals provided almost 60% of the deliveries services in Jordan. The main objective of CPP was to reduce the fertility rate in Jordan by providing high quality family planning services. Services provided at the CPP centers included antenatal care, postnatal care, newborn health care, and family planning. All centers were renovated, furnished, equipped. A computerized MIS was

developed. Protocols and a quality assessment manual were developed and staffs were trained in their use. An IEC campaign was conducted to promote utilization of services and IEC materials were developed to improve client education. Community workers visited homes in the communities to educate women about modern contraceptive methods and to refer women for services.

Unfortunately, neither baseline nor ongoing data was collected about the percent of women delivering at the hospitals who subsequently accepted family planning. Furthermore the acceptor data that is available is contaminated by the fact that some family planning clients served by the centers were not postpartum.

Contributions to the improvement of antenatal care were not documented. Improvement in newborn health, while not directly documented, can be inferred to be slight given that few referrals were made for problems identified during newborn visits and no child immunizations were provided at CPP centers. Improvement of the mothers' postpartum health was also probably not significant because postpartum problems are relatively rare and those that do occur are almost always symptomatic and would cause women to seek care without active recruitment.

The CPP centers are each under the sole authority of their hospital directors; even the MOH facilities do not receive technical support from the MCH. Some directors do not even collect family planning statistics from the centers. Some of the CPP family planning providers report feeling "lost." In spite of its shortcomings, CPP does appear to have significantly contributed to USAID's old strategy, primarily by the expansion and enhancement of family planning services. Breast cancer is a leading killer of women in Jordan. Breast cancer ranked first among female cancers as it is responsible for 34% of cancers in Jordanian women. Jordanian women fear this disease and therefore, it is very difficult to have them take the necessary measures to detect and manage this disease early in the process. Women are self conscious about performing a self exam, and therefore, most of the cases are discovered at a very late stage which makes management difficult and chances for cure very slim. Mammography is expensive in the private sector. The public sector facilities have few machines, far too few to meet the needs of high risk groups or to provide regular screening.

Violence against women is an emerging problem that needs to be addressed. The JFPHS 2002 has new modules with questions and data on "wife beating." 87% of women indicated they believed their husband was justified in hitting or beating her if she committed one of a variety of acts: burning the food, neglecting the children, or disobeying the husband. Till now there is no social safety net that can address and help resolve this problem.

Health seeking behavior challenges: Approximately 50 percent of the Jordanian population rely on primary health clinics or centers (PHCs) for outpatient services. The MOH remains the main and sometimes sole source of health services for populations living in remote areas and for the lower income groups. Informal estimates of poverty range from 15 to 35 percent. Given the current social, demographic, and economic pressures, the role of the primary health care system is vital in sustaining and even advancing the health gains of the prior two decades.

Many different factors prevent women in Jordan from getting medical advice or treatment for themselves. The 2002 DHS outlined the following factors regarding problems of ever-married women who reported they have big problems in accessing health care: knowing where to go for treatment; getting permission to go for treatment; getting money for treatment; distance to the health facility; having to take transport; not wanting to go alone; concern there may not be a female provider; and any of the specified problems.

Existing health services challenges: Approximately 50% of the Jordanian population relies on PHC Centers for outpatient services. The MOH remains the main and sometimes sole source of health services for populations living in remote areas and for the lower income groups. Informal estimates of poverty range from 15 to 35%. Given the current social, demographic and economic pressures, the role of the primary health care system is vital in sustaining and even advancing the health gains of the prior two decades. The important social dimension to the work of USAID-funded organizations is to protect the poor and near poor, and to continue to improve the quality of and access to health care services and information more widely available.

Behavior change challenges: While the knowledge of family planning is very high at more than 90%, its practice does not go hand in hand with knowledge. Similarly other health risk factors are known to the young and adult population; however, practicing healthy life styles does not follow the knowledge. Chronic diseases are prevalent, smoking is a national problem, breast cancer is prevalent, and *exercise infrequently practiced*.

Demand for quality health care. Individuals, families and communities need to be empowered to demand high quality care, change their health seeking behavior, and actively participate in and influence the systems responsible for delivery of their health care services.

Opportunities for high-impact interventions: To establish a robust health system including: health center – community interfaces for information, motivation and civic participation in prioritizing health care needs and services; strengthened PHC quality services and information (further ‘software’ development); PHC to hospital referral/appointment systems; refurbished, equipped and expanded safe motherhood services and information at selected hospitals; etc.

USAID Population and Health Strategic Priorities:

The following are USAID/Jordan’s priority program areas for the duration of the 5-year population and Health Strategy:

- Family Planning
- Reproductive Health
- Maternal health
- Child health
- Primary health care
- Safe motherhood
- Health reform
- Behavior change communication
- Policy

- Systems reform and strengthening
- Human resource development
- Quality of care
- Sustainability, institution building, and institutionalization

Factors Influencing the Selection of Interventions

The new strategy is based on historical experience, lessons learned, GOJ strategies and priorities, and pragmatic decisions for the future. Activities and interventions have been selected based on the following principles and factors:

- Work together in a collaborative and iterative working group process to plan a coordinated and systematic approach.
- Adhere to a set of “Guiding Principles” and USAID’s core values:
 - Managing for results
 - Customer focus
 - Teamwork and participation
 - Empowerment and accountability
 - Valuing diversity
- Adhere to relevant USAID/Washington and USAID/Jordan guidance.
- Work within the overall parameters of GOJ and USG policies, strategies, goals and objectives. For example, the GOJ’s/MOH’s Socio-economic Transition Plan (SETP), the National Population Strategy/Reproductive Health Action Plan.
- Work within USAID/Jordan’s new strategy “Gateway to the Future 2004 – 2009” and its cross-cutting themes of: poverty alleviation, women in development, gender and capacity building. Linkages of health with education, governance (civic participation) and water resources will be optimized.
- Agree to apply rigorous activity and site selection criteria to identify future activities and priority geographical areas.
 - demographic (seek every opportunity to access Jordan’s demographic dividend)
 - epidemiological
 - geographic
 - organizational institutional/human resources (public-private-NGO-donor)
 - behavioral (health seeking and high risk)
- Identify and implement opportunities to address family planning/reproductive health, high impact maternal and child health interventions, preventive health, etc. where/as possible.
- Identify and apply synergies, where appropriate, across interventions
- Identify and apply synergies/collaborations with other INGO, NGO or donor-funded activities or organizations in your programs
- Carry out, collectively, an iterative process whereby the 5-year strategy and annual work plans are regularly monitored and reviewed – monitoring for results.

SECTION IV: GUIDANCE TO TASC 2 OFFERORS

The United States Agency for International Development in Jordan (USAID/Jordan) has developed its integrated PFH program for the next phase of assistance from 2004-2009. The new strategy builds upon years of development assistance to Jordan's health sector where current and former cooperating agencies and contractors have implemented successful activities/programs, produced materials and 'lessons learned,' and continue to expand and strengthen many aspects of health sector. USAID/Jordan's approved intermediate result (proxy strategic objective) for the population and health sector is: "Improved Health Status for all Jordanians." This intermediate result is bolstered by three interconnected Sub-results: (SR1) Improved quality of and access to health care services and information; (SR2) Improved health policies, strategies and systems; and (SR3) Improved practice of healthy lifestyles. The process by which USAID/Jordan has chosen to develop this program is based on the Agency's five core values. These core values and what they mean for this new program effort are elaborated in Attachment 2.

IMPORTANT NOTE: This RFTOP is only for the Health Systems Strengthening Component⁵ of the PFH Strategy and is expected to provide technical assistance, training and service provision and information in full collaboration with the service delivery and support organizations⁶ to the MOH and other local organizations working in health. The Offeror is expected to address areas of complementarities, synergy and shared opportunities across the integrated PHN strategy.

The sections above outline the population and health interventions that are currently being undertaken by USAID/Jordan's ten cooperating agency/contractor partners currently working in Jordan. For the purposes of this RFTOP, these cooperating agencies/contractors are referred to as "service delivery organizations and support organizations." Additional cooperating agencies/contractors, funded through USAID/Washington centrally managed projects complement the service delivery components with technical assistance in policy, contraceptive logistics and security, research, HIV/AIDS, etc.

In partnership with the MOH, USAID achieved major accomplishments in FP/RH/PHC over the last strategy period (1997-2003). The interventions, and their commensurate accomplishments, at the clinic level were focused on improved quality of services through clinical training of service providers, establishing performance improvement review systems, improving the management information system, conducting applied research, using communication for behavior change approaches and upgrading the PHC centers through renovation and provision of furniture and specialized medical equipment. Special emphasis was put on FP/RH as Jordan still

5 For the purposes of this SOW, "health system" is defined holistically to include the existing planning, management and oversight systems at national and sub-national levels; governorate level service delivery facilities, plus the supervisory and referral systems to support them; local NGOs; commercial and other private sector health care providers; and community level organizations prepared to help educate, mobilize and serve the needs of health-seeking clients at the grassroots level.

6 USAID/Jordan's current cooperating agency/contractor partners: Primary Health Care Initiatives (PHCI); John Snow/Jordan Association for Family Planning and Protection (JSI/JAFPP); Johns Hopkins Health Communication Partnership (JHU/HCP); Commercial Market Strategies (CMS); Partnerships for Health Reform (PHRplus); Centers for Disease Control and Prevention (CDC); POLICY/DELIVER; FHI/IMPACT; MACRO/DHS; Initiatives, Inc.

faces rapid population growth that counteracts advances made in the socio-economic sectors and Jordan's very limited natural resources.

USAID/Jordan and the MOH are interested in sustaining the gains achieved to date by further expanding these interventions to achieve increased modern method CPR, more rapid reductions in the fertility rate (currently high at 3.6), continuing reductions in maternal and child mortality and morbidity, and overall improvements in primary health care indicators such as the prevention and control of infectious (including HIV/AIDS) and chronic diseases⁷, improved life expectancy and improved burden of disease. To achieve these goals, special focus will be placed on expanding and strengthening FP/RH/PHC information, services and systems at the PHC and central levels. Safe motherhood initiatives at public sector hospitals and improving FP/PHC services at the public hospitals' outpatient clinics will be a new activity.

The vision and goal of the Health Systems Strengthening component will be to assist the MOH expand and institutionalize high quality health care services and information at national and sub-national levels. This will be accomplished through the application of an ***integrated (holistic) focus on strengthening and expanding quality of and access to health care services and information at sub-national (governorate) and national levels.***

Main Objectives:

- Expand and improve the quality of and access to FP/RH/PHC information and services at public sector PHC clinics, hospital outpatient clinics and obstetric/delivery wards in selected hospitals throughout Jordan
- Reduce fertility rate and improve mother and child health indicators through expansion of birth spacing initiatives, reduction in discontinuation of family planning and establishing safe motherhood practices at obstetric and delivery wards at public sector hospitals
- Improve prevention and control of chronic and infectious diseases, including HIV/AIDS, leading to a better quality of life for the poor and disadvantaged
- Improve child health through the introduction of "integrated management of childhood illness (IMCI)" approach
- Strengthen service delivery and related public health systems resulting in sustained improvements in the quality of service
- Physically upgrade the obstetric wards and selected outpatient clinics at public sector hospitals resulting in perceived and actual improved quality of care for safe motherhood
- Reduce disparity in provision of PHC through improving PHC services on the national level thus reaching the poor and disadvantaged
- Assist the GOJ in reaching the planned national FP/RH/PHC improvements as required by Jordan Socio Economic Transformation Plan (SETP) and the National Population Strategy and its sub-strategy the Reproductive Health Action Plan (RHAP)

This five-year, multimillion dollar intervention will build on and expand the achievements to date of the Primary Health Care Initiatives (PHCI) Project, the project primarily focused on improved quality at the PHC level. While PHCI has accomplished a great deal in primary health

⁷ Chronic diseases are showing a sharp increase as Jordan is entering a demographic and epidemiological transition similar to developed countries

care at the clinic level, there remains a great deal to accomplish given the poor quality of health care provision and systems when PHCI started their work in 1999.

This new initiative, supported by several critical support elements funded through Field Support⁸ will work on capacity building and institutionalization of quality improvement and related systems at the primary health center, governorate, and central levels to ensure that the health system at all levels is robust. A system for decentralization of quality management will be established through training and empowerment of people at the governorate level while assisting the central MOH level in standardization, monitoring, certification and accreditation of the services provided. The new initiative for health systems strengthening will establish networks of improved quality approaches between the PHC level, the outpatient department at the hospitals and the obstetric and delivery wards at the hospital.

The required interventions include clinical and management training at peripheral and central MOH levels, systems for improved quality, systems for certification and accreditation, computerized management information system networks, clinic- to-community linkage/interface and physical upgrading of selected facilities. All 380 PHC centers throughout Jordan will be reviewed and, if necessary, included for further refinement. In addition, the 26 MOH hospitals and selected Royal Medical Services hospitals where a large number of deliveries take place could complete the network.

As primary recipient of PHCI's interventions, the MOH is eager to expand and sustain improvements made to date. Improvements in quality PHC are highly cost effective as they reduce the load on the more expensive tertiary care level, are accessible at the national level, and can reduce long-term costs to the health system.

While the MOH may experience short-term budgetary constraints related to the institutionalization process of improved systems and services, USAID and the MOH will need to negotiate these issues early on since USAID is not able to fund all health systems strengthening interventions.

In terms of beneficiaries, this is a national and sub-national intervention that will reach every Jordanian. The public sector services are still highly subsidized; therefore, the poor and disadvantaged will be special beneficiaries of this program as MOH services are geographically accessible all over the country. If the life stages approach to behavior change is applied, mothers, children and young people will be the most direct beneficiaries of the FP/RH/PHC interventions. Male involvement will be expanded and older people will benefit from the broad spectrum of improved PHC services which will include standardized management of chronic diseases. Finally, the interface between communities and health facilities will be enhanced so that individuals and communities are best served. A special group of beneficiaries will be women in labor and post partum as they have special needs for clinical care and FP counseling.

The health system's development and maturation are fundamental to achieving success in all intervention areas of individual, family and community health, particularly in the areas of

⁸ For example: Commercial Market Strategies, Futures Group's Policy Project, Family Health International's IMPACT Project (HIV/AIDS), EngenderHealth (clinical contraception), and contraceptive procurement (GHB).

maternal/child health, reproductive health, safe motherhood and primary health prevention and care. Without an integrated approach, all other interventions are just tinkering around the edges. Under this component, USAID and the MOH will address the individual and family health problems noted above by strengthening the capacity of the Jordanian health system to provide an essential package of health services (Essential Services Package) predominately at the PHC level, something Jordan's health system does not now possess. For the purposes of this RFTOP, "health system" is defined holistically to include the existing planning, management and oversight systems at national and sub-national levels; governorate level service delivery facilities, plus the supervisory and referral systems to support them; local NGOs; commercial and other private sector health care providers; and community level organizations prepared to help educate, mobilize and serve the needs of health-seeking clients at the grassroots level. The latter support mechanisms are to the success of the strategy.

A distinctive aspect of USAID's integrated strategy is that it will focus a significant portion of its future investment in measures that will substantively improve the institutional, managerial and human capacity of the public health system to provide high quality health care services and information. While this approach might produce less evident quantifiable achievements in the short term, it is likely to produce a more sustainable host country delivery capacity over the medium-to-long term especially since the GOJ/MOH is committed to health systems strengthening and other health sector reforms. It should also be noted that the USAID strategy, unlike those of other donors, will not include any salary supplements or other inducements for public sector employees.

To date, USAID-assisted activities in population and health have been implemented within a carefully focused strategy in Jordan's twelve governorates. Each governorate has a number of health facilities including clinics and hospitals under its jurisdiction [See: Attachments 1]. For 2004–2009, USAID/Jordan and its partner organizations will be building on activities and successes to-date as well as reviewing the geographic coverage for health services in the twelve governorates. Currently some 300 PHCs throughout the Kingdom are providing quality health services and information regularly and on demand. The next tier of health services and information is at the referral hospital level.

While a variety of activities have been introduced in these governorates over the years, it is important that any new options be carefully considered in regard to the provision of services, local conditions, effort involved, the effect on patient/client relations, and cost effectiveness. Thus, the offeror(s) should carefully review the current program and consider new approaches or more flexible and opportunistic interventions to help strengthen the health system and its attendant health information and service delivery mechanisms. It will be especially important for the offeror(s) to describe system approaches/strategies and interventions that are simple, sustainable, workable, amenable to changing course/alteration, and are situation-specific within the context of Jordan and that could be sustainable once USAID assistance ends a few years hence.

Given the site selection criteria and the administrative, structural, managerial and geographical considerations within the Jordanian context, offerors are expected to synthesize the various sectoral interventions [technical components and their cross cutting themes] into a 5-year

Strategic Plan and Annual Plan for the first year. Use the attached documents (attachments), other key documents of your choosing, or your experience in Jordan to complete this task. Justify how you/partner(s) would achieve the intended results. Feel free to suggest other interventions or approaches that you believe may strengthen and/or focus the Health Systems Strengthening work within the context of Jordan.

SECTION A: PROPOSAL FORMAT

Important Note: All TASC 2 offerors for the health system strengthening component are requested to use the following format for their proposals. As you will note, this format is keyed to the selection criteria outlined in Section B below.

I. TECHNICAL APPROACH (See Selection Criteria - I)

A. Proposal Framework

Definition of Proposal Framework: The proposal should clearly lay out the items that contribute to achieving a particular result. It consists of people, funding, authorities, activities, and associated documentation required to achieve a specified result(s) within an established time frame. The proposal represents the development hypothesis including those results necessary to achieve an intermediate result and their causal relationships and underlying assumptions. The proposal framework also establishes an organizing basis for measuring, analyzing, and reporting results of the operating unit. It typically is presented both in narrative form and as a graphical representation.

As part of the proposal presentation, offerors should develop and clearly present the following:

- i. Their own "proposal framework" which will lead to achievement of the Mission's intermediate result and sub-results. In completing the proposal framework, offerors need to take into consideration the population/health desires of Jordanian customers, the description of the health situation in Jordan, the Jordan Evaluation Report (see Attachment 4), the Jordan DHS Report (see Attachment 4), and other relevant documents as the offeror determines appropriate. If offerors believe that proposed illustrative approaches or activities outlined above are unrealistic, they may propose and justify alternatives.

The illustrative desired approaches and activities outlined above are examples of what USAID/Jordan and its partner organizations feels should be considered by the offeror(s). Experience to date suggests that these illustrative approaches/activities are important factors in achieving progress in indicators at the intermediate result level. Offeror(s) are encouraged not to limit themselves to these illustrative approaches/activities or treat them as absolute parameters. Fresh ideas regarding approaches/activities are welcome.

- ii. How the offeror would anticipate achieving the results.

- iii. What would be accomplished by the end of the program.
- iv. How the offeror will set priorities among the many options for interventions.
- v. How the offeror will link service delivery activities with the other components of USAID's population and health program (i.e., private sector, NGO, surveillance, health sector reform, etc.)
- vi. As part of its presentation, the offeror should define in its own terms the following key elements of this health systems strengthening component of USAID/Jordan's population and health portfolio:
 - integrated services
 - reproductive health care services/ family planning
 - primary health care
 - accessibility
 - safe motherhood
 - quality
 - sustainability
 - institutionalization

B. Managing Risks and Problem Solving

The contractor who will be awarded this Task Order is likely to encounter a wide range of obstacles, risks, and problems in the implementation of activities as proposed in their proposal. Offerors should, at a minimum, present:

- i. An analysis of the potential risks, obstacles, and problems they expect to encounter in the course of implementation; and,
- ii. A description of how they will identify and address or minimize potential difficulties, including possible severe or unanticipated reductions in funding.

C. Program Efficiency and Sustainability

Proposals should demonstrate approaches designed from the onset to maximize cost-effectiveness and long-term sustainability and institutionalization. Offerors should address the following:

- i. How will/can the offeror ensure that TASC2 sub-contractors or others (e.g., local entities/organizations), if applicable, are meaningfully involved in cost-effectiveness and long-term sustainability and institutionalization?

- ii. What cost-efficiencies/comparative advantages in terms of cost savings does the offeror bring to the program that will reduce the costs of the implementation of the health systems strengthening component?
- iii. What approaches will the offeror employ to ensure that the desired results of the activity will be sustained after completion of the component?
- iv. What approaches will the offeror employ to ensure the sustainability and institutional development and of local entities/organizations supported under this program?

II. COLLABORATION/TEAMWORK (See Selection Criteria - II)

A. Collaborative Work Relationships

- i. How does the offeror envision collaboration among TASC2 or other partners, if applicable, submitting this proposal?
- ii. What relationships in terms of delegation of authority and accountability does the offeror foresee between its office in Jordan and its headquarters?
- iii. How does the offeror envision approaches to working with sub-contractors in the development, implementation and monitoring of activities/interventions and achievement of results in the field?
- iv. How does the offeror envision collaboration/teamwork with the partners working on the other components of the population and health program?
- v. How does the offeror foresee its role in the national population and health program, including the Jordanian Government, donors and local development organizations?
- vi. How does the offeror envision USAID's role in the implementation of the health systems strengthening component?

III. INSTITUTIONAL CAPABILITY (See Selection Criteria - III)

Given the breadth of the program, the mix of skills needed among potential staff members, and the various possible organizational configurations which could be developed, USAID is not specifying the organizational configuration and staffing plan for this component.

- i. Proposals should demonstrate the experience, staff, and facilities that give the offeror the capability to implement health systems strengthening interventions or programs in countries with similar conditions to those of Jordan and to successfully achieve the results described in this SOW.

The offeror should also describe:

- a) 1-2 successes and lessons learned in the last 3 years

b) 1-2 failures and lessons learned in the last 3 years

ii. The offeror should present how you envision the organization of your office in Jordan and headquarters/support office in order to implement an effective and efficient program.

iii. Present a workplan, including identification of personnel and level of effort.

IV. STAFFING (See Selection Criteria - IV)

i. Offerors should provide summary job descriptions. The rationale behind the technical and/or management responsibilities assigned to each position should be described in relation to the qualifications required of the position. Critical staff should have extensive experience and expertise in designing, implementing and evaluating health systems strengthening interventions or programs in countries with similar conditions to those of Jordan.

NOTE: Critical staff should have the following specific skills/experience: safe motherhood, FP/RH, health systems strengthening, clinical/technical, FP/RH/PHC training, computer MIS, renovation/medical equipment/furnishings, cost containment, human resources development/manpower planning, IEC/BCC.

ii. The offeror should identify the person(s) and their qualifications who will be involved in the implementation of the health systems strengthening component.

iii. The offeror should describe the **critical personnel and skills mix** it will utilize to implement the health systems strengthening component.

iv. *Curricula vitae* for all proposed critical professional staff should be provided, including language skills and Jordan, Middle East or developing country experience. **Each C.V. must be limited to no more than three pages.**

The following broad, general questions/issues should be considered in developing proposals:

1. Based on your experience elsewhere and your knowledge of Jordan, what does your organization/partnership consider as the most appropriate geographic/demographic coverage for: (a) on-going work at the PHC level; and (b) development and strengthening of the health system, particularly in hospital outpatient clinics and obstetric/delivery wards? Are there other approaches that should be considered?

2. How would your Plans complement that of other USAID-funded cooperating agencies/contractors, other local organizations, or donors working in health systems strengthening [e.g., other donor support for infrastructure/renovation, equipment, human resources training/development, service delivery of related health services at the governorate level]?

3. How would your organization/partnership utilize and build upon the current [PHCI-assisted] program (interventions, products, lessons learned) to complement the full-service preventive care approach utilized at the PHC level (“Family Medicine Model”)?
4. How would your Plans institutionalize human resource development and systems within MOH and the National Programs to strengthen sustainability [organizational, programmatic and financial]?
5. How should the health systems strengthening component target scarce resources in order to maximize capacity building to strengthen the institutionalization of human resource capabilities and systems [planning, management and oversight systems] within the health system, particularly at the governorate level, to ensure capacity building and sustainability (organizational, programmatic and financial)? Which interventions, where, and why?
6. How might complementarity, synergy, cost-sharing/cost-recovery, and other linkages with other programs and sectors be achieved, especially at governorate and community levels?
7. How can flexibility of response or intervention be built into the component design, given the possibility of demographic/epidemiologic change, policy/regulatory changes, or a changing political environment?
8. Are there policy or regulatory reforms that, if made, would greatly assist current or proposed interventions?

The following, specific questions/issues should also be considered in developing proposals:

1. Recognizing that a systems approach is called for, describe how you would address the essential elements of governorate level health services (Primary Health Clinics/Centers, PHC outreach, Hospitals) and the referral mechanisms, and linkages between them.
2. What kinds of technical assistance will be required for a systems approach?
3. How would your organization/partnership develop and/or strengthen a referral and appointment system from PHC to hospital level (outpatient departments or obstetric/delivery wards)?
4. In your opinion, what are the most important and doable safe motherhood interventions for Jordan? Why?
5. What kinds of training would you include, through both formal and informal mechanisms, for PHC and hospital staff to improve clinical, counseling/interpersonal, and managerial skills?
6. What kinds of linkages are there, or should be put in place, to connect the PHC with communities? Within communities, what kind of linkage should be established to provide an essential mechanism for improving PHC-community relations, mobilizing the community for outreach sessions and promoting health practices and utilization of preventive services?

7. Beyond the five site selection criteria, what additional criteria or data would you use to determine geographical site selection of focus governorates? Why?
8. How does your organization/partnership propose to reach vulnerable and/or hard-to-reach segments of Jordanian society, particularly women and young children?
9. Given the general state of human resource capacities in Jordan, what kind of plans, policies and resource allocation for local staff development, and deployment of a critical mass of professional staff at the field level, with phased in devolution of authority and responsibility to them, would you recommend?
10. Given the many contributions made and products developed to-date by USAID/Jordan's cooperating agency/contractor partners, how would your organization/partnership utilize or integrate existing contributions, systems, materials, products into your Plan to address health system strengthening? For example, how would you utilize and/or integrate the lessons learned from PHCI, EngenderHealth, LINKAGES, etc. in your Plan?
11. Specify how your organization/partnership will coordinate and cooperate with other USAID-funded cooperating agencies and contractors working under the other sub-results. For example, how will your organization/partnership coordinate your Plan for health systems strengthening with related efforts in service delivery in the public and NGO sectors, health reform, behavior change communication, surveillance, etc.?

Elements to consider are: (a) activities and/or interventions and geographic locality; (b) role, type and number of partners required both in terms of implementing partners and governorate level in Jordan; (c) cost effectiveness of alternative interventions and partnerships; (d) local organization capacity building and long term competency and viability; and (e) appropriate performance indicators.

SECTION B - SELECTION CRITERIA

The criteria presented below have been tailored to the requirements of this SOW. The relative importance of each criterion is indicated by approximate weight by points. The offeror should note that these criteria serve to identify the significant matters, which offerors should address in their proposals, and to set standards against which all proposals will be evaluated. To facilitate the review of proposals, offerors are requested to organize the narrative sections of technical proposals according to the evaluation criteria set forth below.

The criteria are:

I. TECHNICAL APPROACH [30 points]

1. Demonstrated understanding of the appropriate, cost-effective health system strengthening interventions/approaches most likely to have a significant impact on achieving

USAID/Jordan's Intermediate Result (the IR acts as a proxy Strategic Objective) in the population and health (PFH) sector.

2. Merit of the proposed implementation plans in terms of its ability to achieve the intermediate result (proxy strategic objective), taking into consideration the health needs of Jordanians.
3. Appropriateness of the offeror's description of linkages of the health systems strengthening component with the other components of USAID/Jordan's integrated population and health program (e.g., maternal and child health, reproductive health/family planning, health reform, behavior change communication, HIV/AIDS, etc.)
4. Strength of the analysis of potential obstacles, risks and problems that could be encountered during program implementation and feasibility of the proposed solutions for addressing the identified problems.
5. Merit of the offeror's approach to ensure that the program results can be sustained after completion of the five-year implementation program.
6. Approach to institutional development and sustainability of local organizations at national and sub-national level that will implement this component.

II. COLLABORATION AND TEAM WORK [20 points]

1. Strength and appropriateness of the proposed TASC2 partnership and other potential local and/or international organizations that are awarded the Task Order for this program.
2. Merit of proposed relationships between headquarters/support office and the planned Jordan office and adequacy of local delegation of authority and responsibility.
3. Merit of the proposed approach for working with cooperating agencies/contractors and their local partners implementing the other components of the USAID-supported Jordan program, host government, with local development organizations, donors and USAID in assuring on-going collaboration of field implementation efforts to achieve the results and support Jordan's national health program.

III. INSTITUTIONAL CAPABILITIES OF THE OFFERORS [20 points]

1. Demonstrated knowledge, capability and long term experience of the offeror in providing health systems strengthening interventions or programs in areas, regions or countries with similar conditions to those of Jordan.
2. Merit of proposed organization of the offeror's Jordan and headquarters/support office and extent to which the offeror's proposed organizational structure is managerially streamlined, practical and efficient.
3. Strength of the work plan to ensure a smooth and effective launch of program implementation.

IV. STAFFING [30 points]

1. Merit of critical professional staff for program implementation in terms of:
 - a. Demonstrated experience and competency in the implementation of health systems strengthening interventions or programs;
 - b. High level experience in technical fields appropriate to proposed positions and roles;
 - c. Experience in coordinating diverse activities that produced documented results;
 - d. Demonstrated experience in the use of varied modalities (e.g., technical assistance, technology transfer, training, information dissemination, etc.) to transfer concepts and skills;
 - e. Experience in training, system development/implementation, clinical/technical interventions, cost analysis, etc. in countries similar to Jordan;
 - f. Experience in working with or knowledge of USAID-supported cooperating agencies, donors, USAID missions, and international counterpart organizations;
 - g. Relevant experience working in developing countries, particularly Jordan (Arabic language capability is viewed favorably); and
 - h. Extent to which the proposed staff skills complement one another.
2. Appropriate number and skills mix of the staff proposed to for implementation and on-going program monitoring.

SECTION V: RESULTS TO BE ACHIEVED

This 5-year Health Systems Strengthening initiative requires a holistic, integrated approach to health systems development and strengthening. For the purposes of this SOW, “health system”

is defined holistically to include the existing planning, management and oversight systems at national and sub-national levels; governorate level service delivery facilities, plus the supervisory and referral systems to support them; local NGOs; commercial and other private sector health care providers; and community level organizations prepared to help educate, mobilize and serve the needs of health-seeking clients at the grassroots level.

Offerors are encouraged to be innovative/creative in suggesting other interventions for health systems strengthening.

The main tangible interventions and results to be achieved, which will build upon experience and lessons learned to-date, include:

- clinical and management training at peripheral and central MOH levels
- systems for improved quality
- systems for certification and accreditation
- computerized management information system networks
- clinic-to-community linkage/interface
- physical upgrading (renovation) and provision of medical equipment and furniture at selected facilities.

SPECIFIC RESULTS TO BE ACHIEVED

1. Assist the MOH conduct an assessment of: (a) primary health care facilities that refer to hospitals in their areas to assess provider practices and attitudes, patient load, referral/appointment practices, and other related issues; (b) referral hospitals (i.e., obgyn and outpatient wards) to assess renovation, medical equipment and furniture needs as well as provider practices and attitudes, patient load, patient capacity, and related issues. While this assessment should include all referral patients to assess how primary health interventions can be strengthened, it should place special emphasis on pregnant, or about to be pregnant, women (safe motherhood continuum).
2. Physically upgrade selected obstetric wards and hospital outpatient clinics, and primary health care facilities, at the public sector, based on the findings of the needs assessment and joint agreement with USAID/Jordan.
3. Assist the public sector (MOH and RMS) develop appropriate referral and appointment systems to adequately manage normal versus complicated deliveries. This system(s) should be from primary health clinic/center level to referral hospital level obgyn and MCH wards (safe motherhood interventions).
4. Assist the public sector (MOH and RMS) develop and/or expand both Basic Obstetric Care (EOC) and Comprehensive Essential Obstetric Care facilities. EOC interventions should include: clinical standards (if not already available in Jordan); supervision; management of problem pregnancies; medical treatment of complications; manual procedures; monitoring labor; neonatal special care; surgical interventions; anesthesia; blood replacement; etc.

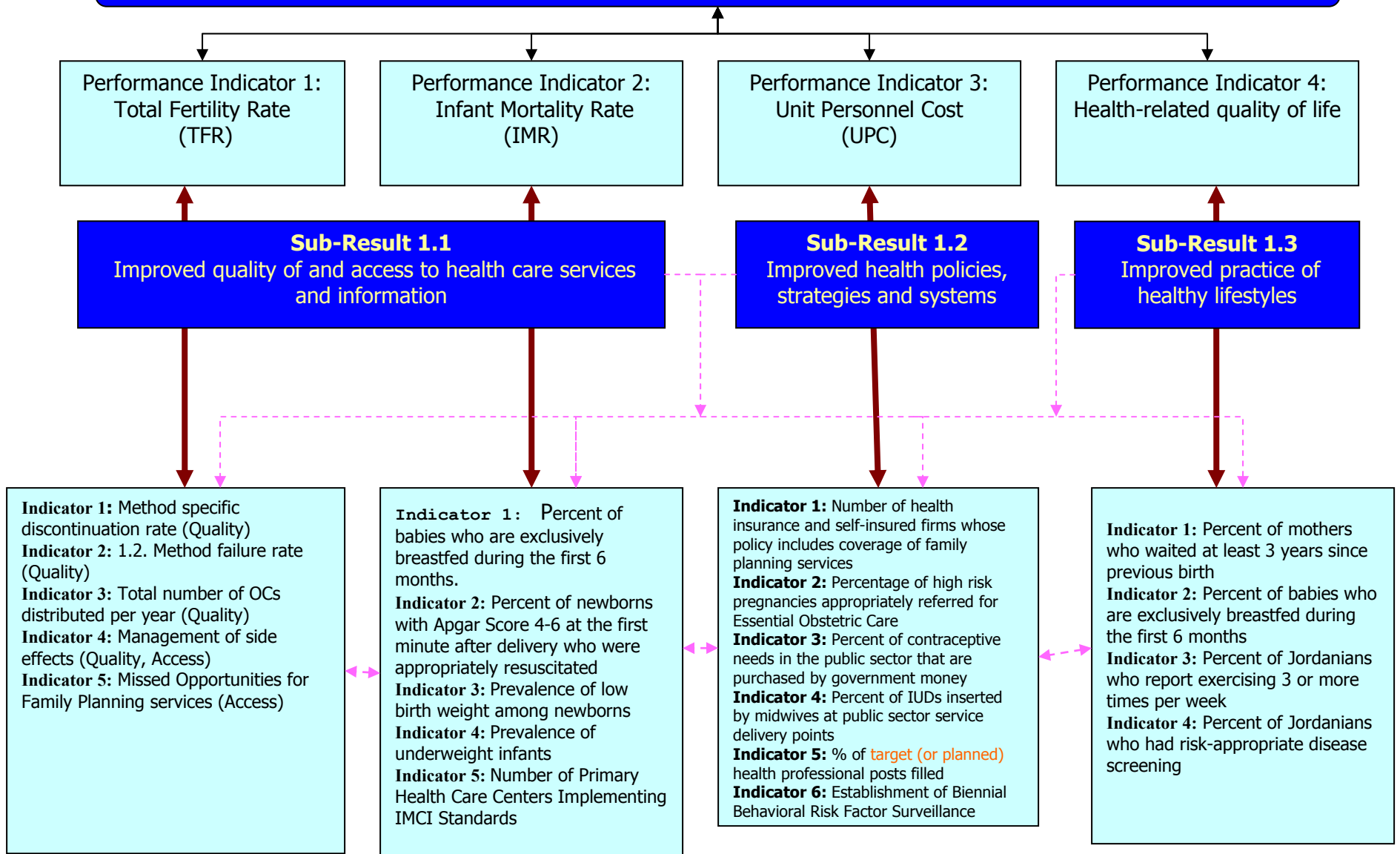
5. Assist the MOH to continue to build capacity and to institutionalize quality improvement and related systems at the primary health center, governorate, and central levels to ensure that the health system at all levels is robust. [Note: This component will be supported by several critical support elements funded through Field Support mechanisms and builds upon the work of several local USAID-funded partner organizations.]
6. Assist the MOH develop and institutionalize MOH-funded systems for: (a) facility maintenance and cleaning (janitorial services) in hospitals and PHCs; and (b) computer hardware/software maintenance in PHCs and hospitals.
7. Expand and strengthen FP/RH/PHC information, services and systems at the PHC and central levels. Interventions should include expansion of voluntary surgical contraception (female and male); modern contraception methods and counseling; post abortion care; breast-feeding; IMCI; and similar MCH interventions. Especially important are safe motherhood initiatives at public sector hospitals and improving FP/PHC services at the public hospitals' outpatient clinics.
8. Since the provision of primary health care at the clinic level has been shown to be highly cost effective as it reduces the load on the more expensive tertiary care level, assist the MOH establish a system to continue to improve the quality of and access to primary health care clinics/centers to reduce long-term costs to the health system.
9. Assist the MOH to develop an Essential Service Package (ESP) at the primary health clinic/center level and strengthen the capacity of the Jordanian health system to provide an essential package of health services.
10. Coordinate/collaborate with the MOH and other USAID-funded partners to improve and maintain a robust network of public-private-NGO clinics and health providers and facilities.
11. Assist the MOH in establishing three training centers for family planning and reproductive health. These training centers should be appropriately located geographically.
12. Strengthen planning, management, and clinical/technical skills at all levels from primary health care facility level to referral hospital level.
13. Assist the MOH continue to improve use of data for decision making at operational and management levels.
14. Transfer program skills and responsibility gradually to host country organizations
 - *strengthen the human and organizational capacity of health service providers*
 - *strengthen the skills of health providers in management, facilitative supervision and use of data*

SECTION VI: MONITORING AND EVALUATION

Adhering to USAID's Strategic Framework and M&E requirements, offerors should propose a monitoring and evaluation plan for assessing the potential inputs, processes, outputs, outcomes,

benchmarks and impact for the most relevant Sub-result or Sub-Results for the health systems strengthening component under the 5-year PFH Strategy. Once the Task Order has been awarded and the offeror has established a presence in Jordan, the proposed M&E plan will be modified and more fully developed to directly contribute to PFH's Performance Monitoring Plan (PMP). This modification/refinement will be done in collaboration with the other members of the implementing partnership. In other words, the successful offeror, in coordination with USAID/Jordan, its service delivery and support cooperating agencies/ contractors and their local partners, and the MOH, will develop a detailed M&E plan when the multi-year strategy and annual workplan/s are being finalized (based on the USG fiscal year of October – September).

Intermediate Result 1: Improved health status for all Jordanians Timeframe: 2004-2009



ATTACHMENTS

ATTACHMENT 1: Geographic Focus: PFH's Preliminary Safe Motherhood Needs Assessment of hospitals, and the lists of renovated and equipped health care clinics/centers under the PHCI and ROC projects)

ATTACHMENT 2: USAID's Core Values

ATTACHMENT 3: USAID Terminology

ATTACHMENT 4: Selected Key Documents

ATTACHMENT 1

GEOGRAPHICAL FOCUS

A. PFH's Preliminary Safe Motherhood Needs Assessment/Hospitals

Background:

The new PFH strategy FY2004-2009 has three Sub-Results. The first one, which concentrates on service delivery and information is "Improved Quality of and Access to Health Care Information and Services."

A major component of this Sub-result as articulated at the October 2003 strategic planning consensus building workshop is to improve safe motherhood interventions.

In March 2004, the PFH team visited the head of the MOH's GYN/OBS department, Dr. Issam Shraideh to discuss future safe motherhood initiatives for MOH and RMS hospitals. The team used a simple questionnaire to help in the dialogue about delivery and neonatal services provided at the MOH hospitals as explained by Dr. Shraideh. The team also requested Dr. Shraideh to get some quantitative data on safe motherhood services offered at all MOH hospitals (according to a simple questionnaire provided to Dr. Shraideh). This preliminary Needs Assessment report summarizes the discussion with Dr. Shraideh and the data shared from the MOH hospitals on safe motherhood services.

To further verify the data received from the MOH hospitals and to collect additional qualitative and quantitative information about safe motherhood services the PFH team conducted several fact finding field trips to a number of MOH hospitals that offer deliveries, GYN/OBS services and neonatal services. This report is a preliminary and incomplete report which should be used as a guide to prospective TASC 2 offerors.

Summary of the current safe motherhood status as described by Dr. Shraideh:

1. The MOH operates 26 hospitals that have delivery wards
2. Six of these are teaching hospitals
3. Nature of services:

Most of the hospitals have a first stage delivery room and a second stage delivery room.

The general impression of the physical status is good as described by Dr. Shraideh. Emergency room is divided into GYN/OBS.

Major problems with safe motherhood services:

- a) Unmet need
- b) Very deficient referral system; high risk should be transferred to the hospitals only through referrals from the Comprehensive Health Centers to the hospitals, but there are many ways to by-pass the PHC and CHC system
- c) 60% of delivery cases are "un-booked cases", which means no pregnancy history available at the time of showing up for delivery

- d) Although standards of care for delivery, antenatal, postnatal and neonatal care have been developed they are not used
- e) Medical equipment and instruments are deficient such as:
 - Quality and durability of instruments is poor
 - Insufficient monitoring equipment and systems
 - Acute shortage/number of neonatal incubators
 - Obstetric beds are deficient/expensive

MOH priorities for a Safe Motherhood Initiative intervention (in case of funding constraints):

- First priority: the 6 teaching hospitals
- Second priority: the 14 biggest hospitals
- Third priority: the remaining six smallest hospitals (the list of prioritization needs further verification based on field trips)

6. Training needs:

- Feto-maternal medicine for specialists
- Regular aborters, amniocentesis
- Nurses and midwives need upgrading for skills

Dr. Shraideh advised the PFH team to consider the following list of hospitals from his understanding of the MOH's priorities for safe motherhood interventions.

1. Al-Basheer, Amman
2. Princess Badia, Irbid
3. Al-Zarka, Zarka
4. Faisal Bin Alhussein/Yajouz, Zarka
5. Mafraq/GYN/OBS, Mafraq
6. Al-Hussein, Salt
7. Jamil Tutunji/ Sahab, Amman
8. Missing
9. Jerash, Jarash
10. Karak, Karak
11. Ramtha, Irbid
12. Al-Amera Raya, Irbid
13. Eman, Irbid
14. Ma'an , Ma'an

Dr. Shraideh also agreed with the PFH team about the importance of including the RMS's major hospitals in the Safe Motherhood Initiative. The following RMS hospitals were prioritized by Dr. Shraideh:

1. King Hussein Medical Center, Amman
2. Aydoun/Ameer Rashed, Irbid
3. Karak, Karak
4. Aqaba is a very important hospital from a service and political point of view (Dr. Shraideh recommended strongly that it should be included, as Aqaba is becoming a highly visible zone from an economic and political view)

Summary of quantitative data received from the hospitals:

Data was received from 23 out of 26 hospitals. In general the data received was very useful. However, the definitions were not applied uniformly by the hospital staff that completed the questionnaire. In

addition the data on some parameters was deficient and therefore further verification by field visits or phone calls will be essential.

Attached are two tables that describe the data received from the hospitals on delivery and neonatal services.

There are three major categories of hospitals in terms of number of deliveries. This data below and Table 1 provides a summary of the delivery wards all over the country.

- a) hospitals with more than 4000 deliveries/year (7)
- b) hospitals with 1000-4000 deliveries/year (10)
- c) hospitals with less than 1000 deliveries per year (9)

In addition, the tables show the huge number of clients visiting the GYN/OBS outpatient clinics and highlights the need to develop safe motherhood interventions there.

In terms of surface area of the delivery wards, only seven hospitals provided the surface area values. The range is:

- More than 400 Square Meters (3)
- 100-400 Square Meters (4)

Tables 1 and 2 provide summary of neonatal wards and services (for guidance only); the prospective proposer shall verify all information provided in these tables, and to make his own investigations.

Table (1)
Summary for delivery wards in the MOH hospitals for the Year 2003

No.	Hospital Name	Governorate	Number of deliveries	Number of clients at GYN/OBS clinics	Admissions GYN/OBS ward	No. of Beds in Delivery ward	Surface area of Delivery Ward/ Sq/M	Number of delivery rooms	No/ delivery beds	No./ delivery operating rooms	Surface area delivery rooms and/or operating rooms Sq/M	No.of C/S
1	Al-Basheer	Amman	14,000	49433	18500	80	106	4	12	1	150	2239
2	Zarka	Zarka	8000	11138	N/A	76	N/A	3	9	29	128	1200
3	Al-Amara Raya	Irbid	N/A	12928	3440	18	90	1	4	N/A	N/A	N/A
4	Princess Badia	Irbid	8742	16527	12075	66	N/A	1	4	N/A	500	N/A
5	Fiasal Bin Al-Hussein	Zarka	5342	24857	7339	26	125	8	10	3	177	N/A
6	Mafrak/gyn/obs	Mafrak	5240	11803	6261	309	n/a	n/a	42	n/a	130	N/A
7	Al-Hussein	Balqa	4398	12208	6048	27	N/A	1	11	N/A	240	N/A
8	Jamil Tutanji/Sahab	Amman	3729	6387	4940	30	120010	1	6	N/A	N/A	N/A
9	Karak	Karak	3273	9200	3680	N/A	N/A	N/A	N/A	N/A	200	593
10	Al-Nadeem Hospital	Madaba	3132	7315	4018	19		2	3+2	N/A	69	433
11	Jerash	Jerash	2985	13045	4362	25	456	??	N/A	2	187	214
12	Ramtha	Irbid	2468	N/A	3119	12	N/A	1	N/A	N/A	33	N/A
13	Al-Eman	Ajloun	2356	8690	3115	20	N/A	1	4	N/A	48	N/A
14	Ghour-Alsafi	Kerak	1440	4800	480	12	N/A	1	2	N/A	32	N/A
15	Abi-Obeidah	Irbid	1340	?	1556	17	N/A	1	2	N/A	35	N/A
16	South Shouneh	Irbid	1213	4464	1498	10	n/a	1	2	N/A	36	N/A
17	Amara Iman/Maadi	Balqa	1000	4944	1419	N/A	230	1	11	N/A	N/A	N/A
18	Yarmouk	Irbid	811	4443	1103	14	Data not provided	2	2	1	52	
19	Moaz ben Jabal	Irbid/north Shounah	787	8623	1157	6	N/A	1	1	N/A	25	N/A
20	Queen Rania Al-Abdalla	Ma'an	700	6000	2848	13	N/A	1	1	N/A	40	N/A
21	Ma'an	Ma'an	520	9395	2741	37	481	1	N/A	N/A	80	N/A
22	Rushed	Mafrak	185	1105	322	5	N/A	1	2	N/A	35	N/A
23	Princess Salma/Theeban	Madaba	178	1226	366	18	N/A	2	4	N/A	66	N/A

9 Yarmouk hospital is new, started to function only in March 2003

10 Surface area is provided for the total of GYN/OBS ward and neonatal ward

Table 2
Summary of neonatal services and wards at MOH hospitals

Number	Hospital Name	Number of incubators in the neonatal unit	Surface area of neonatal ward	Number of cases admitted to neonatal care
1	Al-Basheer	32	363	1426
2	Zarka	24	110	N/A
3	AL-Amera Raya	4	20	N/A
4	Princess Badia	30	180	N/A
5	Fiasal Bin Al-Hussein	6	50	429
6	Mafrak/Gyn/Obs	13	150	N/A
7	Al- Hussein	8	80	N/A
8	Jamil Tutanji/Sahab	9	N/A	N/A
9	Karak	N/A	N/A	N/A
10	Al-Nadeem	N/A	47	N/A
11	Jerash	10	39	395
12	Ramtha	7	28	N/A
13	Eman	8	130	N/A
14	Ghor Al-Safi	N/A (5??)	20	N/A
15	Abi-Obeidah	6	35	N/A
16	South shouneh			
17	Amera Iman/Maadi	5	24	92
18	Yarmouk 11	5	86	N/A
19	Moaz ben Jabal	6	25	N/A
20	Queen Rania Al-Abdalla	7	70	100
21	Ma'an	12	324	N/A
22	Ruwashed	3	36	N/A
23	Amera Salma/Zeiban	3	35	N/A

11 Yarmouk hospital is new, started to function only in March 2003, the neonatal unit starting date was January 2004.

B. Lists of the physically improved health centers by PHCI/ROC

Table (3)

List of the primary and comprehensive health clinics renovated and equipped by PHCI project

No.	Governorate	Health Directorate	ID	Health Center Name	TYPE*
1	Amman	Capital	11907	East Al-Weibdeh	CHC
2	Amman	Capital	11909	Jebal Al-Hussein	CHC
3	Amman	Capital	11916	Al-Nasser	CHC
4	Amman	Capital	11910	Al-Awdah (Um-Tineh)	PHC
5	Amman	Capital	11943	Al-Hashimieh	PHC
6	Amman	Capital	11935	Al-Bassa	PHC
7	Amman	Capital	11937	Tabarbour (Tareq)	PHC
8	Amman	Capital	11946	Al-Zouhour	PHC
9	Amman	Capital	11906	Al-Taj	PHC
10	Amman	Capital	11903	Marka (Al-Tatweer Al-Hadari)	PHC
11	Amman	Capital	11905	Al-Manara	PHC
12	Amman	Capital	11917	Al-Mahatta	PHC
13	Amman	Capital	11915	Marj Al-Hamam	PHC
14	Amman	Capital	11940	Al-Adassieh	PHC
15	Amman	East Amman	12901	Sahab	CHC
16	Amman	East Amman	12935	Khreibat Al-Souq	PHC
17	Amman	East Amman	12939	Al-Jweideh	PHC
18	Amman	East Amman	12938	Um- Nouwara	PHC
19	Amman	East Amman	12937	Um-Qasseer Al-Maqablein	PHC
20	Amman	East Amman	12936	Al-Qweismeh	PHC
21	Amman	East Amman	12949	Al-Taybeh	PHC
22	Amman	East Amman	12934	Abu-Alanda	PHC
23	Madaba	Madaba	41901	Madaba Al-Sharqy (East Madaba)	PHC
24	Madaba	Madaba	41907	Ma'een	PHC
25	Madaba	Madaba	41906	Jreineh	PHC
26	Madaba	Madaba	41905	Maleeh	PHC
27	Madaba	Madaba	41902	Madaba Al-Gharby (West Madaba)	PHC
28	Madaba	Madaba	41903	Mukhayam Madaba (Madaba Camp)	PHC
29	Zarqa	Zarqa	71904	Hai Al-Ameer Mohammed	PHC
30	Zarqa	Zarqa	71905	Hai Al-Ameer Abdullah	PHC
31	Zarqa	Zarqa	71901	Subhi Shbeeb	PHC
32	Zarqa	Zarqa	71938	Al-Zarka Al-Jadidah	PHC
33	Zarqa	Zarqa	71937	Awajan	PHC
34	Zarqa	Zarqa	71916	Isskan Al-Hashimieh	PHC
35	Zarqa	Zarqa	71934	Al-Rsseifah Al-Janoubi	PHC
36	Zarqa	Zarqa	71919	Al-Rasheed	PHC
37	Zarqa	Zarqa	71939	Hai falah	PHC
38	Zarqa	Zarqa	71909	Al-Roussaifah Al-Shamali (North Rssseifah)	PHC
39	Zarqa	Zarqa	71914	Bereen	PHC
40	Zarqa	Zarqa	71915	Al-Sukhna	PHC
41	Zarqa	Zarqa	71911	Al-Tatweer Al-Hadari / Al-Naqab	PHC
42	Zarqa	Zarqa	71903	Subhi Al-Zawahreh	PHC
43	Zarqa	Zarqa	71906	Isskan Al-Amir Talal Yajooz	PHC

No.	Governorate	Health Directorate	ID	Health Center Name	TYPE*
44	Zarqa	Zarqa	71908	Jabal Al-Amir Faisal	PHC
45	Balqa	Salt	A1919	Allan	PHC
46	Balqa	Salt	A1918	Al-Sbeih	PHC
47	Balqa	Salt	A1915	Salhoub	PHC
48	Balqa	Salt	A1901	Al-Salt	PHC
49	Balqa	Salt	A1902	Wadi Al-Akrad	PHC
50	Balqa	Salt	A1906	Al-Mudari	PHC
51	Balqa	Salt	A1907	Abu-Nsseir	PHC
52	Balqa	Salt	A1905	Mahess	PHC
53	Balqa	Deir Alla	A2904	Al-Twall Al-Janoubi	PHC
54	Balqa	Deir Alla	A2907	Khazma	PHC
55	Balqa	Deir Alla	A2905	Dirar	PHC
56	Balqa	Deir Alla	A2902	Deir Alla	PHC
57	Balqa	Deir Alla	A2901	Ma'adi MCH / T.C.	CHC
58	Balqa	South Shouneh	A3904	Al-Karamah	PHC
59	Balqa	South Shouneh	A3906	Al Hajar Al-Twall (Al-Nahda)	PHC
60	Balqa	South Shouneh	A3902	Al-Jofah	PHC
61	Irbid	Irbid	D1921	Samad wa Al-Za'tarah	PHC
62	Irbid	Irbid	D1938	Fo'ara	PHC
63	Irbid	Irbid	D1909	Al-Mwathafeen	PHC
64	Irbid	Irbid	D1964	Al-Tatweer Al-Hadari / Beit Ra'ass	PHC
65	Irbid	Irbid	D1959	Al-Razi	PHC
66	Irbid	Irbid	D1903	Ibn Seena	PHC
67	Irbid	Irbid	D1923	Dei Youssef	PHC
68	Irbid	Irbid	D1925	Al-Mazar	PHC
69	Irbid	Irbid	D1931	Samma	PHC
70	Irbid	Irbid	D1933	Qameem	PHC
71	Irbid	Irbid	D1948	Al-Na'imeh	PHC
72	Irbid	Irbid	D1953	Hawarah	PHC
73	Irbid	Irbid	D1919	Aydoun	PHC
74	Irbid	Irbid	D1949	Al-Husson	PHC
75	Irbid	Irbid	D1904	Al-Barha	PHC
76	Irbid	Irbid	D1902	Dahiyat Al-Hussein	PHC
77	Irbid	Irbid	D1918	Katm	PHC
78	Irbid	Irbid	D1907	Hanina	PHC
79	Irbid	Irbid	D1913	Sal	PHC
80	Irbid	Irbid	D1914	Al-Mgheiber	PHC
81	Irbid	Irbid	D1915	Bushra	PHC
82	Irbid	Irbid	D1955	Hofa	PHC
83	Irbid	Irbid	D1922	Arhaba	PHC
84	Irbid	North Agwar	D2909	Kreimeh	PHC
85	Irbid	North Agwar	D2903	Al-Shounah Al-Shamalieh	PHC
86	Irbid	North Agwar	D2906	Wadi Al-Rayyan	PHC
87	Irbid	North Agwar	D2902	Waqass	PHC
88	Irbid	North Agwar	D2904	Al-Manshiah	PHC
89	Irbid	North Agwar	D2905	Al-Mashare'e	PHC
90	Irbid	Ramtha	D3905	Al-Shajrah	PHC
91	Irbid	Ramtha	D3908	Al-Turra	PHC

No.	Governorate	Health Directorate	ID	Health Center Name	TYPE*
92	Irbid	Ramtha	D3911	Al-Turra Al-Janoubi (Al-Turra South)	PHC
93	Irbid	Ramtha	D3901	Al-Ramtha	PHC
94	Irbid	Ramtha	D3902	Al-Ramtha Al-Gharbi (Ramtha West)	PHC
95	Irbid	Ramtha	D3903	Al-Ramtha Al-Shamali (Ramtha North)	PHC
96	Irbid	Ramtha	D3904	Al-Ramtha Al-Janoubi (Ramtha South)	PHC
97	Irbid	Ramtha	D3906	Al-Bweidah	PHC
98	Irbid	Al-Kura	D4901	Deir Abi Se'eid	PHC
99	Irbid	Al-Kura	D4907	Kufor Eibel	PHC
100	Irbid	Al-Kura	D4902	Kufur Al-Ma'a	PHC
101	Irbid	Al-Kura	D4904	Kufur Rakeb	PHC
102	Irbid	Al-Kura	D4905	Beit Eidess	PHC
103	Irbid	Al-Kura	D4908	Samou'e	PHC
104	Irbid	Al-Kura	D4911	Tibnah(2)	PHC
105	Irbid	Beni Kenanah	D5920	Malka	PHC
106	Irbid	Beni Kenanah	D5911	Um-Qaiss	PHC
107	Irbid	Beni Kenanah	D5919	Hatem	PHC
108	Irbid	Beni Kenanah	D5917	Kharja	PHC
109	Irbid	Beni Kenanah	D5913	Sahem	PHC
110	Irbid	Beni Kenanah	D5912	Al-Mkheibah Al-Foqa (Al-Hemma Al-Ordineiah)	PHC
111	Irbid	Beni Kenanah	D5909	Koufor Soum(2)	PHC
112	Irbid	Beni Kenanah	D5904	Al-Mansourah	PHC
113	Irbid	Beni Kenanah	D5902	Al-Rafeed	PHC
114	Irbid	Beni Kenanah	D5921	Aqraba	PHC
115	Irbid	Beni Kenanah	D5908	Yabla	PHC
116	Irbid	Beni Kenanah	D5915	Samar	PHC
117	Irbid	Beni Kenanah	D5906	Hibrass	PHC
118	Ajloun	Ajloun	G1901	Ajloun	CHC
119	Ajloun	Ajloun	G1904	Sakhra	PHC
120	Ajloun	Ajloun	G1909	Rajeb	PHC
121	Ajloun	Ajloun	G1921	San'ar	PHC
122	Ajloun	Ajloun	G1919	Abeleen	PHC
123	Ajloun	Ajloun	G1912	Halawa	PHC
124	Ajloun	Ajloun	G1905	Al-Hashimiah	PHC
125	Ajloun	Ajloun	G1907	Arajan	PHC
126	Ajloun	Ajloun	G1903	Anjara	PHC
127	Ajloun	Ajloun	G1906	Ein Jana	PHC
128	Jarash	Jarash	J1907	Training center/Jarash	PHC
129	Jarash	Jarash	J1902	Souf	PHC
130	Jarash	Jarash	J1903	Sakeb	PHC
131	Jarash	Jarash	J1904	Al-Razy	PHC
132	Jarash	Jarash	J1908	Al-Mastaba	PHC
133	Jarash	Jarash	J1901	Jerash	PHC
134	Jarash	Jarash	J1915	Al-Jazazah	PHC
135	Mafraq	Mafraq	M1904	Sama Al-Sarhaan	CHC
136	Mafraq	Mafraq	M1916	Al-Hamra'a	PHC
137	Mafraq	Mafraq	M1922	Manshiat Bani Hasan	PHC
138	Mafraq	Mafraq	M1917	Al-Harsh	PHC
139	Mafraq	Mafraq	M1914	Al-Za'tari	PHC

No.	Governorate	Health Directorate	ID	Health Center Name	TYPE*
140	Mafraq	Mafraq	M1901	Al-Mafraq	PHC
141	Mafraq	Mafraq	M1903	Hai Al-Hussein	PHC
142	Mafraq	Mafraq	M1915	Tharghrat Al-Jib	CHC
143	Mafraq	Mafraq	M1911	Fa'a	PHC
144	Mafraq	Mafraq	M1931	Nadrah	PHC
145	Mafraq	Mafraq	M1959	Um Al-Nia'am Al-Sharqieh	PHC
146	Mafraq	Mafraq	M1905	Mghayar Al-Sarhaan(2)	PHC
147	Mafraq	North Badiah	M2963	Al-Badiah Al-Shamali	CHC
148	Mafraq	North Badiah	M2908	Al-Safawi	PHC
149	Mafraq	North Badiah	M2927	Rawdat Al-Amira Basma	PHC
150	Mafraq	Mafraq	M1949	Al-Mdwar	PHC
151	Karak	Karak	P1936	Al-Qatranah	CHC
152	Karak	Karak	P1939	Emre'e	PHC
153	Karak	Karak	P1956	Al-Adnaniah	PHC
154	Karak	Karak	P1952	Al-Ghweir	PHC
155	Karak	Karak	P1941	Majra	PHC
156	Karak	Karak	P1943	Mou'ta	PHC
157	Karak	Karak	P1935	Ghor Al-Safi	PHC
158	Karak	Karak	P1908	Areeha wa Abu-Traba	PHC
159	Karak	Karak	P1960	Bteir	PHC
160	Karak	Karak	P1954	Rakeen	PHC
161	Karak	Karak	P1905	Joza	PHC
162	Tafiela	Tafiela	S1901	Al-Tafilah Al-Shamel	CHC
163	Tafiela	Tafiela	S1906	Bassirah	CHC
164	Tafiela	Tafiela	S1905	Al-Hassa	PHC
165	Tafiela	Tafiela	S1904	Al-Qadissiah	PHC
166	Tafiela	Tafiela	S1908	Ayma	PHC
167	Tafiela	Tafiela	S1907	Ein Al-Baidah	PHC
168	Ma'an	Ma'an	W1901	Ma'an	CHC
169	Ma'an	Ma'an	W1904	Al-Shobak	CHC
170	Ma'an	Ma'an	W1902	Al-Manshiah	PHC
171	Ma'an	Ma'an	W1918	Al-Jafer	PHC
172	Ma'an	Ma'an	W1919	Eil	PHC
173	Ma'an	Ma'an	W1932	Al-Mreigha	PHC
174	Ma'an	Ma'an	W1945	Al-Amir Hamza (Al Amira Rahma)	PHC
175	Ma'an	Ma'an	W1925	Al-Husseiniyah	PHC
176	Ma'an	Ma'an	W1926	Al-Hashimiah	PHC
177	Ma'an	Ma'an	W1946	Al-Abdaliyah	PHC
178	Aqaba	Aqaba	Z1901	Al-Aqaba	CHC
179	Aqaba	Aqaba	Z1906	Al-Reesha	PHC
180	Aqaba	Aqaba	Z1916	Al-Amira Basma	PHC
181	Aqaba	Aqaba	Z1911	Al-Khazzan (Al-Shlalah)	PHC
182	Aqaba	Aqaba	Z1904	Al-Deesah	PHC
183	Aqaba	Aqaba	Z1903	Rahma	PHC
184	Aqaba	Aqaba	Z1919	Al-Baldah Al-Qadeemah	PHC
185	Aqaba	Aqaba	Z1902	Al-Qweirah	PHC

Table (4)
List of the primary and comprehensive health clinics renovated and equipped by ROC project

No.	Governorate	Health Directorate	ID	Health Center Name	TYPE*
1	Amman	Capital	11902	Al-Hilal (Abu Ayoub Al-Ansary)	PHC
2	Amman	Capital	11904	Abu-Nsseir Housing	CHC
3	Amman	Capital	11908	Al-Thira'a (Hai Nazzal)	PHC
4	Amman	Capital	11912	Hamzah (North Marka)	PHC
5	Amman	Capital	11918	Na'our	CHC
6	Amman	Capital	11920	Um-Albasateen	PHC
7	Amman	Capital	11921	Al-Rawdah	PHC
8	Amman	Capital	11923	Al-Rabwah (Hamlan)	PHC
9	Amman	Capital	11925	Jabal Amman	PHC
10	Amman	Capital	11927	Um Al-Oussoud	PHC
11	Amman	Capital	11931	Al-Hashimi Al-Shamali	CHC
12	Amman	Capital	11932	Al-Amira Basma (Ra'ss Al-Ayn)	CHC
13	Amman	Capital	11933	Al-Nathif	PHC
14	Amman	Capital	11936	Dahiat Al-Hussein	PHC
15	Amman	Capital	11939	Al-Qoussour (Al-Hasimi Aljanoubi)	PHC
16	Amman	Capital	11942	Mattar Al-Malikh Alia'a (Queen Alia Airport)	PHC
17	Amman	Capital	11944	Jabal Al-Jofeh	PHC
18	Amman	Capital	11945	Bader	PHC
19	Amman	Capital	11947	Al-Muraqab	PHC
20	Amman	Capital	11950	Husban	PHC
21	Amman	Capital	12916	Khashafiat Al-Dabaybeh	PHC
22	Amman	East Amman	12902	Al-Jeeza	CHC
23	Amman	East Amman	12903	Natel	CHC
24	Amman	East Amman	12906	Al-Muagar	CHC
25	Amman	East Amman	12910	Al-Jmaiel	PHC
26	Amman	East Amman	12914	Rujm Al-Shami	PHC
27	Amman	East Amman	12942	Al-Rmail	PHC
28	Amman	East Amman	12950	Al-Mustanada	PHC
29	Madaba	Madaba	41904	Theeban	CHC
30	Madaba	Madaba	41909	Al-Areed	PHC
31	Madaba	Madaba	41910	Al-Faisalieh	PHC
32	Madaba	Madaba	41915	Lub	PHC
33	Madaba	Madaba		Hanina	PHC
34	Zarqa	Zarqa	71910	Al-Tatweer Al-Hadari /Yajooz	PHC
35	Zarqa	Zarqa	71913	Al-Azraq	CHC
36	Zarqa	Zarqa	71935	Al-Msheirfeh	CHC
37	Zarqa	Zarqa	71941	Al-Batrawi (Hai Ma'asoum)	CHC
38	Zarqa	Zarqa	71942	Jabal Tareq	PHC
39	Balqa	Salt	A1908	Subhi Al-Bqei'e	CHC
40	Balqa	Salt	A1910	Al-Fuheiss	PHC
41	Balqa	Salt	A1912	Al-Yazidieh	PHC
42	Balqa	Salt	A1914	Eira Yarqa	PHC
43	Balqa	Salt	A1916	Armeimeen	PHC
44	Balqa	Salt	A1917	Safout	PHC
45	Balqa	Salt	A1921	Al-Sleih	PHC

No.	Governorate	Health Directorate	ID	Health Center Name	TYPE*
46	Balqa	Salt	A1923	Zay	CHC
47	Balqa	Salt	A1941	Al-Maghareeb wa Um-Al-Zaytoon	PHC
48	Balqa	Deir Alla	A2901	Ma'adi	CHC
49	Balqa	Deir Alla	A2903	Al-Twall Al-Shamali	PHC
50	Balqa	Deir Alla	A2906	Al-Balawneh	PHC
51	Balqa	South Shouneh	A3901	Al-Shounah Al-Janoubiah	PHC
52	Balqa	South Shouneh	A3905	Sweimah	PHC
53	Irbid	Irbid	D1905	Al-Turkman	PHC
54	Irbid	Irbid	D1908	Al-Zahrawi	PHC
55	Irbid	Irbid	D1910	Hakma	PHC
56	Irbid	Irbid	D1911	Elaal	PHC
57	Irbid	Irbid	D1912	Bait Ra'ass	PHC
58	Irbid	Irbid	D1916	Kufur Jayez	PHC
59	Irbid	Irbid	D1917	Al-Sareeh	CHC
60	Irbid	Irbid	D1920	Habka	PHC
61	Irbid	Irbid	D1924	Al-Farouq	CHC
62	Irbid	Irbid	D1926	Anbah	PHC
63	Irbid	Irbid	D1927	Kufur Youba	CHC
64	Irbid	Irbid	D1928	Beit Yafa	PHC
65	Irbid	Irbid	D1929	Deir Al-Sa'anah	PHC
66	Irbid	Irbid	D1930	Al-Taibeh	CHC
67	Irbid	Irbid	D1936	Soum	PHC
68	Irbid	Irbid	D1956	Jheifeh	PHC
69	Irbid	Irbid	D1960	Jamia'at Al-Yarmouk (Yarmouk University)	CHC
70	Irbid	Irbid	D1963	Al-Twaal	PHC
71	Irbid	North Agwar	D2901	Subhi Al-Sheikh Hasan	PHC
72	Irbid	North Agwar	D2914	Al-Ma'abar Al-Houdoudi Al-Shamali	PHC
73	Irbid	Beni Kenanah	D5903	Hriema	PHC
74	Irbid	Beni Kenanah	D5914	Hartha	PHC
75	Ajloun	Ajloun	G1902	Kufranjah (Al-Amir Hasan)	CHC
76	Ajloun	Ajloun	G1910	Rasoun	PHC
77	Ajloun	Ajloun	G1927	Al-Istiqlal	PHC
78	Jarash	Jarash	J1905	Burma	PHC
79	Jarash	Jarash	J1906	Qafqafa	PHC
80	Jarash	Jarash	J1923	Al-Qadissiah	PHC
81	Mafrq	Mafrq	M1902	Al-Hai Al-Janoubi	PHC
82	Mafrq	Mafrq	M1909	Bal'ama	CHC
83	Mafrq	Mafrq	M1915	Rihab	CHC
84	Mafrq	Mafrq	M1918	Hayyan Alrweibedh Al-Gharbi	PHC
85	Mafrq	Mafrq	M1919	Al-Khalidiah	CHC
86	Mafrq	Mafrq	M1930	Al-Dajniah	PHC
87	Mafrq	Mafrq	M1932	Khaled Bin Al-Walid (Al-Zeina	PHC
88	Mafrq	Mafrq	M1937	Hosha	PHC
89	Mafrq	Mafrq	M1980	Houdoud Jaber (Jaber borders)	PHC
90	Mafrq	North Badiah	M2906	Sabha	PHC
91	Mafrq	North Badiah	M2913	Amra wa Ameira	PHC
92	Mafrq	North Badiah	M2920	Al-Rweished	PHC
93	Mafrq	North Badiah	M2925	Deir Al-kahf	PHC
94	Mafrq	North Badiah	M2934	Al-Mkeifteh	PHC

No.	Governorate	Health Directorate	ID	Health Center Name	TYPE*
95	Mafrq	North Badiyah	M2935	Al-Dafyaneh	PHC
96	Mafrq	North Badiyah	M2964	Um Al-Qutein	CHC
97	Karak	Karak	P1910	Muhee'	PHC
98	Karak	Karak	P1913	Al-Rabba	CHC
99	Karak	Karak	P1932	Al-Karak	CHC
100	Karak	Karak	P1934	Al-Mazar	CHC
101	Karak	Karak	P1937	Ay	CHC
102	Karak	Karak	P1938	Talal	PHC
103	Karak	Karak	P1940	Mu'aab	PHC
104	Karak	Karak	P1942	That Ra'ass	PHC
105	Karak	Karak		Al-Taibeh	PHC
106	Karak	Karak	P1946	Al-Qsseir	PHC
107	Karak	Karak	P1947	Al-Samakiah	PHC
108	Karak	Karak	P1953	M. C Kuthraba	PHC
109	Karak	Karak	P1961	Sarfa	PHC
110	Karak	Karak	P1962	Wadi Al-karak	PHC
111	Karak	Karak	P1968	Al-Ma'amourah	PHC
112	Karak	Karak	P1975	Al-Sa'er	PHC
113	Tafiela	Tafiela	S1902	Al-Tafilah	PHC
114	Tafiela	Tafiela	S1903	Al-Eiss	PHC
115	Tafiela	Tafiela	S1921	Al-Mansourah wa Al-Teen	PHC
116	Ma'an	Ma'an	W1912	Al-Taibeh Al-Janoubieh	PHC
117	Ma'an	Ma'an	W1915	Wadi Mousa	CHC
118	Ma'an	Ma'an	W1928	Athruh	PHC
119	Ma'an	Ma'an	W1942	Al-Madawara	PHC
120	Ma'an	Ma'an		Al- Muqare'e	PHC
121	Aqaba	Aqaba	Z1912	Qreiqrah	PHC
122	Aqaba	Aqaba	Z1913	Rum	PHC

ATTACHMENT 2

USAID'S CORE VALUES

USAID's five core values are: (1) managing for results; (2) customer focus; (3) teamwork and participation; (4) empowerment and accountability; and (5) valuing diversity. Throughout the implementation of this program, the work of USAID/Jordan, in partnership with the GOJ and other local partner organizations working in the health sector will be guided by these five core values.

Managing for results: Managing for results means that we seek to define and organize our work around the end result we seek to accomplish. This means making intended results explicit; ensuring agreement among partners, customers, and stakeholders that proposed results are worthwhile; and organizing our day-to-day work and interactions to achieve results as effectively as possible.

In the development work that is the core of our programs, we almost never have total control over the results we seek to accomplish. Indeed, development results that would be within our control are not likely to represent sustainable development. Rather than limit ourselves to mundane, safe, but not useful results, our goal is to select objectives that reach high and inspire others but that are also within our manageable interests. The concept of manageable interest recognizes that achievement of results requires joint action on the part of many other actors such as host country governments, institutions, other donors, civil society, and the private sector. When an objective is within our manageable interest, it means that we have reason to believe that:

- Our ability to influence, organize, and support others around commonly shared goals can lead to the achievement of desired results; and
- The probability of success is high enough to warrant expending program and staff resources.
- In such cases, the concept of accountability for results means that Strategic Objective Teams, Operating Units in the field, and Washington Operating Units are expected to
- Make intelligent, informed choices on what results to pursue;
- Manage proactively towards those results;
- Respond effectively to the inevitable changes in the development and policy environment that affect the feasibility of our selected results by modifying tactics or strategies including the use of public-private alliances as a way to meet those objectives;
- Provide transparency and objectivity when reporting problems and progress; and
- Help the entire Agency learn from successes and failures.
- Accountability is achieved through meeting these requirements, rather than simply by achievement of agreed-upon (numerical) targets.

Managing for results means establishing a "results framework" and annual workplans which include setting the intermediate and sub-results necessary to achieve the strategic objectives, and underlying causal relationships and assumptions. A results framework also establishes the basis for measuring, analyzing, and reporting results. Work is organized in a way that keeps USAID

and its partners focused on intended results (not inputs), and progress is assessed on a regular basis using agreed performance indicators and targets.

USAID/Jordan and its partners (including GOJ/MOH), have established the strategic framework and have agreed upon various partners and interventions under the framework. As the strategy is further developed, and as trends in progress are assessed, approaches and annual workplans may be adjusted, based on mutual discussion and agreement to ensure the best results possible.

Customer focus: While an interest in customers is not new to USAID, customer focus has increasingly been strengthened to provide earlier recognition of and more active and prominent attention to, the role of customers' own perceptions of their own needs and concerns. In this way, USAID expects to make progress in delivering measurable and sustainable development results.

Our development assistance objectives require that we identify who our customers are and secure their participation to help us choose a variety of approaches. We focus on our customers to understand their needs and help us focus our efforts and resources on the most productive tasks.

There are several types of USAID customers:

- **Ultimate customer** — Those host country individuals, especially the socially and economically disadvantaged, who are beneficiaries of USAID assistance and whose participation is essential to achieving sustainable development results.
- **Intermediate customer** — Those organizations, including host country governments that receive USAID services and resources to implement programs that are designed to benefit the ultimate customer.
- **Internal customer** — Bureaus, Operating Units (both in Washington and in the field), and individuals within USAID that benefit from, and participate in, the activities undertaken by other Bureaus, Offices, and individuals within the Agency.
- **Washington and U.S.-based customer** — Those entities at whose behest USAID carries out foreign assistance. This includes Congress, the taxpayer, and other relevant Government agencies, including the Department of State.

USAID results-focused programming systems are intended to help ensure that our programs and priorities are as responsive as possible to customer needs. In many cases, we will not be able to produce the products and services some customers prefer. In such cases, customer focus means being clear with our customer about what we can and cannot do. Another aspect of customer focus involves managing potential conflict between customer groups who perceive themselves as gaining or losing as a result of a particular intervention.

The new 2004 – 2009 population and health strategy, approaches and interventions were designed to reach every Jordanian. The public sector services are still highly subsidized; therefore, the poor and disadvantaged will be special beneficiaries of this program as MOH services are geographically accessible all over the country. If the life stages approach is applied through the national health communication strategy and at the service delivery level, mothers, children and young people will be the most direct beneficiaries of the FP/RH/PHC interventions. Male involvement will be expanded and older people will benefit from the broad spectrum of improved PHC services which will include standardized management of chronic diseases. Finally, the interface between communities and health facilities will be enhanced so that individuals and communities are best served. A special group of beneficiaries will be (safe motherhood

continuum -- women in labor and post partum as they have special needs for clinical care and FP counseling.

USAID/Jordan has not conducted a formal customer survey, as other Missions sometimes do to assess the stated needs of its ultimate customers. However, USAID/Jordan and its partners have used other types of information, surveys and anecdotal data to shape its strategy and activities so that they are focused for the direct benefit of its customers. This process started in the fall of 2002 when USAID embarked on an inclusive consultative process involving public-private-NGO partners, private citizens, implementing partners, and international donors to develop its overall strategy. Analyses and evaluations were conducted on the current SOs, gender issues, education, the environment, donor coordination, democracy and governance, conflict mitigation, and the macroeconomic situation.

Specific to the evaluation and development of the new population and health strategy, in January 2003, USAID/Jordan invited an external evaluation team to conduct an assessment of the Population and Family Health Strategic Objective (S03), and to provide its recommendations for the follow-on health/population strategy. The evaluation report, entitled “Evaluation of USAID/Jordan’s Strategic Objective 3: Improved Quality of and Access to Reproductive and Primary Health Care,” is available upon request from PFH. The majority of the evaluation team’s recommendations were incorporated into the new PFH health and population strategy.

Finally, in October 2003, USAID conducted a two-day consensus-building strategic planning workshop where the new five-year population and family health strategy was jointly developed with the MOH and other Jordanian counterparts and partner organizations working in health. The workshop recommendations and program approaches and activities outlined in the “Outcome of the Consensus-building Workshop” report were incorporated into the new PFH health and population strategy. A copy of the report is available upon request from PFH.

Teamwork and participation: The core value of teamwork and participation represents a belief that we are more effective when we work collaboratively with others, through teams or joint consultations with those who have expertise or interest in the outcome of our work. Working more effectively is directly linked to managing for results. Therefore, the teamwork and participation core value is also directly linked to our results orientation.

a. Teamwork. Teamwork is the coming together of a group of people who are

- Committed to achieving defined results;
- Vested with the authority to make decisions; and
- Willing to be held jointly accountable for achieving results.

These points help to distinguish teams from committees or work groups that include representatives from different units. In a traditional office-based structure, committees and groups are formed with the idea that each member represents and promotes the goals of his or her unit. There is no presumed commitment to accept responsibility to pursue a new goal or result that transcends the different units represented on the committee. If the members of a group agree to share responsibility for achieving common results and have the agreement and support of their home unit to take on this responsibility, then the group takes on the characteristic of a team.

Teams are used in USAID for many different purposes. They may have specific, long-term or short-term tasks and have full-time or part-time members.

b. Participation. Participation is the active involvement of people in decisions that affect them. At USAID, we seek to involve customers, partners, and stakeholders. Partners are those individuals and organizations who work with us (formally or informally) to achieve shared objectives. Stakeholders are individuals and organizations who have an interest in the outcome of USAID programs.

The objective of participation is to improve the quality of our decisions and to ensure that we have the support we need from others to succeed. In the case of public-private alliances, participation means jointly defining the development problem and its solutions with partners. An agreement is then reached between the development partners to share resources, risks, and results in pursuit of an objective that can be better obtained through joint effort. Alliance participation is intended to leverage significant resources that may include financial resources, in-kind contributions, and intellectual property. In some cases, participation in public-private alliances will mean looking toward new partners. The principle of joint planning means developing plans with those who have a stake or interest in our programs. The object of joint planning is to ensure broader Agency ownership and support for our plans and actions.

In our programming system, we practice teamwork and participation by establishing and supporting Strategic Objective (SO) or sectoral Teams to manage each SO or sector that is financed by USAID. SO Teams are structured to permit inclusion of a broad range of members beyond USAID staff, including other federal agencies, grantees, contractors, other partner organizations, customers, and stakeholders.

The results of effective teamwork and active participation include:

- Better decisions,
- More effective work or business processes,
- An increased sense of broad-based ownership for program results,
- An improved likelihood of sustainable program impact, and
- In the case of public-private alliances, leveraging resources more effectively to meet Agency development objectives.

Teams are groups of individuals coming together on a common approach to achieve agreed upon objectives. Teams function in a collaborative and supportive fashion, drawing on the strengths of individual members. They work best when these individual strengths are combined into a congregation of interested parties working effectively because they have agreed to this union and because they understand that "together each achieves more." Moreover, by collaborating on a mutually agreed set of objectives, teams ensure that redundancies are reduced or eliminated and that complementarities and interrelationships are enhanced.

USAID/Jordan has formed two basic teams for the purpose of overseeing the strategy and activities. One, the core team of USAID personnel ultimately responsible for carrying out the U.S. government's responsibilities related to the program, is currently functional. It is called the Population and Family Health Section. The other is an expanded team, which includes the USAID core team, the MOH, the Higher Health and Population Councils, co-operating agency

and contractor partners and other local organizational partners working in health. The core team will have leadership and quality control responsibilities over the overall process.

In the context of the PFH program in Jordan, teams will be expected to function on three levels: first, each participating partner will be expected to organize its staff on a team basis to achieve individual component results. Second, each partner will be expected to work on a USAID program-wide expanded team with other partners (including USAID and GOJ, as appropriate) to ensure that all components are working together in a coordinated fashion and toward the mutually agreed common program goals. Third, each partner will be expected to work, as appropriate, with other donors in achieving the goals of the larger national health program in Jordan.

Empowerment and accountability: The core value of empowerment and accountability reflects the belief that success requires that we push decision-making to those organizational units that are closest to the “front lines” and that we maintain an appropriate balance between authority and responsibility. Empowerment and accountability directly complement the core values of teamwork and managing for results.

In practice, this means delegating authority to those who need it to help the Agency succeed in achieving important results. It also means that authority should be delegated consistent with the capacity to carry it out in a responsible and accountable manner. This value recognizes that delegating responsibility alone, without the necessary concurrent authority, is a recipe for failure. It recognizes that to succeed, we must delegate authorities to the people closest to the action, who are in the best position to see and react to a changing environment and to the changing needs of ultimate customers, partners, and stakeholders. Finally, it recognizes that managers who delegate and empower their staff have a responsibility to ensure that staff are adequately trained and supported so that they can meet the accountability requirements that correspond to the authority delegated. This can include providing information on changing internal and external policy mandates.

Empowerment means that we are accountable for our decisions. If a manager (or team) is empowered to make decisions, he or she must have sufficient knowledge of the legal, ethical, and policy-related issues that affect those decisions.

Part of accountability means exercising high ethical standards and personal integrity in all matters. This expectation pertains to both teams and individual employees.

We use empowerment and accountability to give Strategic Objective Teams official authority to make and implement decisions and to accept responsibility for decision-making. As an organization that focuses on its customers, we put the authority for decisions as close as possible to the point where the impact is achieved. Empowerment means we allow teams to take considered risks and to adjust their programs in light of new developments and the constantly changing broader environment affecting the Agency. With accountability, we must provide them with parameters related to Agency goals as well as legal, policy, and ethical standards and requirements. We can achieve this balance between empowerment and accountability by eliminating or replacing unnecessary rules and policy directives and by being transparent and clear about the rules and policies that we must have. The continual upward and downward flow of information, to and from Strategic Objective Teams, particularly concerning changing internal

and external foreign policy and Congressional factors, is an essential component of empowerment and accountability.

Within a team structure there is individual accountability; therefore, team input is necessary for individual performance evaluations. When individuals successfully show results from teamwork, we must reward both team and individual performance.

All partners, in particular USAID, the MOH and USAID-funded CA/contractor partners, have formed an expanded team in which: (1) the results framework for the PFH strategy has been developed through an iterative and collegial process; and (2) where five-year umbrella and annual plans for the implementation of this framework will be developed and monitored. Detailed plans and anticipated results will include assignments of responsibility to specific partners. The results framework and workplans will be consistent with the population and health information and service needs of USAID's customers and USAID/Jordan's new strategic framework. Because both PFH and the MOH have been in close consultation, it will be their responsibility to ensure full agreement with the program/activities as it progresses and that it fits within the overall strategies, goals and objectives of Jordan's national population and health policies, strategies and programs.

Once the implementation stage under the new strategy starts in October 2004, each partner will be empowered and accountable for achieving its portion of the plan and related results in coordination with the other grantees/contractors, as agreed. The full implementation team (including USAID and MOH) will be empowered and accountable for achieving the program's strategic framework. The full team will therefore need to meet regularly in order to monitor the program's overall progress and make adjustments, if necessary.

Valuing diversity: Valuing diversity reflects a belief that there is more than one way to look at the world and that our work will improve if we consciously seek to take into account the diversity of views, experience, skills, capabilities, and beliefs of those around us.

Valuing diversity recognizes that our success as an organization depends on having a multicultural workforce that works effectively with diverse customers, stakeholders, and partners all around the world. We must ensure that our own workplace environment promotes:

- Diversity, experience, and contributions of others;
- Mutual respect for all individuals;
- Opportunity for team members to contribute to the full extent of their ability on Strategic Objective Teams and other settings;
- Synergy and the benefits of bringing together people of different backgrounds and skills to accomplish the Agency mission; and
- Non-discrimination based on race, color, religion, national origin, physical or mental disability, sex, age, or sexual orientation.

Valuing diversity is demonstrated within the Agency by the way teams are composed and, more importantly, by the way program decisions are made. For example, are discussions on vision and problem analysis conducted with a broad and diverse audience? Do team decisions respect all members' input regardless of race, color, religion, national origin, physical or mental disability, sex/gender, age, sexual orientation, ethnicity, nationality (especially in the case of Foreign Service (FSN) and Third Country National (TCN) staff within USAID and host country partners), and organizational status (such as rank, grade, and position)?

ATTACHMENT 3

USAID Terminology Strategic Framework (or) Results Framework

A planning, communications, and management tool, which conveys the development hypothesis implicit in the strategy and the cause-and-effect linkages between the Intermediate Results (IR) and the Strategic Objective (SO). A Results Framework includes the SO and the IRs necessary to achieve the SO, whether funded by USAID or its partners. It includes any critical assumptions that must hold for the development hypothesis to lead to achieving the relevant objective. Typically, it is laid out in graphic form supplemented by narrative.

Results Package

A results package is a shorthand designation for items that contribute to achieving a particular result. While the term is no longer “officially” used, it consists of people, funding, authorities, activities, and associated documentation required to achieve a specified result(s) within an established time frame.

Strategic Objective/Intermediate Results

Strategic Objective (SO)

The most ambitious result that a USAID Operating Unit, along with its partners, can materially affect, and for which it is willing to be held accountable. SOs can be designed for an Operating Unit to provide analytic, technical, logistical, or other types of support to the SOs of other Operating Units (whether bilateral, multi-country, or global in nature). Note: The Intermediate Result for population and health functions as a proxy Strategic Objective.

Intermediate Result (IR)

An important result that is seen as an essential step to achieving a Strategic Objective (SO). IRs are measurable results that may capture a number of discrete and more specific results. IRs may also help to achieve other IRs as they also help achieve sub-results (SRs).

Strategy (ies) / Strategic Plan

A document used to describe and obtain approval for one or more Strategic Objectives or Special Objectives to be implemented by an Operating Unit. Approved Operating Unit Strategic Plans represent an Agency-wide commitment to a set of objectives and Intermediate Results (IRs) to be accomplished by an Operating Unit.

Sub-Result (s)

A set of strategic actions undertaken to achieve an intermediate result.

Performance Indicators

A particular characteristic or dimension used to measure intended changes defined by a Results Framework. Performance indicators are used to observe progress and to measure actual results compared to expected results. Performance indicators help answer how or if an Operating Unit or SO Team is progressing towards its objective, rather than why such progress is or is not being made. Performance indicators may measure performance at any level of a Results Framework (Strategic Objective level or Intermediate Results level).

Activity

A set of actions through which inputs, such as commodities, technical assistance, training, or resource transfers, are mobilized to produce specific outputs, such as vaccinations given, schools built, micro enterprise loans issued, or policies changed. Activities are undertaken to achieve Strategic or Special Objectives that have been formally approved and notified to Congress.

“Results Package” = Intermediate Result + Sub-Results [USAID/Jordan + Local Partners]

Consists of people, funding, authorities, activities, and associated documentation required to achieve a specified intermediate result(s) within an established time frame.

ATTACHMENT 4

SELECTED KEY DOCUMENTS

1. The Jordan 2002 DHS survey. The latest DHS was conducted in 2002 (Department of Statistics) <http://www.dos.gov.jo> or from the MARCO website
2. SO3 Evaluation Report entitled “Evaluation of USAID/Jordan’s Strategic Objective 3: Improved Quality of and Access to Reproductive and Primary Health Care,” (available from the POPTECH Project or upon request from PFH)
3. Multiple surveys on private sector and public sector insurance (available from PHRplus Project, Jordan)
4. Market Segmentation for FP users (available from Policy Project, Jordan)
5. Unmet Need for Family Planning (available from PHCI Project, Jordan)
6. KAP of Family Planning Among Providers and Clients (available from JHU, Jordan)
7. KAP of Family Planning Among Religious Leaders (available from JHU, Jordan)
8. KAP for Tubal Ligation Among Providers and Clients (available from Engender Health, Jordan)