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USAID'S HEALTH EVALUATION AND APPLIED RESEARCH DEVELOPMENT (HEARD) PROJECT

EVALUATION REPORT

MIDTERM PERFORMANCE EVALUATION OF THE USAID/JORDAN HEALTH SERVICE DELIVERY ACTIVITY

EXPANDING AVAILABILITY, ACCESS AND QUALITY OF INTEGRATED REPRODUCTIVE, MATERNAL, NEWBORN, CHILD HEALTH SERVICES

December 2019

Health Evaluation and Applied Research Development (HEARD), is funded by the United States Agency for International Development (USAID) under cooperative agreement No. AID-OAA-A-17-00002. The project team includes prime recipient, University Research Co., LLC (URC), and sub-recipient organizations. The evaluation team included sub-recipients, CUNY School of Public Health and UC Berkeley School of Public Health.

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Cover photo:

USAID funded training RMNCH facility, King Hussein Medical Center/Royal Medical Services in Amman, Jordan (May 16, 2019).

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December 2019

Midterm Evaluation

Jordan Health Service Delivery (HSD) Activity (AID-278-A-16-00002)

Distributed to:

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ABSTRACT

The United States Agency for International Development's (USAID's) Health Evaluation and Applied Research Development (HEARD) Project conducted a mid-term evaluation of the USAID/Jordan Health Service Delivery (HSD) Activity (AID-278-A-16-00002). This report summarizes the key findings and recommendations of the evaluation which was completed April–October 2019. The evaluation explored the quality, management, sustainability, and USAID alignment of HSD and its activities to expand the access to and availability of integrated health services to quality Reproductive, Maternal, Newborn and Child Health (RMNCH) services in Jordan. To evaluate the effectiveness and efficiency of the HSD approach and activities, the team used a combination of qualitative data collection (key informant interviews, focus group discussions, small group interviews), surveys, facility checklists and observations, validation of select monitoring data, and analysis of secondary data sources.

The evaluation found that HSD's focus on clinical pathways through the Integrated Service Delivery Improvement Collaborative (ISDIC) model has successfully improved the quality of RMNCH+ service delivery and care throughout Jordan. However, there are significant improvements to be made to ensure sustainability and effectiveness of HSD. For quality gains to be improved and sustained, emphasis on evidence-based practice needs to heighten focus on respectful care, gender-related barriers and facility-specific challenges, as well as bottom up consultation and engagement. There also needs to be a reorientation of efforts beyond clinical pathways towards systemic changes in terms of accountability, supervision, leadership and ultimately ownership of the program at the facility and Health Area Directorate level. Facility-specific targets and benchmarking, and sustaining staff motivation through mentorship and incentives that rely on the engagement of high-level managers will improve sustainability of the ISDIC process to increase ownership and contribute to future sustainability. Future programming should explicitly link practice and policy with other USAID projects to not miss opportunities to sustain gains made from successful project interventions.

CONTENTS

ACRONYMS

ANC	Antenatal care
CHC	Community Health Committee
CHW	Community Health Worker
CSS	Client Service Station
CU5	Children under 5
DHS	Demographic and Health Survey
EMPHNET	Eastern Mediterranean Public Health Network
FBSS	Facility Based Supportive Supervision
FGD	Focus Group Discussion
FP	Family Planning
GFA	Geographic Focus Area
GOJ	Government of Jordan
GP	General Practitioner
HAD	Health Area Directorate
HCAC	Health Care Accreditation Council
HEARD	Health Evaluation and Applied Research Development
HR	Human Resources
HSD	Health Service Delivery
HSS	Health System Strengthening
IUD	Intrauterine Device
ISDIC	Integrated Service Delivery Improvement Collaborative
JAFPP	Jordan Association for Family Planning and Protection
JMMSR	Jordan's Maternal Mortality Surveillance and Response System
KII	Key Informant Interviews
LAM	Lactational Amenorrhea Method
mCPR	Modern Contraceptive Prevalence Rate
MoH	Ministry of Health
MTE	Mid-Term Evaluation
OCP	Oral Contraceptive Pill
PHC	Primary Healthcare
RMNCH+	Reproductive, Maternal, Neonatal and Child Health Plus
RMS	Royal Medical Services
SDP	Service Delivery Point
TFR	Total Fertility Rate
UNHCR	United Nations High Commission for Refugees
USAID	United States Agency for International Development
WRA	Women of Reproductive Age

EXECUTIVE SUMMARY

Purpose and Background

This report summarizes the findings and recommendations of the USAID/Jordan Health Service Delivery (HSD) mid-term evaluation conducted between April and October 2019. HSD is a five year (2016-2021), $50 million program aiming to expand access to and availability of integrated health services to improve the quality of integrated Reproductive, Maternal, Newborn and Child Health (RMNCH) services.

The target audience for this evaluation is USAID Jordan, the country mission overseeing activities to enhance and support a long-standing partnership between Jordan and the United States. The USAID Jordan Country Development Cooperation Strategy 2013-2019 (CDCS) outlines a broad plan about how USAID will support the Government of Jordan (GOJ) in carrying out its stated commitment to broad-based political and economic reforms to meet the legitimate aspirations of Jordanians—with one development objective (DO) being to improve social sector quality.

Intermediate Result 3.1 (Health Status Improved) in the CDCS is the foundation for the USAID/Jordan Health Service Delivery Project (AID-278-A-16-00002) and its Results Framework, which speaks directly to the need of improved RMNCH services to promote voluntary family planning and reproductive health to improve health outcomes by expanding access to and availability of integrated health services.

Evaluation Questions

Four overarching research questions guided this evaluation:

1. Quality: To what extent did the HSD project contribute to RMNCH service improvements, including availability, accessibility, quality, integration, and gender responsiveness of services in Jordan? Which interventions can be considered good practice? How should interventions be strengthened for sustainability after the life of the project?
2. Management: To what extent did HSD employ appropriate and effective management, operational and monitoring mechanisms?
3. Sustainability: To what extent have HSD initiatives demonstrated potential for post-investment sustainability?
4. USAID Alignment: What are the implications for future USAID support to RMNCH programming in Jordan?

Methods

The midterm evaluation used pre-post and realist evaluation analysis approaches, drawing on a combination of qualitative data collection (key Informant Interviews, focus group discussions, small group interviews), surveys, facility checklists and observations, validation of select monitoring data, and analysis of secondary data sources. It aimed to evaluate the relevance, effectiveness, efficiency, sustainability and value-add of HSD as a strategic investment for USAID.

Major Findings and Recommendations

The following findings and recommendations emerged:

1. Quality

The focus on clinical pathways through the Integrated Service Delivery Improvement Collaborative (ISDIC) model has successfully improved the quality of RMNCH+ service delivery and care. HSD has recorded substantial improvement on targeted quality of care related indicators. However, for those quality gains to be sustained there needs to be a reorientation of efforts beyond clinical pathways towards systemic changes in terms of accountability, supervision, leadership and ultimately ownership of the program at the facility and Health Area Directorate level.

While awareness of the clinical pathways is strong among providers, clients report that the service they received often falls short on the delivery of evidence-based practice and respectful care. For example, many

clients did not receive comprehensive family planning counselling, reporting that providers did not adequately explain contraceptive options or procedures, and that staff were often rude or aggressive towards clients particularly during delivery care. Validation and assessment of quality care from the client perspective is needed to increase compliance to evidence-based practice.

Efforts were made to reach the most vulnerable through HSD's selection of Service Delivery Points (SDPs), however, given shifting demographics, facility-specific strategies may be needed to overcome local barriers in access to care. Gender-related barriers are not well recognized by HSD stakeholders, despite some training on the issue. Inclusion of gender specific indicators in the change packages can focus attention on gender barriers and their mitigation.

Client Service Stations (CSSs) are a potentially important contribution to integrating care. They are currently being implemented and not yet fully functional. HSD needs to work with facilities to contextualize their implementation to make them work for clients and providers with facility specific strategies and approaches.

A pilot effort to work with private sector physicians to improve delivery of integrated RMNCH+ services was modest, not cost effective as incentives were insufficient to sustain and expand engagement to make the intervention impactful.

2. Management

Priorities for the ISDIC session are based on data and preset indicators. Providers, Community Health Committees (CHC) and managers have additional priorities. Adding more bottom up consultation and engagement (and possibly facility-specific targets and benchmarking) to the ISDIC process will increase ownership and contribute to future sustainability. Including the Health Directorate in the definition of these additional targets is vital for their support into the future. Facility-based Supportive Supervision (FBSS) has the potential to motivate staff when the manager/provider is fully engaged, which was not always the case, leaving HSD staff to provide much of the mentoring where it existed.

Project accountability requires HSD to implement a parallel data collection system that focuses energy of staff on maintaining numbers instead of mentoring and quality assurance. More efforts should be made to combine monitoring with mentoring to build ownership of staff for the process. In addition, the lack of a unified Ministry of Health (MoH) Monitoring and Evaluation (M&E) system has resulted in providers and managers not understanding the value of using data to inform practice and prioritization in decision-making. USAID has an important opportunity to partner with the Government of Jordan to address this significant gap in knowledge capture in the health sector.

3. Sustainability

Facility staff turnover and retention are the biggest challenges to sustaining quality of care improvements generated by HSD. Sustaining staff motivation can be facilitated by a non-monetary incentive system, such as expansion of the recognition program. Institutionalization of ISDIC will require HSD to engage more actively with the Directorate level. More engagement and involvement by high-level managers is urgently needed and new approaches should be tested to gain their interest and commitment. There needs to be a systems approach to sustain improvements across HSD SDPs, especially hospitals.

4. USAID Alignment

USAID has been a significant supporter of the health sector in Jordan over many decades. Past efforts have combined policy and practice guidance and support. The current HSD project has been designed to build on some of these past successes but not all. Policy advocacy and support is not a focus of HSD limiting the possibility of institutionalizing programs and achievements in the system, particularly at the hospital level. Future programming should explicitly link practice and policy within the same projects to not miss opportunities to sustain gains made from successful project interventions. Greater consideration and reflection on past project experiences and learnings should inform future sustainability planning and implementation.

Conclusions

HSD's focus on clinical pathways through the Integrated Service Delivery Improvement Collaborative (ISDIC) model has successfully improved the quality of RMNCH+ service delivery and care throughout Jordan. However, for quality gains to be improved and sustained, emphasis on evidence-based practice needs to heighten focus on respectful care, gender-related barriers and facility-specific challenges, as well as bottom up consultation and engagement. There also needs to be a reorientation of efforts beyond clinical pathways towards systemic changes in terms of accountability, supervision, leadership and ultimately ownership of the program at the facility and Health Area Directorate level. Facility-specific targets and benchmarking, and sustaining staff motivation through mentorship and incentives that rely on the engagement of high-level managers will improve sustainability of the ISDIC process to increase ownership and contribute to future sustainability. Future programming should explicitly link practice and policy with other USAID projects to not miss opportunities to sustain gains made from successful project interventions.

INTRODUCTION AND CONTEXT

The USAID/Jordan Health Service Delivery (HSD) activity is a 5-year agreement (2016 – 2021) with a total budget of $50 million, which was awarded in March 15, 2016 to Abt Associates and its partners, the Jordan Health Care Accreditation Council (HCAC), the Eastern Mediterranean Public Health Network (EMPHNET), the Population Council, and the American College of Nurse-Midwives.

The United States Agency for International Development's (USAID's) Health Evaluation and Applied Research Development (HEARD) Project conducted a mid-term performance evaluation of the HSD activity between April–October, 2019. The objective of the evaluation was to work with stakeholders and partners to understand project effectiveness against the results framework, including an analysis of best/good practices, lessons learned so far, engagement of public/private sectors, and factors affecting post-investment sustainability of service delivery processes and outcomes. This report summarizes the key findings and recommendations of the evaluation.

The target audience for this evaluation is USAID Jordan, the mission overseeing activities to enhance and support a long-standing partnership between Jordan and the United States. The USAID Jordan Country Development Cooperation Strategy 2013-2019 (CDCS) outlines a broad plan about how USAID will support the Government of Jordan (GOJ) in carrying out its stated commitment to broad-based political and economic reforms to meet the legitimate aspirations of Jordanians—with one development objective (DO) being to improve social sector quality. Intermediate Result 3.1 (Health Status Improved) in the CDCS is the foundation for the USAID/Jordan Health Service Delivery Project and its Results Framework, which speaks directly to the need of improved RMNCH services to promote voluntary family planning and reproductive health to improve health outcomes by expanding access to and availability of integrated health services.

The evaluation process, which uses a co-creation approach, and evaluation findings can enable project implementers and managers to understand how best to improve the implementation of HSD over the remainder of the project, including key areas of focus and potential improvement strategies. The findings and subsequent recommendations can also equip USAID and its implementing partners with an understanding of project successes and challenges to determine implications for future USAID support to RMNCH programming in Jordan and elsewhere.

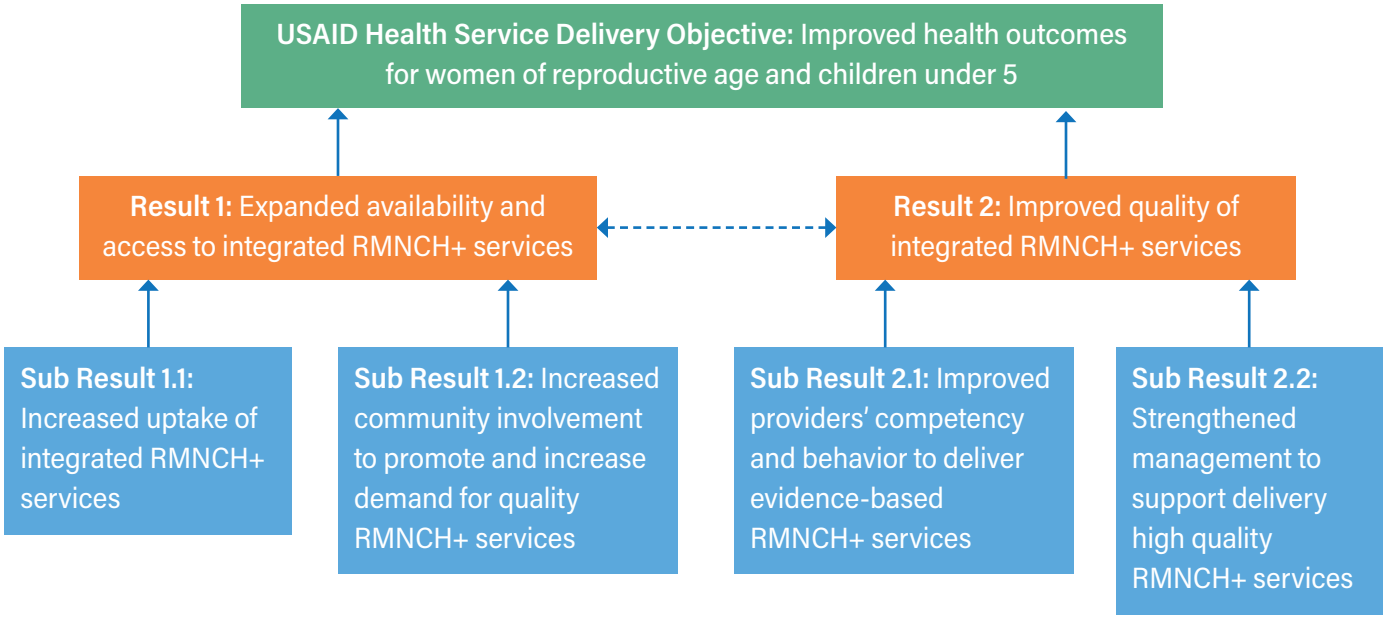
HSD Objectives and Implementation Approach

HSD priorities include expanding access to and availability of integrated health services and improving the quality of Reproductive, Maternal, Newborn and Child Health (RMNCH) services. "RMNCH+" services refer to the further integration of other relevant programs including Non-Communicable Diseases (NCD) awareness raising and screening for iron deficiency anemia, gender-based violence in the public, non-governmental and private sectors in geographic areas of focus, and nutrition. The program is designed to have nationwide impact and a total market approach. HSD plans to work in Geographic Focus Areas (GFAs) where 75% of the population is located.[1]

HSD Vision: *Women of Reproductive Age (WRA) and Children Under five years of age (CU5) in Jordan will access and receive comprehensive, integrated quality health services across a continuum of care, resulting in improved health status.*

[1] Abt Associates. 2016. Health Service Delivery Activity Fiscal Year 2016 Annual Report.

Figure 1: USAID Health Service Delivery Objective



The overarching objectives of HSD focus include two main results and four sub-results:

Result 1. Expand availability of and access to integrated Reproductive, Maternal, Newborn, and Child Health (RMNCH) services.

- Design and implement interventions which increase uptake of RMNCH+ services by targeted populations (Sub result 1.1)
- Increase community involvement in raising awareness of RMNCH+ information and services available in the public, non- governmental, and private sectors (Sub result 1.2)

Result 2. Improved quality of integrated RMNCH+ services

- Improve providers' competency and behavior to delivery evidence-based RMNCH+ services (Sub result 2.1)
- Strengthen management of RMNCH+ services (Sub result 2.2)

The HSD implementation approach focuses on a RMNCH "continuum of care" from preconception to pregnancy, delivery, and post-partum care (see Figure 2). It aims to reach women of reproductive age and children under five years of age via all the critical health service levels:

1) Community and households
2) Non-Governmental Organizations (NGO)/Ministry of Health (MoH) Clinics
3) Private sector (e.g., private providers and pharmacists)
4) MoH/ Royal Medical Services (RMS) Hospitals.

Figure 2: HSD Implementation Approach *(Provided by Abt Associates)*

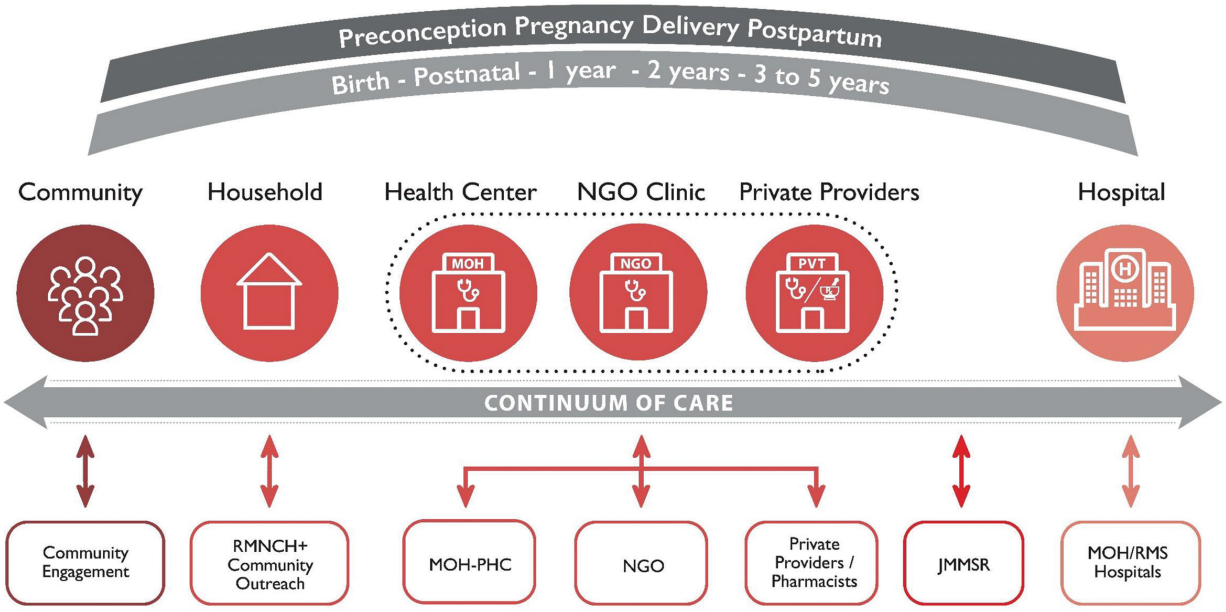


Table 1: Reach of program interventions and community engagement/outreach *(Provided by Abt Associates)*

Type	FY17	FY18	FY19
Health Affairs Directorates	6	14 (All)	14 (All)
PHC Health Centers	35	91	91
Hospitals	8 (6 MOH + 2 RMS)	17 (12 MOH + 5 RMS)	19 (13 MOH + 6 RMS)
NGO Clinics*	9	20	31*
Private Physicians	26	54 (All)	65 (All)
Community Health Committees	29	65	75

Project Design Overview

Since commencing activities in 2016, HSD has begun program interventions in a growing number of Service Delivery Points (SDP's), and engaged in community in health promotion and outreach.

HSD includes a variety of intervention areas that should act synergistically to improve health service delivery. Key programs include:

- Quality and Access Improvement at the Primary Healthcare (PHC) Level and Hospital Levels through the **Integrated Service Delivery Improvement Collaborative (ISDIC)** model
- **Jordan's Maternal Mortality Surveillance and Response System** (JMMSR)
- **Community Engagement** activities, which implement Community Scorecards,[2] Community Health Committees, and health promotion activities across Jordan's health directorates*
- The RMNCH+ Community Outreach Program, which supports household visits to promote family planning

[2] Community scorecards are a tool facilitated by the Community Health Committees to seek community input into evaluating quality of care in the facility, which is then fed into the ISDIC cycle to help to develop action areas to improve upon.

and RMNCH services, as well as screening and referral for child anemia

- The facility based RMNCH+ program*
- Private Sector Engagement
- Newly Hired GP Training Program*
- Health Management Information Systems*

(Integrated across programs)*

Two other programs that are somewhat independent of the other activities include Innovation Grants and Minor Facility Improvements.

Focus on ISDIC model for quality improvement

Among all the programs, the ISDIC model is the focused approach to improving access to and quality of RMNCH+ services in selected Service Delivery Points (SDP's) with high volume of Maternal and Child Health (MCH) services across the 14 Health Affairs Directorates overseen by the MoH. It also targets selected RMS and NGO facilities. The ISDIC is a customized data-driven approach that is meant to address RMNCH+ service delivery bottlenecks, improve quality and the uptake of RMNCH+ services. Selected RMNCH providers and managers from SDPs are invited to participate in collaborative sessions that take place in 4-month cycles. In the sessions, facility teams use their facility data to define areas for improvement known as clinic-based "Change Packages" that also incorporate performance-based monitoring, analysis and change implementation, mobilizing classroom collaborative sessions and action periods. A predefined list of indicators that were based on the gap analysis and the needs assessment conducted at the inception of the USAID Health Service Delivery project are the focus of HSD activities. These include indicators related to clinical pathways. Training is also provided to ensure providers and managers are familiar and able to implement the selected clinical pathways.

At the PHC level, ISDIC has been implemented in 91 MoH clinics, 31 NGO clinics and amongst approximately 65 private providers.[3] In FY18, 128 U.S. Government supported service delivery sites provided the Integrated Services Delivery Package, with targets set to increase this to 143 facilities in FY19. As part of the "Change Package" clinics have incorporated Client Service Stations to facilitate access for women to integrated services at each visit, training programs, the development of educational materials, and the collection of HSD defined indicators through a supplementary collection system. This was needed because some of the quality improvement indicators monitored by HSD are not part of the MOH

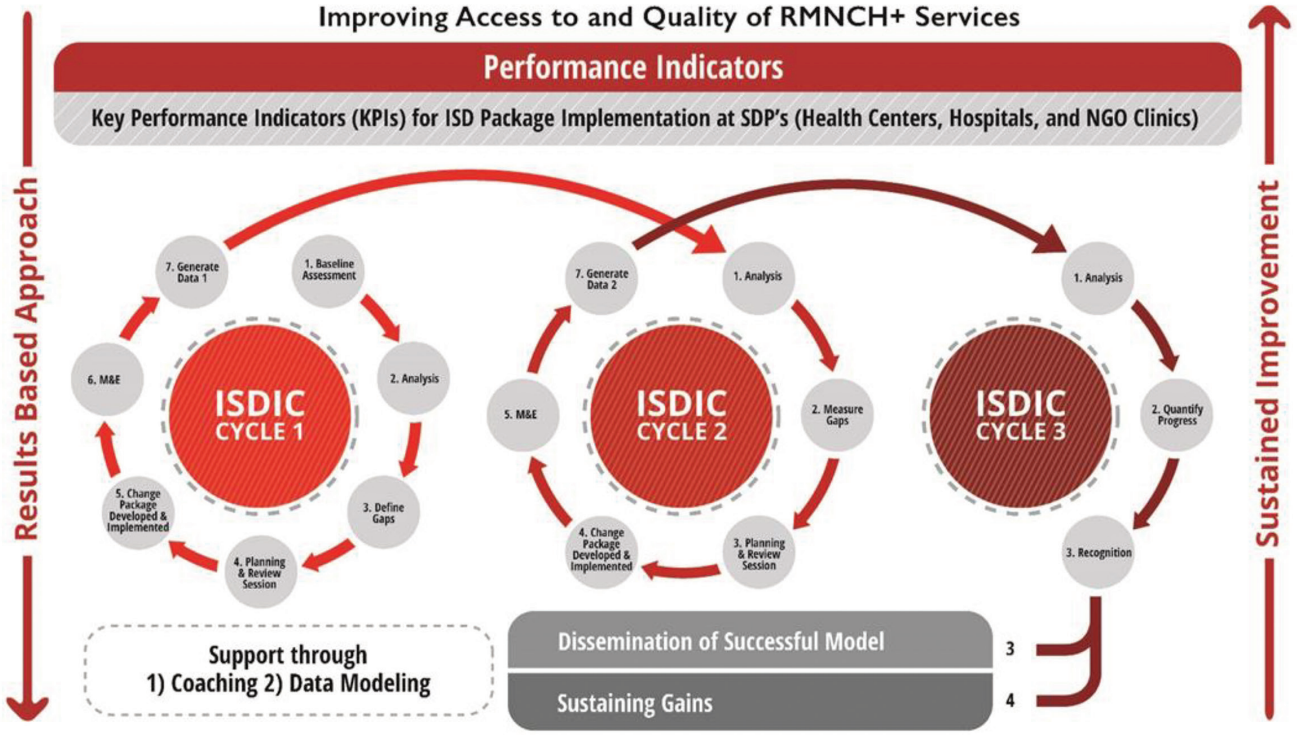
Table 2: Progress against selected clinical pathways (Data from HSD Monitoring and Evaluation Plan)*

Clinical Pathway	Baseline (FY16)	FY18
Percent of women giving birth who initiate breastfeeding within the first hour of birth in GFA hospitals	20%	89%
Percent of clients who received family planning services according to the family planning quality of care index in SDPs in GFAs	16% (FY17)	95%
Percent of women receiving Active Management of Third Stage of Labor protocol in USG supported sites	29%	98%
Percent of pregnant women managed according to antenatal care clinical pathway in SDPs in GFAs	6%	76%

** Note: while the significant increase in achievement of targets is impressive, it is in part related to the poor documentation of data at baseline, resulting in low baseline levels.*

[3] Provide providers receive training on clinical pathways (albeit based on MoH training rather than customized to the private sector). They do not receive the full ISDIC program.

Figure 3: ISDIC model for improving access and quality of RMNCH+ services *(Provided by Abt Associates)*



reporting mechanisms as there are currently not yet electronic and the paper version do not allow simple monitoring and evaluation analysis. At the Hospital level, 19 MoH and RMS hospitals are involved in ISDIC. Change packages have included the standardization of maternal and neonatal practice through clinical pathways, competency based training, a Postpartum Counseling Program, and activities aimed at enabling hospital midwives to provide IUD services.

ISDIC also incorporates activities to improve managerial skills and quality improvement activities such as RMNCH+ Manager Certification Program, Facility-Based Supportive Supervision using the Clinical Performance Monitoring Checklists, and Facility Recognition Program.

Partners and Subcontractors

HSD has engaged a number of partners in the public and private sector to implement its key programs. In the public sector, key collaborators include the Ministry of Health, the Royal Medical Service, Community Health Committees (formerly established by the MoH with the support of predecessor USAID-funded Health Systems Strengthening (HSS) projects); as well as University Hospitals (related to JMMSR only). In the private sector, key collaborators include NGO's (the Institute for Family Health (IFH), International Rescue Committee (IRC), and the Jordan Association for Family Planning and Protection (JAFPP), private providers, and organizations that are recipients of Innovation Grants. Locally, HSD has subcontracted with the Health Care Accreditation Council (HCAC) on quality improvement activities in both clinics and hospitals (i.e., manager certification, facility recognition programs, GP training). The Eastern Mediterranean Public Health Network (EMPHNET) supports the implementation of the JMMSR system. Other subcontractors include the Population Council and the American College of Nurse-Midwives. Also part of the partnership framework are networks that support recent, past or other current USAID/Jordan Health Activities such as the Jordan Communication, Advocacy and Policy (JCAP), Human Resources for Health (HRH2030) and the Health, Finance and Governance (HFG).

HSD Results Framework as a Theory of Change

The HSD Results framework and constructed Theory of Change depicted in Figure 4 is comprised of two primary results areas: **Result 1** focuses on RMNCH+ integrated service availability and access through demand side Interventions to increase uptake (Sub result 1.1) and awareness raising of service availability through community engagement (Sub-result 1.2). **Result 2** aims to improve quality of integrated RMNCH+ services by improving providers' competency and behavior to deliver evidence-based RMNCH+ services (Sub result 2.1) and by strengthening management of RMNCH+ services (Sub result 2.2). Result 1 is reflected on the left side of the model and result 2 on the right side. HSD inputs and mode of operation to achieve these results include making resources available, facilitating collaboration between service delivery partners, and supporting coordination between USAID projects that also contribute to aspects of the same results.

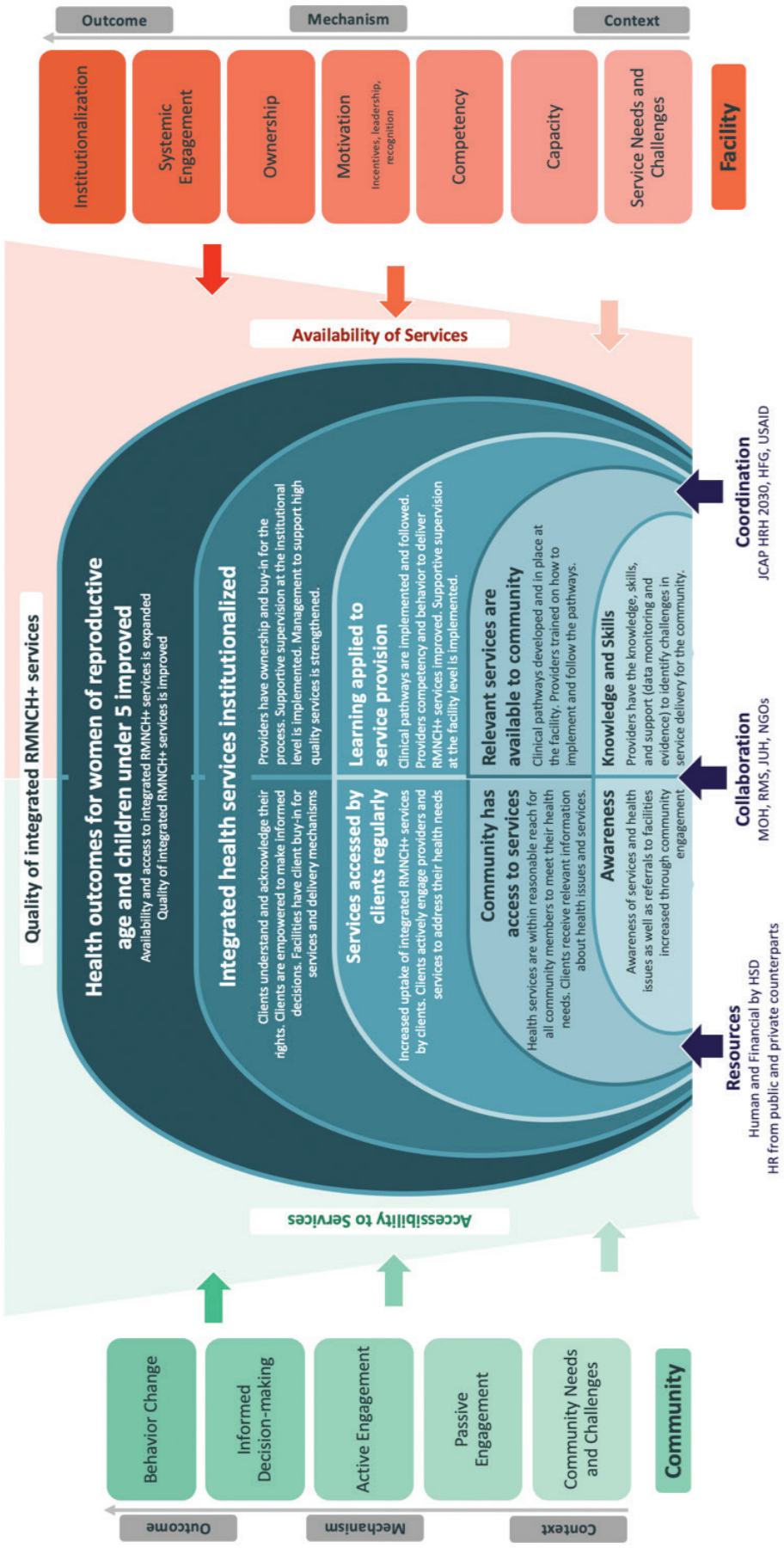
Along the left and right sides of the diagram are the hypothesized steps inherent in the HSD Theory of Change. To achieve accessibility and availability of services for the community, community needs and challenges must be understood (through understanding of the data). This information should then be shared with the community (through awareness-raising activities). It is hypothesized that information sharing will motivate community members to actively engage with their own health and that of their children to make informed decisions to seek care and ultimately to use services (change behaviors).

On the service improvement (facility) side of the diagram, improved quality of integrated care is hypothesized to be achieved by identifying service needs and challenges (informed by service delivery data) and then building skills and competencies to deliver better quality care. By engaging providers and managers in a quality improvement process (e.g. ISDIC), there is the assumption that staff motivation will increase and greater ownership of the improvements will be fostered within the health system at all levels. This would in turn be demonstrated by systemic change that is ultimately institutionalized.

These assumptions are derived from the **context** to define the **mechanism** that should be activated by the process to deliver the desired **outcome**.

Fundamental to the model is the notion that key stakeholders (community members, decision-makers, providers and managers) will be motivated and committed to achieving the project aims through engagement and the provision of information. Realization of this hypothesis is essential if sustainability of project achievements are to be realized.

Figure 4: HSD Results Framework and associated assumptions *(developed from the HSD Results Framework for the evaluation)*



METHODS

Approach

The midterm evaluation was structured to test the assumptions inherent in the HSD Theory of Change and Results Framework (as shown on the previous page in Figure 4). To do this, the research team used a combination of qualitative data collection (key informant interviews, focus group discussions, small group interviews), surveys, facility checklists and observations, validation of select monitoring data, and analysis of secondary data sources to evaluate the effectiveness and efficiency of the HSD approach and activities. This was done through the more classical (pre-post) evaluation approaches and application of more innovative realist evaluation analysis method to get to a deeper level of understanding of what works (effectiveness and best practice), for whom (public versus private, different population groups, different providers, etc.), in what respects (lessons learned), to what extent (sustainability), in what contexts (relevance), and how (efficiency)?

The following diagram outlines the key data collection approaches and methodologies used for the evaluation.

Data collection instruments can be found in **Appendix 5**. A full list of data sources can be found in **Appendix 1**.

Evaluation Questions

Four overarching research questions guided the evaluation:

1. **Quality:** To what extent did the HSD Project contribute to RMNCH service improvements, including availability, accessibility, quality, integration, and gender responsiveness of services in Jordan? Which

Figure 5: Key Evaluation Methodology and Data Collection Approaches

Key Stakeholder Learning

Focus Group Discussions

- Clients of the SDP
- Non-clients of the SDP
- CHC Members
- Beneficiaries of the CHC

In-Depth Interviews

- Providers (Hospital, NGO and health center)
- Health system managers
- Policy-makers, Implementing partners, Donors

Surveys

- Provider survey
- Private provider survey

Data Reviews and Validation

Document Review

- Annual Reports, strategy documents, Information Education and Communication materials, training materials, community scorecards, ISDIC cycle reports etc.

Validation of Monitoring Data

- Validation of HSD Monitoring Evaluation and Learning data against provider survey and observational checklists

Facility Checklist and Observation

- Observational checklist of 'deep dive' facilities

Realist Evaluation

A theory based evaluation which hypothesizes a middle range theory of change which is then tested through the evaluation process using realist approach. Specifically, thwe approach asks what mechanisms will generate the outcomes and what features of the context will affect whether or not those mechanisms operate. The context-mechanism-outcome (CMO) configuration is used as the main structure for realist analysis.

interventions can be considered good practice? How should interventions be strengthened for sustainability after the life of the project?

2. **Management:** To what extent did HSD employ appropriate and effective management, operational and monitoring mechanisms?
3. **Sustainability:** To what extent have HSD initiatives demonstrated potential for post-investment sustainability (e.g. which are more likely to continue after HSD ends, what are the cost and quality implications if they do, and which ones will likely not be sustained)?
4. **USAID Alignment:** What are the implications for future USAID support to RMNCH programming in Jordan?

In the original evaluation plan, a fifth question on value for money was included, but was removed from the final plan as there was insufficient data on cost and outcomes for such an analysis. In addition, no counterfactual was available for comparative purposes. (Note: The full evaluation plan can be found in **Appendix 3**, and includes a full description and limitations of the evaluation methodology).

Analysis and Evaluability

Analysis was done through both qualitative and quantitative methods. The HSD Theory of Change was tested using a classic pre-post analysis and a "Deep Dive" case study approach. The Deep Dives were done on nine facilities and four hospitals to capture progress achieved and challenges encountered/overcome as requested in the scope of work. Since these approaches may be limited when applied to complex health systems interventions, we added a Realist Evaluation approach to further explore the data from the deep dives where more contextual information was available. With this analysis, we were better able to appreciate progress to date at a more granular, contextualized level, appreciating past, current, and future activities.

Sampling

We employed different sampling methods based on the study design for each stakeholder group.

Key Government and Partner Stakeholders

We purposively sampled key informants serving in leadership and management positions pertinent to the implementation of HSD's RMNCH+ interventions, including representatives of the Central MoH, Health Affair Directorates, Royal Medical Services, NGOs operating primary care clinics and community outreach programs, other major national stakeholders, key HSD Partners, and the core HSD team at Abt Associates.

Primary Health Care Facilities (MOH Health Centers and NGO Clinics)

Selection of primary health care facilities, including HSD-supported MoH health centers and NGO health clinics was achieved by evaluating all HSD facilities on a specific set of criteria that would eventually allow us to assess and compare facility data using the following variables: length of time participating in ISDIC, performance on project performance indicators, service volume, and geographical distribution.

To select facilities, we:

- Stratified facilities based on when they began participating in ISDIC - facilities that have been doing ISDIC longer (e.g. since FY17 – 44 SDPs – 35 MoH + 9 NGO) versus those that began ISDIC more recently (e.g. in FY18 – 67 SDPs – 56 MoH + 11 NGO)
- Within these two groups we stratified based on:
  - High performing versus low performing facilities
  - High volume versus low volume facilities

We then randomly selected two facilities in each of the eight strata. Figure 6 on the following page shows a map of the PHC and hospital facilities selected.

Private Physicians

A random group of N=20 private providers were also included in the sample. Private physicians engaged by HSD were sampled using probability proportionate to size formula to ensure representativeness across the three

Facilities Sample Overview

The final sample of facilities included:

17 clinics: 14 MoH and 3 NGO clinics

- 8 'light touch' facilities (7 MoH and 1 NGO) that received tablet survey, observational checklist
- 9 'Deep Dive' facilities (7 MoH and 2 NGO) that also received KIIs with 2 providers and CHC members; FGDs

6 hospitals: 4 MoH and 2 RMS

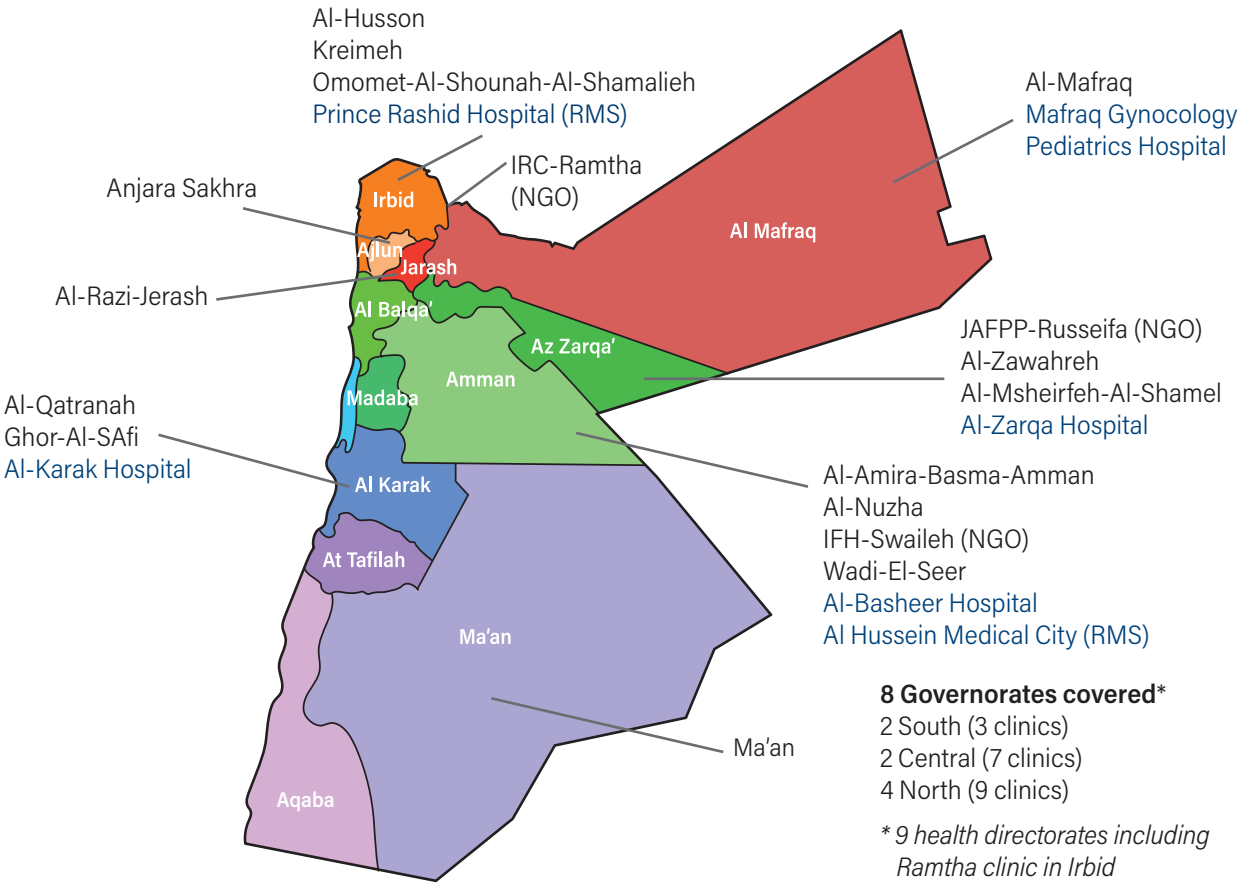
- 3 'light touch' facilities (2 MoH and 1 RMS)
- 3 'Deep Dive' facilities (2 MoH and 1 RMS)

directorates in which private physicians are engaged to conduct a telephone survey. The Evaluation Team did not sample pharmacists as well as HSD has not yet begun working with pharmacists.

Key Limitations

The evaluation team made use of data collected by HSD as government health service delivery data that could not be independently validated within the scope of the evaluation period. Robust data collection by HSD is considered sufficient to provide a midline stats report of activity progress. The MTR validated this information through other qualitative and quantitative means and triangulated the results to provide an alternative perspective on progress achieved by the project. In addition, HSD collected data on proxy indicators, which were not sufficient for measuring health outcomes. To overcome these limitations, the Midterm Review (MTR) worked with HSD to identify appropriate outcome measures to consider documenting in the remaining project period. This new data can help to demonstrate the full effect of their interventions as contributions in health outcomes. HSD is considering options for measuring impact after the close of the project.

Figure 6: Map of the Governorates and their facilities included in the evaluation sample



KEY FINDINGS

EVALUATION QUESTION 1: QUALITY

Evaluation Question 1 considered: "To what extent did the HSD Project contribute to RMNCH service improvements, including availability, accessibility, quality, integration, and gender responsiveness of services in Jordan? Which interventions can be considered good practice? How should interventions be strengthened for sustainability after the life of the project?"

1.1 Quality of care improvements achieved through ISDIC interventions

HSD met or exceeded almost all targets set for quality of care, albeit with variation across directorates.[4]

Clinical pathways were a successful strategy to improve quality of care. Nurses, midwives, and doctors were positive about the use of clinical pathways as a way to improve the quality of care, however they also noted that it led to increased stress and workload.[5] Specific examples of improvement in quality of care as a result of the clinical pathways include increase in anemia screening, early use of CPAP and proper use of antibiotics, with the latter contributing to a reported decline in mortality and morbidity of neonates at the RMS hospital.[6] One health area directorate manager reported:

> *"Prior to the clinical pathways there was chaos; not all the people working in the clinics…are aware of procedures. The clinical pathways created a consistent procedure and protocol across all the clinics. A great example is anemia testing."* [7]

Integration of services through the client service station is seen as a good approach in theory to increase awareness of postnatal care and family planning, but not yet functional in practice. Common challenges arose due to staff turnover, staff shortages and infrastructure limitations.[8]

In general, adherence to clinical pathways was recorded through the HSD monitoring data and the provider surveys conducted for this mid-term evaluation. According to HSD collected monitoring data and from the evaluation provider survey self-reported responses by providers, adherence to clinical pathways was near universal. However, client perceptions suggested that in spite of provider-reported knowledge of the clinical pathways, implementation of the full clinical pathway was lacking indicating further attention to quality of care is needed (Table 2).

1.2 Challenges in making quality of care improvements

There were a number of common challenges across facilities in terms of improving quality of care. These include: staff turnover/human resource (HR) challenges; limited engagement of senior management; prioritization that was not inclusive of provider, manager and CHC representatives' views; barriers to access; and systemic problems such as infrastructure deficiencies. Each will be discussed in turn.

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[4] Document review; KII implementing partners.

[5] KII managers; document review; KII clinic providers; KII hospital providers; provider surveys.

[6] KII hospital providers, KII managers, document review.

[7] KII managers.

[8] KII providers, observational checklist, document review, FGD clients.

Table 2: Adherence to clinical pathways according to independent data sources *(Client feedback; provider survey and interviews; and HSD monitoring data)*

	Baseline – HSD monitoring data (FY16)	HSD monitoring data (FY18)	Provider survey and interviews (mid-term evaluation)	Client perceptions (KIIs and FGDs, mid-term evaluation)
Family Planning	16% of clients receive FP services according to quality of care index (FY17 baseline)	95% of clients receive FP services according to quality of care index 100% facilities provide FP counselling	93% facilities always offer FP counselling	FP counselling not consistently delivered; evidence of provider bias or misinformation in FP advice; counselling often not delivered in a private place
Antenatal Care	6% women managed according to ANC clinical pathway	76% women managed according to ANC clinical pathway 90% pregnant women assessed for high risk factors in first ANC visit	Essential ANC procedures reported to be delivered in the appropriate visit 83% clinics screen for high risk in the first trimester	Fewer ANC visits than the expected 8 visits (between 3 – 6); Some women did not receive full range of tests; iron and folic acid not always available
Delivery Care	29% women receive AMTSL protocol	98% women receive AMTSL protocol	82% hospitals receive AMTSL protocol	Most women reported not being treated with respect, dignity, and humanity during their delivery
Post-Partum Care (Breast-feeding)	20% women giving birth initiate breastfeeding within first hour of birth	89% women giving birth initiate breastfeeding within first hour of birth 94% hospitals always initiated breastfeeding within first hour after delivery (Q2 FY19)	100% hospitals always initiated breastfeeding within first hour after delivery	More than half respondents did not receive support with breastfeeding (challenge with staff shortages)

1.3 Staff Turnover/Human Resources Challenges

High staff turnover hindered the effectiveness of the ISDIC program. Staff turnover was especially problematic for general practitioners in primary healthcare, as well as midwives and doctors in hospitals in a context of increased client flow. Furthermore, only MCH staff at a facility were trained on ISDIC (leaving other providers not engaged in the quality improvement process within the facility). New staff may have not been exposed to the clinical pathway training or other components (i.e. CSS, FBSS) of the ISDIC process, and there was no evidence that the trained staff oriented newcomers or other colleagues on what they learned. Preservice training, for example, for new staff to become proficient on clinical pathways would have helped institutionalize quality improvement. Once the trained staff leave, all progress is lost making retraining fundamental to sustaining the program.[9] There appears to be no effort to address the HR issues on a policy level through HSD as the issue was to be addressed by the USAID Human Resources for Health (HRH) project.[10]

[9] Document review (Annual Reports, ISDIC cycle meeting notes, workplans, change packages); KII managers; KII clinic and hospital providers

[10] KII policymakers

1.4 Engagement of senior management

Despite HSD efforts to involve HAD directors in annual work planning, quarterly visits, monthly project monitoring and trainings, many HAD directors remained disengaged limiting sustainability of the program. Resentment by HAD directors interviewed was observed as they felt overstepped and ignored by HSD (in contrast to the prior HSS project). Senior Directors may have been less engaged because they were new (due to high turnover of directors), considered their staff were involved in HSD and thus did not need to engage, or were less interested because they did not receive the remuneration provided in previous projects. In addition, some providers at the facility level and most senior level persons at the directorate level, as well as the senior managers and directors at the hospitals were not aware of the project.[11] Awareness was greatest for health facility level managers.

1.5 Priority-setting

Prioritization of issues for ISDIC was focused exclusively on the HSD selected focus indicators and engagement was not conducted in a bottom-up manner. Providers, managers and CHC representatives participating in the ISDIC process were not asked to identify priority areas for improvement and key issues facing clients. Some respondents noted that critical issues such as workload (providers) and opening hours (clients) were never addressed. A scorecard was developed to facilitate dialogue on specific facility issues as assessed by clients and providers. It was facilitated by the CHC but only involved a handful of clients in a FGD session to capture community perspectives on quality of care and other facility issues. The CHC was then charged with bringing the scorecard results to the ISDIC process for discussion but without client involvement. As a result, most respondents were unaware of the scorecard activity as the scope of the intervention was limited and the results were not always reflected in the change packages.[12]

1.6 Barriers to access

The program was not designed to create demand, and did not prioritize critical interventions to mitigate barriers that limited demand. For example removing barriers to accessing services (particularly gender based barriers such as preference for a female provider; opening hours; and transport costs). However, recent improvements in some facilities have been made such an updated appointment system to address workload and waiting times for clients, and individual provider initiatives worked to engage men and couples to increase uptake of family planning.

1.7 Systemic problems

Further challenges included physical infrastructure deficiencies, periodic shortages of supplements and equipment (e.g. Hemocue device) and staff shortages requiring repeated training for new staff and restricting CSS station functionality.[13]

1.8 Availability of services

Frontline health workers delivering MCH service were provided competency training from HSD on the clinical pathways. As a result, in HSD SDPs, most health interventions are consistently available, except IUD insertion and family planning (FP) counselling in some facilities.[14] *This is a concern, because when there is failure to deliver such services it suggests that despite providers knowing the clinical pathways they are still making non-evidence based recommendations based on their personal biases.*

There is a lack of consistency in FP method and counselling availability. All five main methods of modern contraception were generally reported to be available, but clients found IUD insertion services inconsistent. Women were sometimes offered the oral contraceptive pill when injections were not available as shown in Table 3

[11] KII policymakers

[12] KII provider, FGD client

[13] KII clinic provider, FGD community and client

[14] FGD client, provider survey, HSD MEL data

Table 3: Percentage of facilities reporting contraceptive method available, according to four data sources

	HSD monitoring data (Q2 FY19)	Provider survey (mid-term evaluation)	Facility Checklist	Client focus groups
Pill (OCP)	100%	100%	100%	Commonly offered; readily available
Injection	100%	100%	100%	Sometimes injection unavailable: given pill in meantime
Implant	78%	78%	87%	Rarely mentioned by respondents
IUD	100%	100%	91%	Trained staff for insertion inconsistently available (1 day per week)
Male Condom	100%	100%	100%	Commonly offered; readily available
Tubal Ligation	N/A	22%	30%	Information/ referral rarely shared with patients
LAM	N/A	100%	100%	No information recorded in focus groups

(Green indicates always available, yellow sometimes, and red rarely available). Family Planning counselling was routinely available, but generally only provided if client-initiated (for both ANC and postpartum FP counselling).[15] When FP counselling was offered, detailed information on side effects and hormonal changes linked to FP methods was insufficiently explained. Some beneficiaries mentioned that after their first child they were told that they were not eligible for FP. Some did not receive any counselling, others received upon request, and others received it to protocol depending on the facility and provider.[16]

1.9 Quality of services according to the clinical pathways

Providers appear to be aware of the clinical pathway and believe they are following it, but service delivery is not standardized:[17]

- **Family Planning:** There appears to be provider selectivity in offering FP and reports of misinformation in FP counselling. The misconception that FP causes infertility was cited as a reason for providers offering FP to women who have completed childbearing-for use with child limiting rather than spacing. Clients also reported feeling uncomfortable due to a lack of privacy for FP counselling services.
- **ANC:** In general, ANC was provided according to clinical pathways, but there was a lack of clarity on the recommended number of ANC visits by providers, CHC advocates, and clients. WHO and the MoH currently recommend 8 visits but the exact number of visits recommended was not known by providers and clients alike despite clear indication by international standards of which services should be provided in which trimester.
- **Delivery care:** Provider communication before delivery on what will happen during labor and delivery including the possibility of complications was generally not practiced, and some women reported aggressive behavior from providers. Some clients were not aware of the medications/type of anesthesia they were given or that they would be induced.
- **Postpartum care:** Guidance on newborn care was inconsistent. While the majority of clients initiated

[15] HSD MEL data, provider survey, facility checklist, FGD client

[16] FGD beneficiary, FGD community, FGD client, FGD hospital provider

[17] FGD beneficiary, FGD client, FGD community, provider survey.

breastfeeding early, mothers felt the focus of care was on the newborn not them, leaving mothers to rely on family members for support. Providers noted staff shortages are the likely cause of limited individualized attention.

1.10 Treatment with respect and dignity

Respectful maternity care was not included in the list of HSD focus clinical pathways but was expressed as a concern of the project team. As anticipated by the project staff, clients reported that clear and respectful communication with clients was sometimes missing. Many women felt they did not receive adequate information, and some reported rude or aggressive behavior from providers, particularly at the hospital for delivery care or family planning counselling. Conversely in antenatal care (ANC), about half of clients reported that the providers were responsive to their needs, while the other half reported verbal abuse. It is important to note that many women have their ANC with private providers and then go to the hospital for delivery care, which may be reflected in this finding. The majority of women reported that they did not feel treated with respect and dignity during their delivery.[18]

Staff shortages, work overload, and client flow may have affected provider attitudes. Lack of sufficient mentoring and supportive supervision may also have contributed to the sub-optimal provide attitudes. There may also be an issue of the hierarchy between providers and clients, with providers not recognizing client's autonomy to decide what is best for them demonstrating an overall lack of client centered care. Women reported "there is a power difference and not good conversation between the mother and provider."[19]

There is little focus on humanized care in HSD documentation, and it is not included in the Recognition Program Assessor's Guide.[20]

1.11 Accessibility of Services

Despite HSD's efforts to select facilities with access challenges (and work on those issues through ISDIC) issues of transport, distance and geography all continued to contribute to poor access. Access varied greatly between regions and facilities. Another barrier was that clients, especially Syrians, often did not understand their eligibility for services, which services were available, or that access to services was free. Many women prefer to receive care from private providers, but are unable to do so because cost is a barrier.[21]

For example, Mafraq is a large open desert region in which there are 80 health centers spread far apart. The majority of these clinics are classified as "tertiary" or "branch" clinics that do not offer full services. As such, women have a hard time accessing the services they need because of the long distances and cost of transportation.[22]

Conversely in Amman facilities are much closer together; transport is less of an issue; and poverty levels are lower than in other directorates.[23]

The health center at Ajloun is at the top of a hill with no direct access to public transportation. This makes it very difficult to access for infirm and pregnant clients. Consistency of staff availability also appears to be an issue at this facility: staff work at random times and the lab is often unstaffed.[24]

A good practice example of increasing access was in the case of Mafraq where the doctor and midwife make visits to the community to bring health care to remote areas for women who cannot access the facility.[25] These providers in Mafraq, as elsewhere, that extended themselves to do community outreach were supported and encouraged by the CHC's, creating a synergistic environment and collective motivation to reach communities in rural areas.

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[18] FGD beneficiary; FGD client; FGD community

[19] Workshop

[20] Document review.

[23] FGD provider

[24] FGD beneficiary; FGD client; FGD community

[25] FGD community

1.12 Supportive Supervision (FBSS)

The FBSS model was designed to provide facility level mentoring and support to staff to improve clinical practice and management issues as a bottom up approach, in contrast to the current supervision system implemented by the MoH by higher-level supervisors. Despite best intentions however, the FBSS appears to be a monitoring/evaluation checklist rather than a supportive supervision tool that could be used for in-service training and mentoring. Where it works, it depends on engaged managers to take a leading role. In facilities with engaged managers, the FBSS checklist was used regularly to monitor progress on indicators and provide support to providers who needed it. Notable achievement in this area was at the RMS hospital maternity ward and the Omomet-Al-Shounah-Al-Shamalieh health center where the engaged manager recently retired.

FBSS is not being done in hospitals as was envisioned; instead it has become a monitoring tool for continuous action planning. When FBSS at the clinic level is conducted, supervisors do not necessarily follow a consistent set of procedures.

FBSS was designed to move supervision to the facility level to facilitate mentoring and quality improvement efforts from the ground up. This differs from the MoH supervision system, which is top down. As FBSS was not aligned to the MoH supportive supervision process, sustainability after the project is unlikely to be maintained without incentives. Greater coordination between programs and systems would facilitate accountability and help maintain quality.[26]

1.13 Client Service Station (CSS) and client flow

Client Service Stations have been observed in all clinics, but functionality was an issue due to the recency of their establishment and staff shortages. Few respondents were aware of the CSS or received direction cards. Where it functioned, the CSS was seen as helpful.

***Realist Analysis:* Lessons learned on what makes an effective CSS**

Context – mechanism – outcome:
Client Service Stations were designed with the intention of improving client flow and integration of service delivery.

Result:
Client Service Stations are new in many facilities, or suffer staff shortages which limit their effectiveness. In facilities with functional CSSs, they are seen as a useful component in improving quality of care.

What works; for whom; under what conditions?
Facilities that report functional client service stations, such as the Zarqa Hospital or Hosn Clinic in Irbid, have in common a dedicated staff member working at the station. Direction cards are being used successfully in some facilities to streamline client flow, to the appreciation of staff and clients alike.

In Arabic, the Client Service Station sign does not identify that it is a station. In practice, it acts as another sign that tells people they are in the right place (mother and child clinic), but does not direct them to the station itself.

Waiting times for RMNCH services were between 30 minutes to 3 hours. The appointment system through HAKEEM in some hospitals was appreciated by clients.

1.14 Health promotion materials

Health promotion materials were available, covering topics including family planning, antenatal care etc. Almost all the beneficiaries had seen or taken the materials, however, about half of those reported found them only partially beneficial. Brochures were consistently seen as helpful only when the provider actually went through the materials with the clients. Some clients noted that making information available on a video or TV in the waiting room may be a better way to share the information.[27]

[26] KII clinic provider; KII manager; KII hospital provider

[27] FGD client; community; beneficiary

1.15 JMMSR – Jordan's Maternal Mortality Surveillance Response System

The JMMSR program has been in operation for the last year with the first year report analyzing cases just released. Given the nascence of the effort, JMMSR is recognized only by those actively involved in the program. It appears to have been well-designed with clear roles/responsibilities, but implementation has only just begun. Accountability for follow up on the feedback loop and answerability has not been well articulated or assigned, and lessons from other countries implementing similar approaches were not evidenced.[28]

1.16 Working with the private sector

HSD incorporated private providers in the training or clinical standards to expand quality improvement of clinical practice to the private sector—a follow up to past efforts to engage private physicians through the Strengthening Health Outcomes in the Private Sector (eSHOPS) project funded by USAID from 20 July 2010 to 30 August 2015.

The private providers and pharmacists respondents in the mid-term evaluation generally had positive experiences to report regarding their interactions with HSD. In general, they felt that although the priorities came from USAID directly, there was a good discussion at the beginning of the project to reach an agreement together about priorities and actions. They also mentioned feeling like they were learning a lot from USAID driven programs.[29]

One challenge that was raised was that it is difficult for private providers, especially pharmacists, to access training and continuous professional development given it can be difficult for them to leave their job for the time that is required to participate in a workshop. One private provider also noted that she was surprised about how few training workshops were being conducted by HSD, given she had received more in the past under previous USAID projects.[30]

A solution discussed to boost sustainability and motivation was the provision of incentives for participation and improvement. This could include certification, such as receiving continuous professional development credits and certificates for attending trainings that USAID provides. Another incentive would be to consider models where pharmacists are given fee or non-fee based incentives for the services they provide, to encourage them to not just be salesmen, but partners in care who can offer expert advice to clients. Additional workshops and conferences were discussed as the typical way to engage the private sector.[31]

Generally, the work with private providers was considered too little to be meaningful in terms of quality of care improvement in RMNCH provision in Amman where the intervention took place. Both staff and providers felt that the engagement was too modest to make a difference, though some of those involved appreciated the training. At the time of the evaluation, HSD had begun to define new approaches with pharmacists that may prove more sustainable. The nature of the client-pharmacist interaction, and services/products offered offer an opportunity for the expansion of FP counseling in pharmacies that benefits both clients and the vendor. The inherent incentive in this relationship offers more potential to increase access for a wider variety of clients including young, unmarried, and uninsured vulnerable populations.

A pilot effort to work with private sector physicians to improve delivery of integrated RMNCH+ services was modest, not cost effective as incentives were insufficient to sustain and expand engagement to make the intervention impactful.

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[28] Document review; KII policymakers

[29] KII private providers

[30] KII private providers

[31] KII private providers

1.17 Community Health Committees (CHCs)

The role of the CHCs was primarily to raise awareness of the services available (mainly anemia testing and ANC) and potentially to link health facilities potentially by bringing in community perspectives into the ISDIC process. In practice, its role was more educational than client advocacy driven however. Presently, the CHCs are not formally in the health system—a situation, which is changing under newly proposed legislation (though not yet confirmed).

Some well-established CHC's have their own agenda and priorities. When engaged for RMNCH+, they can be effective at raising awareness of key issues. How CHCs prioritize the messages (e.g. FP or anemia) they advocate on however is unclear; some perpetuate misinformation about family planning. CHC members were appreciated for their community activities to raise awareness and their information sharing at Mosques and other locations where they reach men. CHC members are perceived as influential and representative of the community. If strengthened, the CHC could be an important contributor for demand creation, potentially in partnership with other programs. There is minimal knowledge of CHC activities at the Directorate level beyond the person responsible for community outreach—for example, the home visits are implemented by NGOs, not the MoH, and there appears to be minimal awareness of this activity within the MoH.[32]

1.18 Community Scorecards

At present, community members are not empowered by the scorecard process: most are unaware of their existence and their perspectives are not included in a sufficient way, even though monitoring data shows that 80 facilities currently use scorecards.[33]

1.19 Community Outreach

There was mixed reaction to the home visit outreach program, with many women indicating positive impressions of the visits, yet this translating to a low uptake of the services offered through the home visit voucher program. Women visited reported that they appreciated the visit and found the information beneficial. An example of good practice includes the Al Shouneh outreach program, in which visits were made to Bedouin and Pakistani communities who did not visit the clinic. Although many households were reached by the outreach program (>259,000) and 12,000 anemia screening vouchers provided, only 30% were redeemed, suggesting that the visits do not necessarily translate into health-seeking behavior.[34]

1.20 Gender-Responsive Programming

Lack of attention to gender is seen at all levels of the program. Although gender issues were included in training modules, gender has only recently received attention more actively through an innovation grant aimed at addressing gender-based violence.[35] Gender-related barriers are often not labeled by providers as gendered issues (e.g. waiting times and opening hours, requiring the husband's permission to access services) indicating a lack of understanding of the terminology. Most centers are not actively working to recognize and mitigate gender-related barriers.[36] Best practice in mitigating gender barriers was found in a few clinics where individual providers extended opening hours, facilitated medicine pick-up for those with insufficient funds; and did outreach in the community to overcome family and husband restrictions and misconceptions.[37]

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[32] FGD community; KII clinic provider; KII manager; workshop

[33] FGD community; KII clinic provider; KII manager; workshop

[34] FGD community; FGD beneficiary; FGD client; document review

[35] Document review; FGD community; FGD beneficiary; FGD client

[36] FGD community; FGD beneficiary; FGD client

[37] FGD community; FGD beneficiary; FGD client; KII manager; KII policymaker; KII implementing partner; KII provider; document review

***Realist Analysis:* Lessons learned on mitigating gender-related barriers**

Context - mechanism – outcome:
Gender is an important consideration for USAID and was included in the design of HSD, but was not always prioritized or discussed consistently across facilities. Gender was incorporated into quality improvement trainings though it was not a specific focus of training by HSD.

Result:
Facilities that prioritized gender developed some successful processes to mitigate gender-related barriers.

What works; for whom; under what conditions?
Best practice in mitigating gender barriers was found in a few clinics where individual providers extended opening hours, facilitated clients to have access to their medicine when they had insufficient funds, did outreach in the community to overcome family and husband restrictions and misconceptions, among others.

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

In the Wadi al Seer clinic in Amman, family violence is a problem for the community that is being addressed by staff. They have created a "secret folder" in which they put the files for women who have been victims of violence and refer them to the services they may need. This is due to the openness and understanding of the staff, and the lack of provider bias in the facility. It is possible that the ability for this facility to take proactive measures is helped by its location in Amman, which has more diversity in terms of culture and a larger catchment area. Some characteristics commonly shared by facilities which prioritize gender include:

- Lower levels of provider bias or strongly held cultural beliefs that might perpetuate gender bias
- Committed individuals either on hospital staff or in the CHC who champion the cause
- Recognition of gender-related issues (such as GBV) within the community.

EVALUATION QUESTION 2: MANAGEMENT

Evaluation Question 2 asked: *"To what extent did HSD employ appropriate and effective management, operational and monitoring mechanisms?"*

HSD employed appropriate and effective management, operation and monitoring mechanisms through a variety of managerial interventions to improve RMNCH quality of care. Challenges to sustaining quality improvements supported by HSD and partners were beyond the Activity's scope of influence or project design (i.e., HMIS, human resource deployment, and other policy related issues).

2.1 Data for decision-making

The MoH does not collect disaggregated data at facility level that can be used locally for decision-making. The HSD project collected monitoring data monthly which was highly appreciated by facility managers and staff, but not always used effectively for decision-making by facility management. Data collection on key indicators of the project best informed quality improvements in hospitals rather than clinics except in selected facilities where individual managers were motivated to use the data for monitoring and supervision. Limited effectiveness occurred in facilities with staff shortages, high staff turnover, or the absence of the HAKEEM data collection system.

Realist Analysis: Lessons learned on accountability for quality of care through data collection

Context - mechanism – outcome:
HSD assumed that by focusing on selected indicators through the ISDIC process, providers and managers would be motivated and committed to make the quality improvement changes needed in their facilities.

Result:
Collection of data on key indicators was appreciated and seen as a success in some facilities, but not others.

What works; for whom; under what conditions?
Good practice outcomes came from the maternity ward at the Prince Rashid Hospital in Irbid and Al Shouneh clinic in Irbid. In these facilities, the manager reported using the indicators each week and month to review staff and facility progress, and offer support for improvements or help in addressing challenges. This active engagement has resulted in better performance by staff with measurable effect on health outcomes. Providers at Al Shouneh commented that the approach taken at their facility enables the manager to differentiate their personal work from the work of others, so that they are able to see how well they are doing individually. This brings motivation to the staff to do the work properly. These facilities demonstrate accountability through the data on a day-by-day basis.

In contrast, feedback from providers at the Zarqa Hospital was that the indicators and data collection process initiated through HSD supplemented what they felt they were already doing and therefore added minimal value and increased their workload by duplicating existing processes. There was a desire to focus the change package and heighten monitoring on priorities identified by staff, which in turn would increase motivation.

Key contextual differences that may have resulted in these different experiences of the data collection process include:

- The state of existing data collection systems in the facility and ability to integrate HSD processes into existing systems without duplicating the work
- The intention of facility managers in using the data and indicators: it seems to work effectively when used as a supportive and motivational tool to monitor and improve staff performance on a regular basis
- Involvement of staff in the decision-making process surrounding the indicators, to build buy-in rather than making them feel like their voices aren't being heard.

The use of process indicators helped to focus on the success of the systems HSD was putting in place; however the lack of outcome measures limits understanding of the impact of the project on women and children, and limits any future value for money analysis .

Data monitoring was seen to be controlled and owned by HSD rather than the facilities or the MoH limiting ownership and potential future sustainability of data collection. The HSD data collection system runs in parallel to the MoH system or HAKEEM (separate programs) in some facilities, which caused an increase in workload through parallel data collection. As the indicators were seen to have been prescribed from a higher level, facility or even district ownership of the data collection process was limited, and for some, with implications on the results such as the availability of monitoring and evaluating indicators unique to a specific facility-specific access and availability.[38]

[38] KII clinic provider; KII manager; KII hospital provider; KII policymaker

2.2 ISDIC prioritization of critical issues

ISDIC priorities were established by HSD at the start of the project. Project indicators were selected a priori in consultation with the MoH and other project partners based on a needs assessment of key health issues in RMNCH+ that needed heightened attention such as anemia screening among others. As noted above, ISDIC supported clinics to collect data on the preselected indicators targeted by the project. At the clinic level, ISDIC prioritized problems were limited to issues raised by the predefined indicators that were being monitored. This meant change packages were driven by the indicators, rather than reflecting staff sentiments of quality of care issues and problems at their facility. While many appreciated the priorities set by HSD, some felt other critical issues and their opinions were not heard. CHC members that participated in the ISDIC process also noted that the priorities of the ISDIC process did not necessarily reflect community health priorities.[39]

While the prioritization through change packages led to positive improvements at the clinic and hospital level (e.g. anemia testing, use of CPAP and antibiotics), some stakeholders felt that important priorities were missed, given the program's close alignment with USAID priorities alone.[40]

About half of the midwives PHCs and hospitals interviewed were not aware of the change packages developed through the ISDIC session. Many understood the importance of working on the indicators and reported that it is their own action plans that are implemented at facility level. This may be because few staff participated in the ISDIC sessions and there was no formal way to disseminate the results to other staff members who had not been involved. ISDIC engaged individual staff and managers and given the high turnover, depth of appreciation of the aims of the project varied significantly.[41]

Given that priorities were not established by providers and managers charged to make the improvements, the approach limited engagement of some, particularly higher-level managers at the Directorates and within the Hospital departments needed for sustaining the quality improvement process. Likewise, engagement of the quality improvement departments in the HSD supported hospitals also varied. Higher level and broader (e.g. involving more staff from facilities) engagement on the change packages was seen as needed to sustain the ISDIC quality improvement process.[42]

The focus on indicators at the ISDIC sessions created competition between Directorates and facilities that while motivating for some, was stressful for others to meet targets rather than focus on quality of patient care.[43]

2.3 ISDIC model as a catalyst for increasing motivation and ownership

The ISDIC model engaged and motivated staff, especially when recognition of achievements was given. Achievements on indicators were highlighted through the ISDIC sessions review on progress on indicators; the recognition program; and individually through supportive supervision. Increased competition and focus on indicators and progress however also increased staff stress and workload.[44]

ISDIC promoted facility teams to create their change packages and find local solutions for some of their challenges. Some facilities and hospitals felt that the quality of care improvements could and should be taken up locally within their facility. ISDIC supported hospitals, for example, found a standalone solution to problems

[39] KII community; KII manager; KII clinic provider; KII hospital provider; KII policymaker

[40] KII clinic provider; KII hospital provider; KII policymaker

[41] KII clinic provider; KII hospital provider; KII policymaker

[42] KII clinic provider; KII hospital provider; KII policymaker, KII manager

[43] KII policymaker; workshop

[44] Workshop; KII manager; KII clinic provider; KII hospital provider

such as managing parents to leave children's files at the hospital, training nearby peripheral health centers on the protocols to relieve pressure on hospital and to facilitate linking clients between centers and hospitals to reduce workload on the hospital.[45]

Ownership and internal motivation within the system to maintain quality of care improvements was limited to selected individuals. Many respondents assumed sustainability was assured because USAID will continue their support for the program.

Despite intentions of ownership by the MoH and facilities, ISDIC is still led by HSD. HSD leads the clinical program but does not "facilitate the sufficient engagement and involvement of the MOH or HAD "to do the quality of care supervision and control the results (although they do attend on some occasions); the same is true for the CHCs and the oversight of them by HAD. In fact, the sentiment among managers was that donors are expected to continue and manage programs; indeed it is not even considered the task of the MoH to monitor HSD (USAID) interventions. It seems this is how the task sharing has always been done.[46]

EVALUATION QUESTION 3: SUSTAINABILITY

Evaluation Question 3 asked: *"To what extent have HSD initiatives demonstrated potential for post-investment sustainability?"*

3.1 Sustainability in program design

The ISDIC model was designed to align with government systems, build on pre-existing processes, and be embedded within the monitoring and action planning of clinics and hospitals. However, implementation has required extensive management and supervision by HSD staff due to human resource limitations in the field, particularly at MoH clinics and hospitals. Due to high MoH staff turnover and heavy workload, there has not been consistent follow up of the project achievements by MoH and HAD supervisors and staff. The result is inconsistency in project delivery and consequently a risk that the efforts will not be sustained. Even at the MoH, where commitment to the program is high, there is no indication that resources will be made available to sustain the program or its effective components and interventions.[47]

HSD designed the project for sustainability by emphasizing strengthening partner institutions and providing training manuals, materials, and organizational structures that could be maintained within facilities by the MoH/RMS. Another program design feature to promote sustainability is the 'train the trainer' approach. Many managers and policymakers saw this as a useful tool to create sustainability and mitigate some of the challenges of high turnover.[48]

Financial investment by the MoH will be needed to sustain progress. HSD appears to rely on assumptions that the very success of the program will be sufficient to motivate the MoH/RMS to maintain continued implementation.[49]

Those that were trained personally felt that their own capacity was improved and were able to apply it to their work concretely. Accompanying the training with the organizational and facility structure also made this possible. For example, one clinic provider said: "The personal support mechanisms were the most beneficial for me. There was the training and workshops which really helped my self-confidence. I believe that it will be sustained. I want to maintain it because it organized my work and has increased the quality."[50]

[45] KII hospital provider

[46] KII policymaker; KII implementing partner; KII manager

[47] KII manager, KII clinic provider; KII Hospital provider; KII policymaker

[48] Document review; KII manager; KII policymaker

[49] KII policymaker; KII manager; KII implementing partner; document review

[50] KII clinic provider

Realist Analysis: Lessons learned on how motivated staff members are an opportunity for sustainability

Context – mechanism – outcome:
HSD is intent on embedding mechanisms to ensure sustainability of the improvements achieved under the ISDIC program.

Result:
A consistent contextual feature across facilities with positive improvements in quality of care under ISDIC is the presence of a committed and motivated staff member that champions continual improvement. This represents both a challenge and opportunity for sustainability.

What works; for whom; under what conditions?
In the Ghor Al Safi clinic, despite the absence of a dedicated doctor for maternal and child health, the head nurse passionately drives improvements in quality of care. While she felt HSD was empowering her, the motivation was intrinsic and in focus group discussions people noted the importance of her strong and positive personality. Her recent retirement however will challenge the sustainability of gains made in Ghor Al Safi unless another equally commitment manager has been hired in her place.

In the Mafraq clinic, it was noted that enthusiastic staff members were an important factor in improving quality of care, despite the substantial contextual challenges such as high cost of transportation for clients, conservative cultural norms preventing the CHC from discussing family planning and rumors hindering demand for family planning.

When it is just one or two strong personalities driving quality of care improvements, it suggests that there might be a sustainability risk because if that person retires the program will lose its champion and its momentum. However, if motivation and leadership can be generated across the staff more broadly, that is a good sign for sustainability.

A good practice example of generating sustained motivation and commitment from staff is in the HSD recognition program in the Al Shouneh clinic. Interviewees claimed that the recognition program was the most important for them as it gave them the motivation and enthusiasm to continue working on the new pathways and other aspects of the project. The recognition program allows them to have the positive feedback to the hard work they believe they are putting in which then allows them to continue working with the clinical pathways and continuing to strive for improved care.

3.2 Health systems changes in policy and practice

HSD was designed to complement other USAID supported projects with roles and responsibilities in common areas parceled out. HSD focuses on implementation and leaves critical policy related actions to sister projects. Lack of a policy agenda, however, limits its effectiveness in some domains. For example, Jordan's human resources challenges could potentially be addressed at a higher level more effectively than the repetitive training for new recruits through ISDIC.

Recent government engagement (with HSD support) on a curriculum for new doctors to quickly "onboard" them in facilities shows potential for improving the lag time it takes for getting new recruits up to speed in the facility, and substantially improving some of the challenges associated with the issue of high turnover. Another policy change that has positively affected healthcare access is the provision of a "white card" for all Syrians, which increases access to health services at the public health facility. In general, HSD has not engaged at this policy-level, and in doing so has arguably limited its potential effectiveness in sustainable health system strengthening.[51]

[51] KII policymaker, KII implementing partner

Some policy and practice problems were nonetheless resolved by HSD such as issues of supply and equipment, despite it being outside their purview (e.g. Hemocue device for anemia testing). This was appreciated by partners but ultimately not sustainable.[52]

EVALUATION QUESTION 4: USAID ALIGNMENT

Evaluation Question 4 asked: *"What are the implications for future USAID support to RMNCH programming in Jordan?"*

4.1 Synergies across USAID programs

USAID programs in Jordan's health sector have been established with the aim to be complementary and synergistic, particularly as many have been implemented by the same contractor (Abt Associates). Many activities build on previous programs, which strengthens capacity building and ownership (e.g. supportive supervision, FP counselling, integrated care etc.). Indeed USAID is credited by the MoH as a major partner that has helped shape the health system of Jordan over the years—largely to a positive effect.

While some critical issues that affected HSD implementation strategies were being addressed by other USAID-supported health programs, there does not appear to be significant cross-fertilization between programs for mutual benefit. Basic issues such as duplication of efforts have been largely avoided, but missed opportunities to create synergy and catalyze effectiveness were reported, particularly related to community-based activities.[53] Some notable examples of cross-fertilization between projects were found such as policy-focused activities that impacted on HSD supported interventions such as increased access to IUDs through midwifery training

Some opportunities to build on past project components (e.g. supportive supervision) using similar terminology to sustain the change process in the health sector was not maximized. New labels and multiple layers of interventions in each new project can confuse partners and limit effectiveness. Equally, shifting approaches to less intensive engagement with senior managers at the Directorate level can have negative effects in terms of ownership and sustainability, particularly if they were significant partners in the previous project (e.g. HSS I and II).[54]

4.2 USAID value-add to other RMNCH+ initiatives

USAID has sought to identify gaps in existing RMNCH+ services and fill them with new projects. This process has been well informed by past and present project implementers and stakeholders. Nonetheless, some respondents questioned why it appears as if USAID is not fully using their leverage with their government to focus on policy issues that underlie the functioning of the public health care system such as health information management (HAKEEM), staff turnover, and infrastructure. HSD does not focus on policy despite the key problems affecting quality of care relating to policy. Aside from select policy actions (see above), a limitation in the design of HSD was the clear delineation that policy would not be a priority which may have been a missed opportunity to affect change in response to evolving circumstances.[55]

USAID is not as effective as they could be in partnering with other donors and stakeholders in the health sector. Rather than leading health sector collaboration on RMNCH+ improvements with the MoH, they tend to work directly with the MoH and RMS.[56]

[52] KII clinic provider, KII hospital provider

[53] Document review; KII policymaker; KII implementing partner; FGD community

[54] Document review; KII policymaker; KII implementing partner; FGD community

[55] Document review; KII policymaker; KII manager

[56] Document review; KII policymaker

KEY CONSIDERATIONS AND RECOMMENDATIONS

RECOMMENDATION AREA 1: QUALITY OF CARE IMPROVEMENTS

1. Sustaining quality of care improvements at the facility level

The improvement processes at facility level that focused on clinical pathways has successfully improved quality of care for RMNCH+ in Jordan. To sustain quality gains achieved through the ISDIC model and other improvement interventions, efforts should be made to institutionalize HSD clinical tools in pre and in-service training. Health system changes are also needed for sustainability (beyond clinical tools) in terms of accountability, leadership and ultimately ownership by facility quality improvement processes that are supported and maintained by the HAD and the MoH. *[Recommendations refer to Findings 1.1, 1.3, 1.4, 2.2, 2.3, 3.1, 3.2]*

2. Compliance with evidence-monitoring based practice to improve quality of care

Providers are up-to-date on clinical pathways yet fall short in the delivery of evidence-based practice. Validation of the quality of care indicators and compliance against standards needs to be actively verified and shortfalls addressed, particularly in cases where the provider is spreading misinformation related to family planning. Measures need to include the client perspective of the quality of care received, possibly through self-administered feedback forms in facilities (paper- or app-based) and semi-annual rapid assessments (includes FGDs with clients). More training is needed to shift provider attitudes and behaviors to deliver quality care including on the job support and mentoring. Use of continuing education and relicensing as an incentive could be further explored to increase compliance with evidence-based practice. *[Recommendations refer to Findings 1.1, 1.8, 1.9, 1.10]*

3. Measuring health outcomes

HSD has achieved significant progress on some quality measures that are showing impact on health outcomes. Ideally, health outcomes should be included in the project design to measure impact and value for money. If the necessary baseline data to measure outcomes is not available, consider conducting research and working on case studies to document success stories. Hospital records of neonatal survival and thriving could be documented as such a case study. *[Recommendations refer to Key Limitations, page 24, in the Methods Section]*

4. Respectful care

Respectful care is not uniformly provided at HSD-supported facilities, particularly at hospitals during delivery and postpartum care. Humanized care is a fundamental component of all quality improvement approaches and needs to be equally measured and reported against from both standardized measures and the client's perspective. Integration of respectful care must be done at all levels from project-supported frontline training of providers through ISDIC (bottom up approaches) to development of MoH supported guidance on respectful care (top down). It will require changes to MoH's quality improvement and supportive supervision policies as well as potential changes to health worker job descriptions. It can also be supported by stronger community provider linkages to the community. Respectful care should be integrated purposefully in HSD and future USAID supported projects. *[Recommendations refer to Finding 1.10]*

RECOMMENDATION AREA 2: CHALLENGES TO MAKING QUALITY OF CARE IMPROVEMENTS

5. Staff turnover and retention

Staff turnover and retention are the biggest challenges to sustaining quality of care improvements generated by HSD. Sustaining staff motivation can be facilitated by a non-monetary incentive system. The recognition program, inter-facility, and Directorate competition through ISDIC sessions raised motivation of staff temporarily and helped with staff retention and turnover challenges. Longer-term incentives (e.g. continuous education certification; recognition letter linked to future promotion opportunities; small facility improvements based on assessed need, etc.) for facilities and individuals are needed to sustain the momentum created by the ISDIC process. HSD can document success stories that can be considered for further scale up by future USAID projects such as PGS. *[Recommendations refer to Findings 1.1, 1.3, 1.7, 1.9, 1.10, 1.11, 1.12, 1.13, 2.1, 2.2]*

6. Institutionalization and ownership

Institutionalization of ISDIC will require HSD to stimulate more engagement with the Directorate level. Despite numerous points of contact with the project, high turnover, and lack of participation in project interventions by HAD Directors directly (versus other staff) minimizes their ownership, and threatens sustainability of successful strategies. More engagement and involvement by high-level managers is needed and new approaches should be tested to gain their interest and commitment. HSD should urgently transfer leadership of the ISDIC process to the MOH and support their leadership through technical assistance (rather than leading the process themselves). The quarterly meetings for shared learning can be used for HAD directors to report on such efforts, as well as their monitoring and supportive supervision over the last quarter as a way forward. There needs to be a systems approach to sustain improvements across HSD SDPs, especially hospitals. *[Recommendations refer to Findings 1.4, 2.2, 2.3, 3.1]*

7. Prioritization

Priorities for the ISDIC session are based on data and preset indicators. Providers, CHC and managers have additional priorities. Adding more bottom up consultation and engagement (and possibly facility-specific targets and benchmarking) to the ISDIC process will increase ownership and contribute to future sustainability. ISDIC should include client and community feedback, and a diversity of facility staff to represent all cadres beyond the health providers of RMNCH services to ensure a variety of opinion and a team approach to the quality improvement efforts. Further, simplify the quality improvement process for MoH leadership and use existing approaches, tools and recognition activities to facilitate problem solving for a limited amount of non-USAID priority issues. Including the Health Directorate in the definition of these additional targets is vital for their support into the future. *[Recommendations refer to Findings 1.2, 1.5, 2.1, 2.2]*

8. Monitring and reporting

Lack of an MoH system to track, monitor and use HMIS data is a critical gap in their capacity to improve health programs. Project accountability requires HSD to implement a parallel data collection system that focuses energy of staff on maintaining numbers instead of mentoring and quality assurance. The MoH does not have a unified HMIS system and as a result, providers and managers do not see the value of using data to inform practice and prioritization in decision-making. Despite interest by some within the MoH, there remains a lack of higher-level commitment within the Government of Jordan. HSD can provide technical assistance to improve the HMIS system if the commitment is present. USAID has an important opportunity to partner with the Government of Jordan to address this significant gap in knowledge-capture in the health sector. Consideration should be given to using 'conditionality' to incentivize accountability on the side of the government upgrade the national health information system and put in place a modern M&E system. *[Recommendations refer to section Introduction and Context, Page 15; and Findings 2.1, 2.2, 3.1]*

RECOMMENDATION AREA 3: BARRIERS TO ACCESS

9. Reaching the most vulnerable

Reaching the most vulnerable through purposeful selection of SDPs was done by HSD using an analysis of demographics. Within each catchment area however, demographics are shifting and facility specific strategies may be needed to overcome local barriers in access to care. A review of facility (and population) specific needs must be the basis of the change package for local ownership and impact. Such a mapping should consider measuring accessibility to document improvements made. *[Recommendations refer to Findings 1.6, 1.16, 1.18]*

10. Gender related barriers

Gender-related barriers to accessing care are not well recognized by HSD stakeholders as a critical issue despite some training on the issue. Mapping specific gender barriers to service and sharing these results with frontline staff at ISDIC sessions and within community activities will heighten attention to the issues. Inclusion of gender specific indicators in the change packages can focus attention on gender barriers and their mitigation through, for example, improved counselling content (e.g. power in decision-making, GBV prevention and treatment; self-care) and facility service improvements (e.g. change of opening hours, appointment systems etc). *[Recommendations refer to Findings 1.6, 1.20]*

11. Information, Education and Communication Materials

IEC materials prove more effective and appropriate if beneficiaries are involved in their design. A human centered design approach could help to design materials that will be used by women and their families. Multiple channels for socio behavioral change are encouraged including through alternative mediums such as videos; group information sharing; and facilitation by a designated staff person to communicate and share information should be explored. A great entry point is respectful maternity care where providers are educated and community knows its rights in receiving respectful care and good counseling for Family planning and RMNCH. In addition, given the finding that IEC materials were most helpful when explained by a provider, IEC materials should be consistently used to complement, rather than replace, the explanation of information to clients by the providers themselves. *[Recommendations refer to Findings 1.14, 3.1]*

RECOMMENDATION AREA 4: HSD PROGRAM COMPONENTS

12. Recognition program

Recognition program has no relicensing system and no follow up. While appreciated, the program needs to be linked to a broader incentive system. HSD needs to develop a sustainability plan to maintain the recognition program as it has been repeatedly cited as a significant source of motivation for facility staff. Engaging with the Health Care Accreditation Council to integrate the clinical pathways and some version of the quality improvement process as a requirement for accreditation should be explored. *[Recommendations refer to Findings 1.10. 2.3, 3.1]*

13. Client Service Stations

Client Service Stations are a potentially important contribution to integrating care. They are currently being implemented and not yet fully functional. HSD needs to work with facilities to contextualize their implementation to make them work for clients and providers with facility specific strategies and approaches. A rapid analysis/ research to identify the strengths and challenges related to clinic efficiencies, client and provider satisfaction and uptake of the integrated services can inform adaptations that make the CSS model for suitable for implementation and scale-up. *[Recommendations refer 1.13]*

14. Jordan Maternal Mortality Surveillance and Response (JMMSR)

JMMSR needs to be followed up throughout the life of the project to assure the quality of the data collection provides meaningful information on gaps and barriers in the system that need to be addressed. Ensuring accountability and quality is critical before the handing over ownership and control to the MoH critical at the close of HSD. Currently

the National Advisory Group (NAG) investigates cases and can in principle, send recommendations to the Prime Minister. Records show that all cases are being investigated but the feedback loop remains untested and final accountability for the process remains unclear. There is precedent. Abt Associates had successfully followed up a midwifery policy (that originated in the RHAP and then was supported by HSS I and II) which was handed over to the Higher Population Council. HSD will need to continue its advocacy for the full functioning of the JMMSR process and further implicate partners such as WHO to ensure national ownership can be achieved. *[Recommendations refer to Finding 1.15]*

15. Facility-Based Supportive Supervision

FBSS is a clinical performance-monitoring checklist to help identify the root causes for "non-compliance" with the clinical pathways at facility level. Though designed to be aligned with the current MCH supportive supervision program (which is more top-down), they are currently working in parallel. The notion of supportive supervision to improve quality of care has yet to be fully developed through FBSS. A supportive supervision and mentoring system is urgently needed to increase ownership and performance of staff. More efforts should be made to combine monitoring with mentoring to build ownership of staff for the quality improvement process. Involving health facility staff in defining the indicators could support this process. HSD should consider shifting focus of human and financial resources for the last phase of the project to build capacity of the MoH quality improvement staff and facility managers to successfully manage FBSS after the close of the project. *[Recommendations refer to Findings 1.10, 1.12, 2.1, 2.3, 3.1, 4.1]*

16. Engaging the private sector

The private sector is a significant contributor of RMNCH+ services in Jordan. HSD has tentatively worked with private sector physicians to improve the delivery of quality RMNCH services to standard. Private sector physicians, however, focus on curative rather than preventive services and their request for incentives limits the possibility for scale up. Training on marketable interventions such as IUD insertion that has a direct monetary benefit (e.g., offering that service to clients) that are considered valuable to private physicians are limited in scope. As a result, sustaining interest and commitment becomes individually based and not cost effective to bring to scale. New efforts are now being made with pharmacists to increase outreach and referral in the pharmacy setting, which offer greater potential as fiscal incentives are incorporated into the design of the intervention in a mutually beneficial way. In addition, certification for continuous training (as mandated by a new law) can be an important additional incentive for sustainability among pharmacists. Such incentive opportunities should be tested by HSD and future USAID-supported projects working with the private sector. *[Recommendations refer to Finding 1.16]*

RECOMMENDATION AREA 5: ENGAGING THE COMMUNITY

17. Community Health Committees (CHC)

The CHCs are respected by the community and have their own agenda which is not always aligned to the HSD evidence-based messages. When aligned and active they are able to mitigate gender barriers, serve as advocates for the community and increase demand for services. More engagement and advocacy of best practices with and between CHCs can help maximize their potential for the benefit of RMNCH+ services and status. Increased pressure on the government by both USAID and HSD to formalize the role of the CHC in the health system is critical for sustaining their role supporting health promotion at the community level, and for bringing the perspective of the community to the quality improvement process. *[Recommendations refer to Findings1.17, 1.20, 2.3]*

18. Scorecards

Scorecards have been reportedly done in over 80 facilities though recognition of them in the field was hardly noted, and when known, they were seen as an HSD activity rather than a community facility process. Scorecards are a good means to foster social accountability between

clients and providers but they must emanate from community perspectives and give voice to their concerns in order to be legitimate. Providers, conversely, need to see their obligations (as a duty bearer in rights terms) to deliver quality health care services that meet the community's needs. Increased attention in the process to community perspectives and dialogue on results between community and providers can bring greater accountability and joint ownership of the healthcare system in a community. If the scorecard process is further elaborated and tested, it could be an important accountability tool to be sustained through the PGS project in the future. *[Recommendations refer to Finding 1.18]*

19. Community Outreach

Community outreach activities have successfully reached a high number of families through door-to-door visits exceeding targets. Their acceptance is largely due to the strong reputation of the NGOs that are leading this process. Where the implementers were less well known, a mixed reaction to the visits was noted. Although improvements could expand the program's effectiveness such as expanding the thematic issues addressed by the outreach workers, the time remaining within the project will not allow for a revision at this late stage. In future projects, consideration should be given to moving beyond information sharing interventions dependent on the reputation of outreach workers to more scalable and efficient ways to more actively engage community members for behavior change. Promotion of behavior change through outreach could also benefit from a more comprehensive strategy that can be measured. *[Recommendations refer to Findings 1.11, 1.17, 1.19]*

RECOMMENDATION AREA 6: USAID SUPPORT FOR THE HEALTH SECTOR IN RMNCH+

20. Policy as a critical component of all projects

USAID has been a significant supporter of the health sector in Jordan over many decades. Past efforts have combined policy and practice guidance and support. The current HSD project has been designed to build on some of these past successes but not all. Policy advocacy and support is not a focus of HSD limiting the possibility of institutionalizing programs and achievements in the system, particularly at the hospital level. Instead HSD has engaged in advocacy to sustain HSD interventions through data and dialogue. Future projects should include policy advocacy explicitly to accompany intervention lines to assure responsiveness and flexibility for the implementer to address policy gaps as they arise. *[Recommendations refer to Findings 1.3, 3.2, 4.1, 4.2]*

21. Learning Agenda

USAID has a strong track record of investment in the health sector, which has created many successful models of engagement and intervention for health care quality improvements. Learning from past investment, success and challenges should be documented in a broader context of previous and current programming. Sustainability planning by projects should include a realistic assessment of which activities and components of implementer partner programming can and should be handed over to the government. This process will also identify where additional technical support for the MoH is needed to sustain successful approaches. Provide technical support for the MoH to engage in this sustainability planning and in identifying what kind of support they will need to assume leadership of the activities or interventions after the project ends. *[Recommendations refer to Findings 1.15, 3.1, 4.1, 4.2]*

APPENDIX 1: SOURCES OF INFORMATION

The following sources of information were used in this evaluation, and each explained in turn below:

1. Documents for Document Review
2. Persons Interviewed
3. Data sources

1. Document Review Reference List

The following documents were reviewed as part of the document review process for this evaluation:

IEC (Information, Education, Communication) materials, including job aids, posters, brochures

- Health Promotion Manual
- FP Counselling Manual (Hospital)
- FP methods brochure
- Specific method leaflets
- Clinical procedures flipbook
- Community Health Worker Family Planning Flipbook
- Maternal and child health instructions booklet
- Family planning wall chart
- Iron rich food cooking booklet

Training materials, including clinical pathways

- All clinical pathways documentation (e.g. initiation of breastfeeding process, family planning services, antenatal care, respiratory distress etc.)
- Maternal Clinical Pathway – Trainer Manual
- RMNCH+ Community Outreach Program Trainee Manual
- Hospital FBSS Presentation
- Training workshop reports (RMS and MoH hospitals)
- Postpartum Counseling TOT and presentations
- JMMSR TOT Training Resource Package – Facilitator's Manual
- Clinical case scenarios training tool
- Respectful Maternal Care for Gender Training 2019
- Primary Healthcare training materials- Logistics training

Information about each sub-component of the HSD project

- ISDIC Technical Brief
- Hospital ISD Recognition Program Assessor's Guide
- Family Guidance and Awareness Center Fact Sheet
- Institute for Family Health Fact Sheet (Innovation Grants)
- Tafilah Women Charitable Society Fact Sheet (Innovation Grants)
- Royal Health Awareness Society Progress Report (Innovation Grants)
- Innovation Grant Steering Committee TOR
- RMNCH+ Community Outreach Program Demographics
- Consult a Community Pharmacist Model Concept Note
- Anemia Outreach Concept Note
- Facility-based Supportive Supervision Instructions (PowerPoint)
- JMMSR booklet

Information from each facility and CHC on their ISDIC cycle

- FY10 ISIC cycle reports for (multiple districts) for MoH Hospitals, RMS Hospitals, Joint MoH hospitals and health centers
- FY19 change packages (multiple districts)
- Community Scorecard process reports (staff, clients and improvement plan) (multiple districts)

HSD Annual and Quarterly Reports

- Annual Report FY18, FY17, FY16
- Quarterly Report FY18, Q1, Q2, Q3
- MEL Plan 2018
- Workplan FY19, FY18, FY17
- Technical Review: Integrated Service Delivery Improvement/Primary Health Care 2019
- HSD Private Sector Strategy
- HSD Gender Action Plan 2019

2. Persons Interviewed

13 Key Informant Interviews: Implementing Partners, Donors, and Policy Makers ("KII implementing partners")

- Director of RMNCH, MoH
- Assistant secretary general for primary health care, MoH
- Manager, Emphnet
- Manager, Emphnet
- Senior Advisor, USAID Jordan
- COP, HSD
- Management and Integration Lead, HSD
- Private Sector Specialist, HSD
- Health Care Service Delivery Improvement Lead, HSD
- MEL Advisor, HSD
- DCOP, HSD
- HCAC
- Deputy Director, USAID Jordan

15 Key Informant Interviews: Health Area Directorate Managers ("KII managers")

- MCH Manager, Amman
- HAD Director, Amman
- CHC Supervisor, Irbid
- HAD Director, Irbid
- MCH Manager, Irbid
- MCH Manager, Ajloun
- CHC Supervisor, Ajloun
- HAD Director, Mafraq
- CHC Supervisor, Mafraq
- MCH Manager, Mafraq
- HAD Director, Zarqa
- CHC Supervisor, Zarqa
- MCH Manager, Zarqa
- MCH Manager, Karak
- CHC Supervisor, Karak

27 Key Informant Interviews: Providers in Clinics and Hospitals ("KII providers") Clinics:

- Clinics
  - Midwife, Irbid
  - Midwife, Ajloun
  - Midwife, Karak
  - Midwife, , Irbid
  - Midwife, Zarqa
  - Midwife, Zarqa
  - Midwife, Mafraq
  - Midwife, Amman
  - Midwife, Amman
- Hospitals:
  - Doctor, Karak
  - Head of Quality Improvement, Karak
  - Pediatric Doctor, Karak
  - Pediatric Doctor, Irbid
  - NICU Nurse, Irbid
  - Maternal Care Doctor, Irbid
  - Head Nurse, Irbid
  - Head of Quality Control, Irbid
  - Midwife, Karak
  - Nurse, Karak

- Gynecologist, Karak
- RMNCH Coordinator, Amman
- Head Nurse, Zarqa
- Quality Manager, Zarqa
- Gynecologist, Zarqa
- NICU Nurse, Zarqa
- Pediatrician, Zarqa
- Brigadier, RMS

9 Key informant Interviews: Community Health Clinic Representatives ("KII CHC Member")

- Member, Irbid
- Member, Ajloun
- Member, Karak
- Member, Irbid
- Member, Zarqa
- Member, Zarqa
- Member, Mafraq
- Member, Amman
- Member, Amman

2 Key Informant Interviews Private Providers, Pharmacist Association ("KII Private Providers")

- Private Provider, Amman
- Senior Member, Pharmacists Association

7 Focus Group Discussions: Community ("FGD Community")

- 6 Women, Amman
- 8 Women, Mafraq
- 5 Women, Zarqa
- 12 Women, Ajloun
- 4 Women, Irbid
- 4 Women, Amman
- 8 Women, Zarqa

9 Focus Group Discussions: Clients ("FGD Clients")

- 10 Women, Amman
- 10 Women, Mafraq
- 8 Women, Zarqa
- 8 Women, Ajlound
- 7 Women, Irbid
- 7 Women, Amman
- 3 Women, Irbid
- 9 Women, Karak
- 8 Women, Zarqa

4 Focus Group Discussions: Beneficiaries ("FGD Beneficiaries")

- 6 Women, Amman
- 5 Women, Mafraq
- 10 Women, Ajloun
- 10 Women, Karak

3. Data Sources:

Sources of quantitative data used were:

- HSD Monitoring, Evaluation and Learning Dataset
- Observational checklists of 'deep dive' facilities (primary data collected during this evaluation)
- Provider survey and private provider survey (primary data collected during this evaluation)

APPENDIX 2: EVALUATION TEAM INFORMATION

USAID HEARD Evaluation Team

- **Dr. Adriane Martin Hilber (Evaluation Team Lead)** oversaw the evaluation design, and led the team towards key deliverables and activities.
- **Dr. Fouad Mohamed (Sr Advisor)** provided support to interviews of high level managers and policymakers, and advised on design and analysis expertise throughout the project.
- **Dr. Hildy Fong Baker (Technical Manager)** provided technical management and led project operations including the coordination of field implementation, data collection, and other evaluation activities (i.e., drafting of key deliverables and managing research associates).
- **Research Associates** supported data collection activities including quality assurance, note taking for IDIs, FGDs, and overseeing facility data collection. They will support the data collection team to help cohere evaluation strategy and on the ground efforts.
  - Yusef Srouji (Research Associate, UCB)
  - Cara Nolan (Research Associate, UCB)
  - Marvy El Moujabber (Research Associate, CUNY)

Integrated Data and Analysis Team (Amman-based)

The INTEGRATED team provided data collection and study support to the evaluation. Members of the team included:

- **Dr. Nedjma Kovak (Director)** oversaw business development and served as the senior advisor for all aspects of the in-country evaluation design.
- **Dr. Huda Murad (Sr Advisor/Lead)** served as Lead of the Jordan team overseeing all logistics and operations during data collection period.
- **Mary Sayej (Field Operations Director)** coordinated site visits, focus groups, and managed interviewers in the field.
- **Hannah Mufti (Technical Director)** supported data analysis and development of surveys.

APPENDIX 3: EVALUATION PROTOCOL

This evaluation protocol was submitted with the inception report and details the plan and methods for the evaluation, as it was ultimately implemented.

A. Introduction

This protocol complements the Inception report summary and builds on the information presented in the "Statement of Work (SOW): Mid-term Evaluation of the USAID/Jordan Health Services Delivery (HSD) project" report and the "Evaluation Implementation Plan: Midterm Evaluation of the USAID/Jordan health Service delivery (HSD) Activity" (submitted on March 21st, 2019).

The SOW requested an evaluation design that utilizes both qualitative and quantitative methods, and incorporates both in-country data collection, and off-site document review and data analysis. The critical elements of an Evaluation Design include: (1) principles and approach to the evaluation including) known limitations to the evaluation design; (2) methodology including sampling (3) evaluation questions; (4) Data Analysis Plan; (5) Evaluation matrix. The Annex include (6) data collection instruments (Annex I); (7) list of potential interviewees (Annex II); (8) list of data collection sites (Annex III); (8) Suggested members of the Strategy Reference Group (annex IV)

B. Dates

April – October 2019

C. Purpose

The USAID/Jordan Health Service Delivery (HSD) activity is a 5-year agreement (2016 – 2021) with a total budget of $50 million, which was awarded in March 15, 2016 to Abt Associates and its local partners, the Jordan Health Care Accreditation Council (HCAC), the Eastern Mediterranean Public Health Network (EMPHNET), the Population Council, and the American College of Nurse-Midwives.

The Project has two **overarching goals – each with two sub-results:**

1. Expand availability of and access to integrated reproductive, maternal, newborn, and child health (RMNCH) services.
   - Design and implement interventions which increase uptake of RMNCH+ services by targeted populations (Sub result 1.1)
   - Increase community involvement in raising awareness of RMNCH+ information and services available in the public, non- governmental, and private sectors (Sub result 1.2)
2. Improved quality of integrated RMNCH+ services
   - Foster community ownership to increase health facility accountability (Sub result 2.1)
   - Strengthen management of RMNCH+ services (Sub result 2.2)

The **Objective** of this assignment is to conduct a mid-term performance evaluation of the USAID/Jordan Health Service Delivery (HSD). The evaluation engage with stakeholders and partners to review HSD project performance in the first 3 years of implementation (March 2016-March 2019) with the aim of understanding project effectiveness against the results framework. The evaluation will identify and document best/good practices; lessons learned; engagement of public/ private sectors; and factors affecting post-investment sustainability of service delivery processes and outcomes.

The Evaluation findings will be used for two separate but closely related purposes:

- **Purpose 1:** To enable **project implementers and managers** to understand how best to improve the implementation over the remainder of the project, including key areas of focus and potential improvement strategies;
- **Purpose 2:** To equip **USAID and its implementing partners** with an understanding of project successes and challenges to determine implications for future USAID support to RMNCH programming in Jordan and elsewhere.

D. Evaluation Questions

1. To what extent did the HSD Project contribute to RMNCH service improvements, including availability, accessibility, quality, integration, and gender responsiveness of services in Jordan? Which interventions can be considered good practice? How should interventions be strengthened for sustainability after the life of the project?

   1.1 **[Clinical service quality/supply]** To what extent has HSD improved **service quality in terms of evidence-based practices** (e.g. clinical standard and protocol improvements)?

   1.1.1 Integrated care

   1.1.2 Clinical protocols

   1.1.3 Client perceptions of quality (e.g. experience of clinical protocol adherence and integrated care)

   [Methods: ISDIC model case study (FGDs, IDIs, Obs); doc review and validation of monitoring data]

   1.2 **[Managerial quality]** To what extent have **HSD interventions resulted in health systems changes in policy and practice** (e.g. human resources, financing, service organization, logistics, data collection)? (areas where they are intervening)

   1.2.1 Health policy and resources (e.g., including accountability)

   1.2.2 Organizational systems (e.g., forms/checklists, monitoring, etc)

   1.2.3 Client flow

   1.2.4 Supportive supervision

   1.2.5 Data for decision making

   1.2.6 JMMSR implementation and feedback loop

   [Methods: ISDIC model case study (FGDs, IDIs, obs); doc review and validation of monitoring data]

   1.3 **[Clinical service quality (Demand)]** To what extent has **HSD improved service access and availability** (integration) as demonstrated by change in provider/client behavior?

   1.3.1 Home visits via community outreach (with and without voucher)

   1.3.2 Uptake of family planning (e.g., diversification of methods of satisfaction, continued use)

   1.3.3 Marginalized and vulnerable populations (e.g., Syrians/non-Jordanians, young mothers, poor)

   1.3.4 Innovation Grants Healthy Community Clinics

   [Methods: ISDIC model case study (FGDs, IDIs, obs); doc review and validation of monitoring data; coverage analysis]

   1.4 **[Community engagement]** To what extent did the **community engagement model empower and engage clients** and providers to partner for health service and health outcome improvements?

   1.4.1 Community Scorecards (CSC)

   1.4.2 Community Health Committees (feeding into ISDIC

   [Methods: ISDIC model case study (FGDs, IDIs, obs); doc review and validation of monitoring data; coverage analysis]

   1.5 **[Gender responsiveness]** To what extent has **HSD implemented gender responsive programming?**

   1.5.1 In the design of interventions (e.g., gender analysis; intervention is gender-focused) in the implementation (e.g., gender responsive programming), and in the monitoring (e.g., disaggregated data)

   1.5.2 Through supply, demand, community engagement interventions

   [Methods: FGDs, IDIs, doc review]

2. To what extent did **HSD** employ appropriate and effective **management, operational and monitoring mechanisms?**

   2.1 **[Efficiency]** How did these mechanisms influence **HSD's performance and client/beneficiary feedback?**

   2.2 **[Efficiency]** To what extent did HSD **data collection and management strategy facilitate program implementation?** Confidence and use of data by partners?

   2.3 **[Efficiency]** To what extent did the **ISDIC model sustained momentum and commitment of local partners** for RMNCH+ improvements?

2.4 **[Management]** Did HSD have **appropriate staff** to provide support and oversight of the Innovation grants and private sector engagement activities of the program?

2.5 **[Partnerships]** Were the **selected partners appropriate** to carry out the program?

2.6 **[Monitoring mechanisms]** To what extent did HSD **strengthen the MoH system** through its monitoring system?

[Methods: IDIs, doc review]

3. To what extent have HSD initiatives demonstrated potential for post-investment **sustainability** (e.g. which are more likely to continue after HSD ends, what are the cost and quality implications if they do, and which ones will likely not be sustained)?

   3.1 **[Program Design]** To what extent has the HSD Implementing Partner (Abt Associates) **integrated sustainability into implementation?**

   3.2 **[SDP Quality]** To what extent has HSD built **managerial, provider and data collection capacities at SDPs** to sustain quality improvements?

   3.3 **[Community engagement]** To what extent have HSD's community engagement efforts succeeded in shifting the community **from recipient of services to advocates and promotors?**

   [Governance] To what extent have the assisted governorates and the MoH played **contributory roles in supporting implementation** of HSD-developed systems and interventions and what are their plans to sustain these contributions in the coming years (e.g., sustainability of clinical pathways and training providers in private sector and MoH sector)?

   3.4 **[Partners]** To what extent did partners (public, private and NGO) **own the program** design, implementation, M&E?

   3.5 **[Political Will]** What can HSD do in the final years of the program to improve **capacity, commitment and buy-in** from the government?

   [Methods: IDIs, doc review]

4. Can the HSD program demonstrate **cost effectiveness and value for money of their intervention packages?**

   4.1 How can the cost effectiveness of the ISDIC model for service improvement, and for clinical quality improvement (e.g., for health outcome improvements) be demonstrated?

   4.2 How can the Value for Money of integrated care in reducing family size and improving spacing between children be demonstrated?

   [Methods: doc review, costing model]

5. To what extent are USAID supported health programs synergistic, complementary and supportive of the USAID Jordan Country Development Cooperation Strategy (CDCS results framework Intermediate result 3.1 (health improved))?

   5.1 **[Synergies w USAID programs (internally)]** To what extent do USAID programs in the health sector **complement and reinforce** each other?

   5.2 **[Complmentarity]** To what extent can **HSD support the design and implementation of PGS?**

   5.3 **[Value add (externally)]** To what extent do **USAID programs add value** to other RMNCH+ initiatives in Jordan

   5.4 **[Synergies (across all partners)]** To what extent do USAID health programs partner with the same **health system levels and partners?** Are there any adverse effects of multiple programs working with the same local partners?

   [Methods: IDIs, doc review]

E. Evaluation Design and Addressing Potential Limitations

The evaluation is designed to reflect on the successes and challenges the USAID Health Service Delivery project has encountered in its first 3 years. The evaluation questions are derived from the Project Theory of Change to test the assumptions inherent in the model. Realist Evaluation analysis techniques will allow for deeper understanding and learning of what is influencing success (or failure) in specific service contexts. In the process, we will assess

the complementarity of program components and the balance of investment between design, implementation, dissemination and policy making to provide insight on how the project can maximize efficiency and effectiveness (e.g., simplification and integration of strategies) in the remaining project period.

The evaluation is designed to deliver on USAID expectations as defined in the SOW. Beyond what is currently being documented by HSD, the evaluation will explore how to position the project for short and long-term sustainability (via policy and practice changes) and better document outcomes and value for money in the future. It will also engage with USAID and HSD partners in a participatory process of co-creation of recommendations to ensure they are as actionable and relevant as possible for all stakeholders. In addition, the evaluation team will seek guidance from a Strategy Reference Group to further support the recommendation development process.

Principles of our evaluation approach

- Robust evaluation design and quality focused
- Participatory (in the design, verification and validation of evaluation findings)
- Client-oriented, and utilization focus (practical)
- Theory informed
- Considers the historical antecedents of the program, the project current status, and future prospects.

Theory of Change

HSD seeks to help the MoH and the different participating organizations to introduce, adapt, scale up and sustain integrated, client-centered RMNCH+ services and establish a national maternal mortality surveillance and response (MMSR) system to achieve and measure improved health results. The HSD strategy is designed to stimulate management, clinical, and behavioral changes within Jordan's public and private health service system that should lead to improvements in access and quality of reproductive, maternal, newborn and child health services including nutrition (RMNCH+). As a result of improved availability and access, and quality, HSD will have contributed to improvements in the health status of WRA and CU5

The HSD Theory of Change focuses on 2 results:

1. Expanded **availability and access to integrated RMNCH+ services** through increased uptake of integrated RMNCH+ services (Result 1.1); and Increased community involvement to promote and increase demand for quality RMNCH+ services (Result 1.2)
2. **Improved quality of integrated RMNCH+ services** across the public and private sectors through improved providers' competency and behavior to deliver evidence-based RMNCH+ services (Result 2.1); and Strengthened management to support delivery of high quality RMNCH+ services (Result 2.2).

HSD established an Integrated Service Delivery package (ISD) to deliver integrated RMNCH+ services to reduce missed opportunities for the provision of care which in turn they hypothesize will foster health promotion and disease prevention. The ISD is comprised of quality improvement activities such as training on clinical protocols, maximizing every contact with clients to offer additional services such as family planning, and improving management, organization (client flow) and supervision of service provision for great effectiveness and efficiency.

HSD developed and implemented an Integrated Service Delivery Improvement Collaborative (ISDIC) to engage with health facility staff, clients and communities to increase engagement in service quality improvements and to decrease missed opportunities in providing care to women of reproductive age and their children under five. HSD also strengthens and empowers communities through community engagement and mobilization to use services and adopt healthier lifestyles. HSD assumes that through access and quality improvements achieved by their intervention packages (organized through ISDIC cycles), and community engagement strategies will lead to the health outcomes envisioned in the targeted population.

Evaluation Design

The evaluation will test the assumptions inherent in the HSD Theory of Change. We will use a combination of qualitative data collection (Key Informant Interviews, focus group discussions, small group interviews), surveys,

facility checklists and observations, validation of select monitoring data, and analysis of secondary data sources to evaluate the effectiveness and efficiency of the HSD approach and activities. This will be done through the more classical (pre-post) evaluation approaches and a more innovative realist evaluation analysis method to get to a deeper level of understanding of what works (lessons learned), for whom (public versus private, different population groups, different providers, etc.), in what respects (lessons learned), to what extent (sustainability), in what contexts, and how?

To test the assumptions within the Theory of Change (ToC) and answer these questions, the evaluation is organized around three interrelated components:

Component 1: To assess the **effectiveness and sustainability**, from diverse perspectives, of the extent to which specific HSD approaches contributed to RMNCH service improvements (including availability, accessibility, quality, integration, and gender responsiveness). We will also explore how HSD can prepare to demonstrate **cost effectiveness and Value for Money (VfM)** by the end of the project.

The evaluation will focus on the following Intervention strategies and their sub-components:

- The Integrated Service Delivery Improvement Collaborative (ISDIC model) and the
- Jordan Maternal Mortality Surveillance and response System (JMMSR)

Component 1 will validate HSD monitoring data on quality improvements through secondary document review and through the experience of service quality of stakeholder and beneficiary with a view towards documenting changes in service practice, client satisfaction and health outcomes.

Data sources to assess the effectiveness of ISDIC and JMMSR include Key Informant Interviews, focus group discussion (e.g. clients, WRA with CU5 in the community, and providers), a facility checklist and observations, a survey among private providers, and secondary document review.

We will also attempt to design a cost effectiveness and VfM model using program data and secondary sources.

Component 2: To assess the **efficiency** of the HSD project in the delivery of appropriate and effective management, operational and monitoring mechanisms. Component 2 will review the functionality of HSD systems for the delivery of the project.

Data sources to assess the efficiency of HSD includes Key Informant Interviews, focus group discussion (e.g. providers), and secondary document review.

Component 3: To assess the **relevance and added value** of the USAID supported health programs to synergistically, complement and support the USAID Jordan Country Development Cooperation Strategy (CDCS results framework Intermediate result 3.1 (health improved)). Component 3 will review existing data from HSD and other past and current project supported by USAID and stakeholder perspectives to assess alignment, synergy and the value add of the USAID programming. This component will pay particular attention to exploring how past health systems strengthening projects can inform the new USAID supported **PGS program** with the Ministry of Health (MoH) forthcoming in 2020.

Data sources to assess the efficiency of HSD includes Key Informant Interviews, and secondary document review.

Potential limitations

The evaluation team will make use of data collected by HSD as government health service delivery data cannot be independently validated within the scope of the evaluation period. Robust data collection by HSD is considered sufficient to provide a midline stats report of activity progress. The MTR will validate this information through other qualitative and quantitative means and triangulate the results to provide an alternative perspective on progress achieved by the project. In addition, HSD collects data on proxy indicators, which are not sufficient for measuring outcomes. To overcome these limitations, the Midterm Review (MTR) will work with HSD to identify appropriate outcome measures which they can begin to document in the remaining project period. This

new data can help to demonstrate the full effect of their interventions as contributions in health outcomes. A model will be designed for this purpose. It will also establish the basis for a value for money analysis at end line.

F. Methodology

To assess effectiveness and efficiency as defined above, we propose qualitative and quantitative data collection and in-depth analysis of supporting documentation from the relevant project activities across health system intervention sites including MoH, NGO and the Royal Medical Service (RMS) health centers and hospitals, private providers and pharmacists; and in target community. As mentioned above, the evaluation will explore the ISDIC model as the organizing approach to deliver quality of care and managerial and organizational improvements. Specific sub-components to be assessed include: adherence to clinical protocols, facility improvements and recognition programs, supportive supervision, client flow, client service station as a referral mechanism to deliver integrated care, prioritization of actions and progress made through the quality improvement cycle process, amongst others. We will also investigate how the Community Health Committee and the outreach program contribute to access and availability, and quality of services from a client perspective. Finally, we will investigate the functionality of the JMMSR program and its feedback loop.

Data Collection

Six integrated methods of data collection will be utilized including:

Key informant Interviews (KII) with key partners and managers; health system managers and decision-makers, and primary health care facility-based providers. Key informant interviews will allow the evaluators to probe for greater, more in-depth information than is available from surveys alone. They will provide insight into project implement, donor (USAID), government, NGO, and other critical stakeholders' views and experience of the HSD activities. They will also inform on the potential for sustainability of the project interventions. Key informant interviews will be supported by a stakeholder specific *Interview Guide* that follows the evaluation questions.

Focus Group Discussions with health services clients (recruited from post-partum clients post service at facilities) and community members (e.g. women of reproductive age (WRA) with children under 5 (CU5). Focus Group Discussion will include a sample of 6-8 clients and community members that will be selected purposefully. The aim of the FGDs is to get client and community member views of the service they received in terms of the quality and integration of care. We will also ask about their health care service priorities and other observations, concerns and recommendations for improvement. The results of the FGD will provide a user perspective of the ISDIC process and how that has or has not been appreciated by the intended beneficiaries. The FGDs will also explore utilization patterns of Jordanian and non-Jordanian clients and community members as well as health insurance status of participants. The FGDs will be guided per sub-population by *FGD Guidelines.*

Tablet-based Surveys of frontline health workers in the MoH, RMS and NGO health centers and hospitals; and private providers. The evaluation team will conduct a short survey with provider groups to get their views on HSD interventions they have benefited from and the ISDIC process. Private providers will also be asked about how to further engage with the private sector in the future. The surveys will be prepared for each provider group to be as tailored as possible to their engagement level with the project. A survey company will conduct the surveys at selected health centers and hospitals. Use of tablets for the survey will also to be completed by multiple staff at the same time reducing data collection costs. Quality assurance of data that can be uploaded daily during data collection will reduce data problems (as they can be followed up and corrected the next day, for example). Continuous monitoring of data quality and cleaning of the data also reduces post survey data analysis time. The surveys will follow a *survey specific protocol* including *interview question reference document* for interviewers. The surveys will be in Arabic. They will be piloted in advance to reduce complication during the data collection process.

Facility checklists and observations of clinical and service protocol adherence, client flow, infrastructure, supplies, staffing, etc. Health facility checklists and

action plans from the ISDIC; original facility assessment documentation; supportive supervision checklists and other documentation of health service organization and processes may also be reviewed. Visits to health facilities will have an evaluation team members also make observations of service organization, protocol adherence, visibility of materials, and client and provider interaction. Checklist review and observations will follow a *Facility Review and Observation Guideline* to allow for criteria-based assessment of what is reviewed and observed. Data collected will align with the evaluation questions as appropriate.

Evaluator Data Reviews and Validation of monitoring and coverage data, and service records as needed. This may include select follow up on specific case files to accompany client flow, and uptake of integrated services. *Service and Monitoring Data Validation Instructions* and scoring system will be provided to evaluators to ensure comparability of findings.

Evaluator Facilitated Secondary analysis of project documentation, training curricula, and other materials. Documents anticipated to be reviewed includes: HSD quarterly and annual reports; results framework progress reports; study reports; sub-component reports and documentation (e.g. Innovation fund proposals, scoring and internal processes related to selection of grantees; recognition program criteria and its application, etc.). The document review will be guided by the evaluation questions (adapted for document synthesis).

Sampling

Key Government and Partner Stakeholders

We will purposively sample key informants serving in leadership and management positions pertinent to the implementation of HSD's RMNCH+ interventions, including representatives of the Central MoH, Health Area Directorates, Royal Medical Services, NGOs operating primary care clinics and community outreach programs, other major national stakeholders, key HSD Partners, and the core HSD team at Abt Associates. Key informants to be interviewed include:

a. Jordan MoH at the national level – technical focal points for the following areas/directorates: HMIS, Human Resources,[57] Health Communication and Awareness, Primary Health Care, Women and Child Health Directorate, Quality Directorate and Hospital administration **(5 KIIs anticipated)**[58]

b. Jordan MoH at the Health Affairs Directorate level – in up to six directorates where we sample facilities (see facility sampling strategy below) – HAD Director, HAD Health Promotion Supervisor, Women and Child Health Unit Head **(~12 KIIs anticipated – we anticipate reaching saturation after covering 3-4 directorates and will ensure directorates in the South, Central, and Northern regions are included)**[59]

c. RMS – central-level department heads (OB/GYN and Neonatal) and hospital-level managers **(5 (3+2) KIIs anticipated)**

d. NGOs operating primary care clinics that provide RMNCH+ services and those contracted by HSDs to manage HSD's policy component (CHW household visits) – focal points for relationship with HSD on clinics and community outreach for each NGO (JAFFP, IFH, IRC) **(6 (2x3) KIIs anticipated)**

e. Key health provider syndicates in Jordan, including high-level representatives of the nursing and midwifery syndicates (in one group interview) and one or more high-level representative from the medical syndicate **(2 KIIs anticipated)**

f. USAID, including the Director or Deputy Director of the PFH Office, the Agreement Officer Representative for HSD and the Monitoring and Evaluation Specialist a **(3-4 KIIs anticipated)**

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[57] HSD does not have direct relationships with HR other than some coordination work related to the 'Newly Hired GP Training Program'.

[58] We anticipate that JMMSR System National Advisory Group members will be among those sampled within MoH and hospital leadership, but if needed will add KIIs

[59] We anticipate that JMMSR System Directorate Advisory Group members will be among those sampled, but if needed will add KIIs

g. HSD and Partners – Chief of Party and technical leads for M&E and key intervention components from HSD/Abt Associates (6); HCAC (1); Population Council (1); and American College of Nurse Midwives (1) **(9 KIIs anticipated)**

h. Others – such as representatives of a major University Hospital, where HSD is only working on JMMSR, and of other relevant USAID-funded projects (e.g. JCAP, HRH2030, upcoming Partnership for Health and Family Planning **(4 KIIs anticipated)**

Primary Health Care Facilities (MoH HCs and NGO clinics)

Sampling of primary health care facilities, including HSD-supported MoH health centers and NGO health clinics, will enable comparison along the following dimensions: length of time participating in ISDIC, performance on project performance indicators, and service volume.

To select the sample, we will:

- Stratify facilities based on when they began participating in ISDIC - facilities that have been doing ISDIC longer (e.g. since FY17 – 44 SDPs – 35 MoH + 9 NGO) versus those that began ISDIC more recently (e.g. in FY18 – 67 SDPs – 56 MoH + 11 NGO)
- Within these two groups we will stratify based on:
  - high performing versus low performing facilities
  - high volume versus low volume facilities
- We will then randomly select two facilities in each of the eight strata. The intended sample will include:
  - 8 FY17 start SDPs – 2 high perf-high vol, 2 low perf-high vol, 2 high perf-low vol, 2 low perf-low vol
  - 8 FY18 start SDPs – 2 high perf-high vol, 2 low perf-high vol, 2 high perf-low vol, 2 low perf-low vol
  - Total of 16 HCs – 18% of total HSD-supported HCs; of this sample, we will ensure a majority are MoH health centers and anticipate inclusion of 14 MoH health centers and 2 NGO health clinics

	FY17 ISDIC Start		FY18 ISDIC Start	
	Low Performance	High Performance	Low Performance	High Performance
Low Volume	2	2	2	2
High Volume	2	2	2	2

- Within this sample, we will ensure appropriate representativeness of:
  - Facilities with high proportions of Syrian refugees in the catchment area
  - The 14 Health Area Directorates
  - Facilities with active CSS and community components (CHCs, CHWs, trainings) versus those without or with fewer such elements (so a range of 'intervention intensity')

Hospitals (MoH and RMS)[60]

We will purposively sample four (4) MoH hospitals and two (2) RMS hospitals to achieve a sample that includes:

- Among the four selected MoH hospitals
  - Three will be in highly populous directorates, of which one will be in Amman; one in Irbid, which is both highly populous and is among the regions with a relatively higher proportion of Syrian Refugees;[61] and one in another populous directorate TBD
  - One in a less populous directorate (targeting a hospital in the Southern region)
  - The selection of four will aim to include 2 high-performing and 2 low performing hospitals
- Among the 2 selected RMS hospitals, 1 will be in Amman and one outside.

Private Physicians

Private physicians engaged by HSD (54 as of end FY18; additional in the first two quarters of FY19) will be

[60] Of 17 HSD-supported hospitals – eight began ISDIC in FY17, nine more began ISDIC in FY18

[61] Al Mafraq, Al Zarqa, and Irbid all have highest relative proportions of Syrian refugees; could consider one of the other two as an alternative to Irbid.

sampled using probability proportionate to size formula to ensure representativeness across the three directorates in which private physicians are engaged to conduct a survey via smart phones/tablets (paper as back-up). The ultimate sample will seek inclusion of 30-50% of engaged private physicians. The Evaluation Team will not sample pharmacists as well as HSD has not yet begun working with pharmacists.

Data Collection Summary

At each Health Center (MoH + NGO) facility

Among the sample of 16 primary health care facilities, the evaluation team will carry out in-depth ('deep dive') data collection in 8 facilities and a more streamlined, 'light touch' data collection in 8 facilities. This will allow the sample to include more facilities while still keeping data collection and analysis within the time frame and budget for the evaluation.

In the 'light touch' facilities the evaluation team will only conduct facility surveys and observations as well as the staff surveys of 2-3 staff per facility. In the 'deep dive' facilities the team will do those things plus 2 provider KIIs per facility, the CHC survey, and the client and community FGDs.

1. Abbreviated facility checklist + observations **(16)**
2. HC Staff Surveys (2-3 per facility, **max of 40**) - mixed qualitative and quantitative surveys conducted on tablets among clinical staff involved in quality improvement and who have experience with new protocols, and the ISDIC model (mostly likert; one open ended question at end, which is qualitative)
   a. Facility manager
   b. Provider who attends ISDIC trainings
3. In depth interview (IDI's) among providers in 'deep dive' facilities only (including doctor, line nurse or midwife, with particular focus on ISDIC) – 2 per facility in 8/16 facilities **(16 total)**
4. CHCs Surveys (tablets) in 'deep dive' facilities only— **max of 8** (but likely not ALL facilities in our sample will have CHCs) – each answers as a committee; the team may add surveys of Syrian CHC representatives separately to ensure this perspective can be freely provided.
5. FGDs among clients (post partum, recruited from facility) and community members (WRA who have given birth in the last year who may or may not have used facility, but who live near facility), 6-8 per group, in 'deep dive' facilities only = **16 FGDs**

At each Hospital (MoH + RMS) facility

1. Abbreviated facility checklist + observations **(6)**
2. Hospital Staff Surveys **(45 total)** mixed qualitative and quantitative, on tablet, (conducted by INTEGRATED) of staff involved in quality improvement – experience with new protocol, ISDIC model (mostly likert; one open ended question at end, which is qualitative)
   a. Facility manager **(2 per big hospital, 1 per small hospital)**
   b. Who comes to ISDIC trainings (questionnaire?)
      — ANC (2 per big hospital, 1 per small hospital)
      — Delivery (2 per big hospital, 1 per small hospital)
      — FP[62] (2 per big hospital, 1 per small hospital)
      — Neonatal (2 per big hospital, 1 per small hospital)
3. Client FGDs – post-delivery women, 6-8 per group, 3 hospitals = 3 FGDs

Analysis

Analysis will be done through both qualitative and quantitative methods. The HSD Theory of Change will be tested using a classic pre-post analysis and case study approach or "Deep Dives" for specific activity packages (e.g. ISDIC and JMMSR) to capture progress achieved and challenges encountered/overcome as requested in the SOW. We will also assess how a cost effectiveness and Value for Money analysis could be done to capture change in outcomes due to the HSD interventions at end line. A modeling exercise will be done for this purpose. Since these approaches may be limited when applied to

[62] HSD FP hospital interventions are 1) the newly started IUD midwifery training in selected hospitals, 2) FP logistic systems training, 3) Postpartum FP training (now a part of the Postpartum Counseling program).

complex health systems interventions, we propose to add a Realist Evaluation approach to data analysis.

Using a realist data analysis approach[63]

A Realist evaluation of the ISDIC model is proposed to answer the following research question: Is the ISDIC model leading to sustainable service delivery quality improvements? Is the ISDIC model leading to increased uptake of specific services (through integration services, CSS, facility supported supervision, training, recognition program, etc.). A realist analysis is suggested because it will help inform the HSD project on what is working (beyond process indicators), for whom, in what respects, to what extent, in what contexts, and how? Simply put, the realist evaluation aims to identify the underlying generative mechanisms that explain 'how' the outcomes were caused and the influence of context. Like the other analysis methods, a realist evaluation uses standard data collection methods but offers an alternative lens in which to analyze the results. A Realist programme theory specifies what mechanisms will generate the outcomes (or findings as in the case of HSD) and what features of the context will affect whether or not those mechanisms operate. The context-mechanism-outcome (CMO) configuration is used as the main structure for realist analysis. It generates a set of CMO statements: "In this context, that particular mechanism fired for these actors, generating those outcomes" … to explain why the intervention is working in some contexts(and possibly not in others).

In the first phase of analysis, data will be organised in relation to the HSD Theory of Change regardless of whether the data relate to what was done (the intervention activities) or to context, mechanism, outcome and (groups of) actors. Qualitative data are coded and appropriate methods for analyzing quantitative data applies (as detailed below). The data on outputs and outcomes (through proxy indicators) are disaggregated by sub-groups according to evaluation question (which were selected on the basis of the HSD ToC). Once patterns of findings are identified, the mechanisms generating those findings can be analyzed, provided the right kinds of data are available. The contexts in which particular mechanisms did or did not 'fire' can then be determined. Contexts may relate to the sub-groups for whom findings were generated and/or to other stakeholders, processes of implementation, organizational, socio-economic, cultural and political conditions.

The analytic process is not necessarily sequential, but should result in a set of 'context-mechanism-outcome (findings)' (CMO) statements: "In this context, that particular mechanism fired for these actors, generating those outcomes. In that context, this other mechanism fired, generating these different outcomes." The last phase of the analysis consists of determining which CMO configuration(s) offers the most robust and plausible explanation of the observed pattern of findings or outcomes. This resulting CMO configuration is then compared with the initial programme theory, which is modified (or not) in light of the evaluation findings.

Data Analysis and Management

Qualitative analysis of **interview and focus group discussions** includes an iterative process with the research team's time divided into periods of data collection and periods of data review and analysis. The evaluation team staff conducting data collection will meet at the end of each day to debrief, share, discuss, and compare findings, observations, and interpretations related to the data collected that day. Notes will be taken during these staff discussions to identify and document themes that will structure subsequent analyses. The thematic classifications will be based on a priori issues (elaborated as research questions) and emergent themes arising during the data collection and analysis. The initial thematic classifications are applied and compared to subsequently collected data. This iterative process of analysis and modification ensures that the final conclusions and recommendations are comprehensive.

The qualitative data will be collected and analyzed initially in Arabic by the data collection supervisors and evaluation team members by source. It will then be summarized by

[63] Marchal, B., Van Belle, S., Van Olmen, J., Hoerée, T. & Kegels, G. 2012. Is realist evaluation keeping its promise? A literature review of methodological practice in health systems research. Evaluation, 18, 192-212

the evaluation team first in Arabic, and then following validation of the summary (against taped recording of the full content) by a second (Arabic speaking) evaluation team member, coded for inclusion into the evaluation extraction matrix. Summaries of the findings will be included in English in the extraction matrix.

The evaluation team will compile **secondary data** from a variety of sources, including epidemiological and behavioral surveys, the HSD monitoring data, the MoH health management information system, and data regarding usage, coverage, and services for RMNCH+. The document, data and checklist reviews will be analyzed to respond to the relevant evaluation questions and then summarized in English for inclusion in the document extraction matrix.

Survey data will be analyzed using Stata.® Descriptive statistics will be generated and aligned for inclusion in the data extraction matrix in English. Further analysis will be contemplated follow the initial full review of all data.

Synthesis: Once all data sources have been summarized and validated in Arabic, summaries will be presented in English in a comprehensive data extraction matrix. These data sources will then be anonymized in the process of triangulating the results. Findings should have a minimum of 3 independent sources to be considered a significant result. These results will then be summarized by evaluation question for further analysis and interpretation by the team. At this stage, it will no longer be able to trace findings to the original unique data source.

Co-creation of recommendations

Summary triangulated results will be shared internally at an internal **Analysis Workshop** among the evaluation team. In the workshop, the team will further synthesis, validate the findings, and generate preliminary recommendations. As the evaluation will be participatory, HSD and USAID stakeholders will then be invited to "co-create" recommendations based on the evaluation team's preliminary findings and suggested recommendations. This process will be supplemented by an external review from a Strategy Reference Group convened to further inform evaluation results (see below).

A **Strategy Reference Group** of experienced USAID program managers who have previously been 'end users' of such project evaluation will be engaged in a more forward-looking exercise to critically review the findings compiled and analyzed by the evaluation team. This group will participate in a remote review of the summaries and if appropriate the co-creation process with local project and USAID stakeholders. Their participation will ensure that recommendations are actionable and informative for USAID and that they speak to USAID's comparative advantage. The group will be selected in collaboration with USAID. To facilitate their engagement, the evaluation team will develop a Strategy Reference Group Guide to support the group's discussion and development of recommendations in key areas. This guide will present categories of recommendations, that follow defined characteristics, including that they are seen as actionable within USAID operating procedures, will result in cost savings, increased efficiency, and quality and value of product

F. Dissemination Plan

The Evaluation Team will engage upon request with the following groups for face-to-face meetings, presentations and dissemination of the final evaluation document and annexes.

1. USAID/Jordan including COR/AORS and senior staff
2. HSD Project Team
3. National Stakeholders (if deemed appropriate by USAID Jordan)

The final evaluation document will be made publicly available through posting to the USAID Development Experience Clearinghouse.

G. Ethical Considerations

Risks and Benefits: The primary risks of participation are loss of confidentiality and potential discomfort with some evaluation questions.

Confidentiality: The following procedural efforts will be made to avoid breaches in confidentiality. For the Key Informant Interviews, we will not code respondent names or identifying information on the participants. In-depth notes taken by study team members will be stored in

secure locations, including locked offices and file cabinets and/or on password protected computers with access provided only to authorized evaluation team members. Interview and support staff, such as drivers, will be trained in the importance and the procedures for maintaining confidentiality of all clients. When data are collected, data collection forms will only be identified by the type of facility (region, district, CSPS) and role/job type of the respondent. Names will not be associated with notes or other study data. Informed consent will be secured with a verbal assurance from participants. Since a signed informed consent would be the only identifiable link to a participant's name, we are not requesting a signed consent; instead we request a verbal consent.

Discomfort: Because the interviews are mostly about health care delivery and receipt, it is unlikely that participants will experience discomfort. However, particularly for patients, the personal nature of some interview questions may cause distress to some participants. Efforts will be made to minimize this stress by ensuring that well-trained interviewers inform participants beforehand about the nature of the questions and the interview is conducted in a private setting. Participants will be informed that they have the right to decline participation in the study, to refuse to answer any questions, or to withdraw at any time.

Minimizing risks to subjects: Field staff will be trained in ethical conduct of research, how to minimize discomfort caused by interview questions. Privacy and confidentiality will be protected in several ways: 1) no subject will be identified in any report or publication; 2) all study materials and data collection forms will be identified by type of health facility and role of the participant only; 3) notes from interviews will be kept in locked offices and/or in a locked file cabinet or password protected computer; 4) data will be analyzed collectively and individual participant data will remain anonymous.

All eligible participants will be informed during the verbal consent process of their rights as research participants and the possible risks associated with their participation. They will also be told that they do not have to answer any questions that make them feel uncomfortable and that they may withdraw from the study at any time without negative consequences. Furthermore, they will be asked not to reveal any identifying information and to use only first names if they share any names during their interviews.

Participation in this study will not pose any risk to the reputation of staff of the Ministry of Health. We anticipate that health system staff will already know each other and will be very willing to share with the evaluation team their experiences providing RMNCH+ services. Participants can always refuse to participate for any reason.

Benefits to subjects: Participants will receive no direct benefit from the study. Community members invited to a focus group meeting will receive financial reimbursement for their travel to and from the place of the FGD. Given the minimal risk, the overall benefits of the study outweighs the risks.

Benefits to society: The information obtained in this evaluation will provide valuable information for the improvement of the USAID Health Service Delivery Activity Health System Strengthening Project which in turn will help to improve the delivery of RMNCH+ services and outreach for WRA and CU5.

Confidentiality and Privacy: All interviews and FGDs will be done in private locations where discussion cannot be overheard. Participants will not be asked to reveal their names during the discussions; they will be encouraged to participate as fully as they can without revealing anything that makes them feel uncomfortable.

Possible consequences to subjects resulting from a loss of privacy: Interview questions for this proposal do not include report of illegal or controversial behavior, drug use, or other personal information unless that information is freely volunteered by the participant. Instead, questions will focus on perceptions of the RMNCH+ service quality, access and availability and the social, political, and economic contexts in which they take place.

Study Protections: Password protection will be assured. Data will be stored securely on password-protected computers and networks encrypted and maintained by the evaluation team; the key linking the health care delivery location to the interview will be destroyed at

end of study. Electronic data will be protected with a password.

Respecting Social, Cultural and Gender Norms: All data collection will be done in Arabic unless both the respondent and the interview agree beforehand to conduct the interview in English. Survey questions will also be in Arabic. The primary interviewer of WRA will be women from the evaluation team. A male note taker may be present if the interviewee (s) agrees. Women will be informed about the duration of the interview or FGD to ensure she has enough time to participate and can make the necessary arrangements for the care of her young children as necessary. Trained, local fieldworkers who speak the local dialects will perform participant contact and data collection.

Measures to prevent coercion to participate: Because no payment and no medical care is being offered as part of this evaluation, we do not believe that the population is vulnerable to undue influence or coercion to participate. Additional safeguards that have been included in the study to protect the rights and welfare of these subjects and minimize coercion or undue influence include enacting standard operating procedures for ensuring quality and confidentiality.

Informed Consent: Verbal informed consent will be obtained from subjects using an information sheet. Trained interviewers will go over the information sheet with each participant and each individual will have an opportunity to ask questions before providing their verbal consent. Because this research involves only minimal risk and no clinical procedures, we do not foresee that subjects will need more than a few minutes to consider study participation. Investigators will ensure that subjects understand the information provided to them by training the interviewers to administer verbal informed consent, including training to determine whether the subject has fully understood the information provided. Any pictures taken for evaluation report purposes will need a completed consent form.

H. Evaluation Matrix

See Appendix 4.

I. Evaluation Timeline

Inception Visit	11 – 19 May
Agreement on evaluation questions (Debriefing session)	19 May
Draft Inception Report (without tools)	25 May
Final Inception Report (with Tools)	7 June
Piloting, adaptation and logistics for data collection	10 – 15 June
Data collection (4 weeks)	23 June – 19 July
Transcription and analysis	1 – 25 July
Preparation for analysis workshop	28 July – 2 Aug
In-person team analysis workshop (Amman) and co creation feedback to USAID Jordan and HSD on 7 Aug	4 – 7 Aug
Review of findings/recommendations by Strategy Reference Groups	12 – 31 Aug
Draft of Final Report	13 Sept
Final Report	Mid-October

J. Team

- **Dr. Adriane Martin Hilber (Team Lead)** will oversee design, and lead the team towards key deliverables and activities.
- **Dr. Fouad Mohamed (Sr Advisor)** will provide support to IDI's and lend design and analysis expertise throughout the project.
- **Dr. Hildy Fong Baker (Technical Manager)** will provide technical management and lead project coordination of field implementation, data collection other evaluation activities.
- **3 Research Analysts/Assistants** will support data collection activities including quality assurance, note taking for IDIs, FGDs, and overseeing facility data collection. They will support the data collection team to help cohere evaluation strategy and on the ground efforts.
- **Integrated Solutions (Jordanian Data Collection Team)** will provide data collection and study support to the evaluation. Hoda Murad will serve as Lead of this team overseeing all logistics and operations during data collection period.

APPENDIX 4: EVALUATION MATRIX

Evaluation Questions	Sub-Questions	Label	Indicators	Document review	KII (Staff, managers, partners, stakeholders)	FDG (community and clients	Health Provider surveys	Health facility checklist and observation	Modeling
Q1 To what extent did the HSD Project contribute to RMNCH service improvements, including availability, accessibility, quality, integration, and gender responsiveness of services in Jordan? Which interventions can be considered good practice? How should interventions be strengthened for sustainability after the life of the project?	1.1 To what extent has HSD improved service quality in terms of evidence-based practices (e.g. clinical standard and protocol improvements)?	Clinical service quality (Supply)	1.1.1 Integrated care 1.1.2 Clinical protocols 1.1.3 Client perceptions of quality (e.g. experience of clinical protocol adherence and integrated care)	X	X	X	X	X	
	1.2 To what extent have HSD interventions resulted in health systems changes in policy and practice (e.g. human resources, financing, service organization, logistics, data collection)?	Managerial quality	1.2.1 Health policy and resources (e.g., including accountability) 1.2.2 Organizational systems (e.g., forms/checklists, monitoring, etc) 1.2.3 Client flow 1.2.4 Supportive supervision 1.2.5 Data for decision making 1.2.6 JMMSR implementation and feedback loop	X	X	X	X	X	
	1.3 To what extent has HSD improved service access and availability (integration) as demonstrated by change in provider/client behavior?	Clinical service quality (Demand)	1.3.1 Home visits via community outreach (with and without voucher) 1.3.2 Uptake of family planning (e.g., diversification of methods of satisfaction, continued use) 1.3.3 Marginalized and vulnerable populations (e.g., Syrians/non-Jordanians, young mothers, poor) 1.3.4 Innovation Fund/Healthy Community Clinics	X	X	X	X	X	
	1.4 To what extent did the community engagement model empower and engage clients and providers to	Community engagement	1.4.1 Community Scorecards (CSC) 1.4.2 Community Health Committees (feeding into ISDIC)	X	X	X	X		
	1.5 To what extent has HSD implemented gender responsive programming?	Gender sensitive programming	1.5.1 In the design of interventions (e.g., gender analysis; intervention is gender-focused) in the implementation (e.g., gender responsive programming), and in the monitoring (e.g., disaggregated data) 1.5.2 Through supply, demand, community engagement interventions	X	X	X	X		

Evaluation Questions	Sub-Questions	Label	Indicators	Document review	KII (Staff, managers, partners, stakeholders)	FDG (community and clients	Health Provider surveys	Health facility checklist and observation	Modeling
Q2. To what extent did HSD employ appropriate and effective management, operational and monitoring mechanisms?	2.1 How did these mechanisms influence HSD's performance and client/beneficiary feedback?How did these mechanisms influence HSD's performance and client/beneficiary feedback?	Efficiency	2.1.1 Example of performance, feedback, or monitoring data informing program course correction; 2.1.2 Example of use of HSD data for program implementation improvements; 2.1.3 Example of SDP staff and mangement (and partner) engagement and activism in the process.	X	X	X			
	2.2 To what extent did HSD data collection and management strategy facilitate program implementation?	Efficiency	2.2.1 Staff LOE; time schedules; monitoring visits;2.2.2 LOE of partners; assessment of support needed for partners	X	X				
	2.3 To what extent did the ISDIC model sustained momentum and commitment of local partners for RMNCH+ improvements?	Efficiency	2.3.1 examples of integration of HSD monitoring forms into health system practcie (i.e. use of forms)	X	X		X	X	
	2.4 Did HSD have appropriate staff to provide support and oversight of the Innovation grants and private sector engagement activities of the program?	Management	2.4.1 Example os staff leadership in Grants management; 2.4.2 Example staff capacity in private sector engagement	X	X				
	2.5 Were the selected partners appropriate to carry out the program?	Partnership	2.5.1 example of partner leadership and capcity to implemnet ISD	X	X		X		
	2.6 To what extent did HSD strengthen the MOH system through its monitoring system?	Monioring Mechanisms	2.6.1 example of MoH data for decisionmaking improved	X	X		X	X	
Q3.To what extent have HSD initiatives demonstrated potential for post-investment sustainability (e.g. which are more likely to continue after HSD ends, what are the cost and quality implications if they do, and which ones will likely not be sustained)?	3.1 To what extent has the HSD Implementing Partner (Abt Associates) integrated sustainability into implementation?	Program Design	3.1.1 Examples of sustainability mechanisms embedded in program implementation strategies	X	X		X	X	
	3.2 To what extent has HSD built managerial, provider and data collection capacities at SDPs to sustain quality improvements?	SDP quality	3.2.1 Example of partner plans to sustain HSD intervetnion approaches	X	X	X	X	X	
	3.3 To what extent have HSD's community engagement efforts succeeded in shifting the community from recipient of services to advocates and promotors?	Community Engagmenet	3.3.1 Example os clienet led accountability; demand for quality	X	X	X			
	3.4 To what extent have the assisted governorates and the MOH played contributory roles in supporting implementation of HSD-developed systems and interventions and what are their plans to sustain these contributions in the coming years?	Goverance	3.4.1 Example of Governates or Directorates assuming leadership for HSD intervetnions	X	X		X	X	

Evaluation Questions	Sub-Questions	Label	Indicators	Document review	KII (Staff, managers, partners, stakeholders)	FDG (community and clients	Health Provider surveys	Health facility checklist and observation	Modeling
	3.5 To what extent did partners (public, private and NGO) own the program design, implementation, M&E?	Partnership	3.5.1 Example of partner engagement in program design, implementation and M&E (of the same porject activity i.e. ISDIC, FBSS, CSS etc)	X	X	X	X		
	3.6 What can HSD do in the final years of the program to improve capacity, commitment and buy-in from the government?	Political Will	3.6.1 Example of program improvements to increase ownership locally	X	X	X	X		
Q4. Can the HSD program demonstrate cost effectiveness and value for money of their intervention packages?	4.1 How can the cost effectiveness of the ISDIC model for service improvement, and for clinical quality improvement (e.g., for health outcome improvements) by demonstrated?	ISDIC Cost Model	4.1.1 Examples of community and client actors engaged in social accountability or health promotion	X					X
	4.2 How can the Value for Money of integrated care in reducing family size and improving spacing between children be demonstrated?	VfM	4.2.1 Example of partner plans to sustain HSD intervetnion approaches	X					X
Q5. To what extent are USAID supported health programs synergistic, complementary and supportive of the USAID Jordan Country Development Cooperation Strategy (CDCS results framework Intermediate result 3.1 (health improved))?	5.1 To what extent do USAID programs in the health sector compliment and reenforce each other?	Complmentarity between programs	5.1.1 Example of program complimentarity for heightened outcomes	X	X		X		
	5.2 To what extent can HSD support the design and implementation of PGS?	PGS	5.2.1 Example of HSD intervtnions that can be sustained through PGS (MoH)	X	X		X	X	
	5.3 To what extent do USAID programs add value to other RMNCH+ initiatives in Jordan	Value add	5.3.1 Example of Value Add of USAID health programming	X	X		X	X	
	5.4 To what extent do USAID health programs partner with the same health system levels and partners? Are there any adverse effects of multiple programs working with the same local partners?	Synergies (across all partners)	5.4.1 Example of partnerships (positive and negative effects)	X	X		X	X	

APPENDIX 5: DATA COLLECTION INSTRUMENTS

- Key Informant Interview Guide – Clinic (MOH and NGO) & Hospital Providers
- Key Informant Interview Guide – Managers/Policymakers
- Key Informant Interview Guide – Community Health Committee Members
- Focus Group Discussion Guide – Clients
- Focus Group Discussion Guide – Women in the Community
- Tablet Survey Tool for Providers
- Survey Tool for Private Providers
- HSD Health Facility Checklist and Observation Guide

A. KEY INFORMANT INTERVIEW GUIDE – CLINIC (MOH and NGO) & HOSPITAL PROVIDERS

USAID Jordan Health Service Delivery (HSD) Activity

General Information

This Guide has been designed for key informant interviews with healthcare providers from NGO, MoH and RMS SDPs and hospitals. It is intended for doctors, nurses, and midwives depending on the facility.

Name and Title	
Relationship to the project	
Gender	Female _____ Male _____
Time interview started:	
Time interview ended:	
Name of interviewer:	

Integrated Service Delivery Improvement Collaborative (ISDIC) Program

A. We would first like to ask about ISDIC-related gaps and challenges, design solutions, and implemented changes of the Integrated Service Delivery Improvement Collaborative (ISDIC) Program.

1. (Clinic and Hospital KII's) Can you please tell me about your participation in HSD's Integrated Service Delivery Improvement Collaborative (ISDIC) program cycle?
    - How have you been involved in the ISDIC program cycles and related activities? Please explain. [Probe: ISDIC cycle, Training, etc.]
    - How did you become involved? [Probe: Were you nominated? By whom?]
    - How long have you been involved in the program? [Probe: how many cycles have you participated in]
2. (Clinic and Hospital KII's) In your experience as a provider, what are the greatest **challenges and gaps** you confront in your facility? [Probe: Challenges faced by the clients/community in terms of their health and care seeking; Challenges in terms of services delivery challenges faced by providers in the delivering services.]
    - In the ISDIC cycles you participated in, were these included in the discussion? Why / why not? Can you give me examples?
3. (Clinic and Hospital KII's) For the challenges you described, have **solutions** been explored to address the challenges?

- If so, can you give me an example of the solutions identified during the ISDIC process and who came up with the solutions?
- Do you agree with the solutions adopted?

4. (Clinic and Hospital KII's) Were these challenges and solutions the **focus of the Change Strategy** adopted during the ISDIC process for your facility? What was the focus? Please explain.
5. (Clinic and Hospital KII's) During the ISDIC cycle, did your facility achieve the change you aimed for in your **Change Strategy**?
   - If change occurred through the process, what were the most important catalyst for making the changes?
   - If no changes were achieved, what do you think are the reasons they haven't been addressed?
6. (Clinic and Hospital KII's) Gender is analysed as a key determinant of RMNCH+ and agency amongst women in community. Has **gender** been raised as an issue within the ISDIC program?
   - In your practice, are women making health care decision on their own or is she influenced by someone else?
7. (Clinic and Hospital KII's) Have gender barriers to care (e.g. opening times, cost, waiting times, husband/father authorisation/supervision of care) been discussed during the ISDIC program sessions as gaps or challenges facing women in accessing care? Were any of the solutions or change strategies aimed at reducing such barriers?
   - Have you found the reporting of ISDIC data and results to be gender-responsive (Probe: Is monitoring data disaggregated? Have ISDIC trainings included gender-responsive components?)
8. (Clinic and Hospital KII's) Are their specific challenges that Non-Jordanians (Syrians, Palestinians, other] face in accessing care? Please explain.

B. We are now going to ask questions about the extent to which HSD has improved service quality in terms of evidence-based practices (e.g. clinical standard and protocol improvements) for family planning, ANC, Delivery Care, and Postpartum/postnatal care in your facility.

1. In your experience, how has the ISDIC model contributed to improvements in quality of RMNCH+ care?
   - Which specific standards, management or organizational improvements have made the most significant difference to the quality of care improvements in your opinion?
   - Do you see a change in provider attitudes or approaches in how you deal with clients as a result of the training and support received from HSD through the ISDIC program interventions? Please provide an example.
2. What challenges have you and your team in the facility encountered in trying to make the service delivery changes requested by the ISDIC process (i.e. implementation of standards, training, integration of care and client flow, work load, supplies, supervision, etc)?
   - What are the benefits and challenges of MoH/RMS trainers conducting ISDIC Training and Mentoring?
3. Does the current data monitoring and support system (in the current cycle) adequately inform the gaps and solutions of ISDIC?

4. Which support mechanisms have been the most important for the improvements made and how could these be sustained after the end of the project in your opinion?
    - Do you think the changes will be sustained after the program ends?
5. Has the ISDIC process and HSD specifically contributed to policy changes that have worked to improve access, availability and quality of FP.

C. We will now ask questions about RMNCH+ management improvements including MOH and RMS training, guidance, facility based supportive supervision and integrated service stations and data sharing

1. (Clinic and Hospital) In your opinion, has HSD managerial and provider training contributed to improvements in RMNCH+ service delivery management, organization, or approaches (e.g. in how you provide care and support to clients and community members)? [Probe: the following:
    - Client flow (via CSS);
    - Organisation of care (provider time);
    - Community understanding of RMNCH+ services;
    - Awareness of refugees;
    - Materials for IEC;
    - Behavior of providers in addressing clients, particularly Syrian refugees;
    - Other. Explain: _____]
2. (Clinic and Hospital) Has the MCH Instruction Booklet for management of RMNCH+ been distributed and used? Have you or your facility benefitted from the Booklet?
3. (Clinic and Hospital) Have you or your facility benefited from HSD's Facility-Based Supportive Supervision (FBSS)? If yes, which of the following activities were included as part of the facility based supportive supervision (FBSS). [Please tick all that apply.]
    - Managers complete direct observations of clinical care;
    - Review of services statistics and sharing of findings with staff;
    - Records reviewed to verify compliance with protocols;
    - Regular meetings are held to review RMNCH+ performance at SDP, HD and central levels.
4. (Clinic)) Has the presence of Client Service Stations (CSS) increased the demand for other RH services during client visit? YES/NO
    - What are the benefits and the challenges of RH referrals from CSS?
5. (Clinic/Hospital) In your opinion, to what extent does the current data collection system capture and generate data that can be used at SDPs, HAD, MoH and RMS for policy and programming of prevention and service delivery of FP and RMNCH+?

D. We will now ask questions about Community Health Committees, and about how they work with community members to be aware of their health needs, seek care, and become engaged in imporving service delivery in their local facility.

1. (Clinic) Is your facility currently working with a **Community Health Committee?** How long have they been involved with your facility?

2. (Clinic) How well does your CHC represent the diversity and populations in your community? Is the CHC respected in your community?
3. (Clinic) What specific role do CHC or Community Health Workers (CHW's) play in promoting RMNCH+ in your facility?
    - Development and/or Implementation of CHC health promotion plans
    - Promotion of 2 way communication between clients and providers;
    - Awareness raising on RMNCH+ among community members through home visits, health promotion activities or events (tick whichever applies);
    - Support community evaluation of services (Scorecards)
    - Other. Explain _____
4. (Clinic) Do CHC activities benefit service delivery in your facility? YES/NO. Please give examples.
5. (Clinic) To what extent has the CHC /CHWs facilitated community platforms for feedback and accountability (via scorecards, secret shoppers) between your facility and the community? Do the platforms work? How? Please provide an example.
6. (Clinic) Are job aids and Information, Education, and Communication (IEC) materials available for CHC members? In your experience, do the job aids and IEC materials help raise awareness during household and community based activities to promote family planning? YES/NO. Please give examples.
7. In your opinion, has the presence of CHC's improved the health seeking behaviors of clients in your clinic?

E. Equity/Gender Outcomes

1. (Clinic and Hospital) Are RMNCH+ services accessible and available for marginalised and vulnerable populations in the community?
2. (Clinic and Hospital) In your experience, are there RMNCH+ barriers and challenges for women in the community? How about for marginalised and vulnerable populations in the community? If so, can you tell me more about those.
3. (Clinic and Hospital) In your experience, which women have the most trouble accessing RMNCH+ services? Why? (Probe: Are there specific subgroups who are less likely to seek care? E.g. low income Jordanians; Syrian refugees; Palestinian, other)
4. (Clinic and Hospital) Is your facility currently working to mitigate gender related barriers to care in terms of access and availability of services (e.g. opening times, cost, waiting times, husband/father authorisation/supervision of care)?

F. Now we will ask a few questions about Jordan's maternal mortality surveillance and response system (JMMSR)

1. (Hospital) Are you familiar with procedures and protocol of the new JMMSR? Tell me a bit more about your experience with the JMMSR.
2. (Hospital) In your hospital, how often do you receive feedback from the NAG or DAG about the JMMSR, or policy/service changes as a result of JMMSR?
3. (Hospital) In your opinion, has the MOH's Non-Communicable Disease Directorate provided adequate leadership of JMMSR? (Probe: through policy, procedural changes and accountability).

4. (Hospital) In your experience, do the surveillance facilities notify all maternal deaths to the HD according to MMSR system? Is the MMSR system effective? [EQ1.2.1/R2:Q7]

G. The following questions ask about HSD employed appropriate and effective management, operational and monitoring mechanisms.

1. (Clinic/Hospital) Has there been **sufficient staff and HSD support** to facilitate your participation in the HSD program (or ISDIC cycle)? Tell us about the extent to which HSD data collection and managers have facilitated your program implementation (e.g., how often you saw them on visits, how supportive they have been to facilitate your program, how responsive they are to your needs).
2. (Clinic/Hospital) Has the ISDIC model generated momentum and commitment from all of its partners? Please give examples. [EQ2.3.1]
3. (Clinic/Hospital) To what extent has HSD strengthened the MOH system and its decision making through its ISDIC system of monitoring? Please give examples. [EQ2.6]

H. The following questions ask about the post-investment sustainability of HSD program activities.

4. (Clinic/Hospital) **Sustainable Program Design and Quality:** Has HSD provided **data for decision making** to ensure sustainability of the HSD intervention? If so, can you provide examples about how they have done this? [EQ3.2.1]
5. (Clinic/Hospital) **Sustainable Program Design and Quality:** Are current training activities and pedagogical methods used to train managers and providers in your facility sustainable? [EQ3.2.1]
6. (Clinic) **Community Engagement:** Are community members who are reached by HSD empowered to engage as advocates and promotors for quality care? [EQ 3.3.1]

We have come to the end of our questions. Is there anything else you would like to add about the effectiveness, efficiency or sustainability of the HSD program that you have been involved with through your facility?

Thank you for your time and participation in this interview.

B. KEY INFORMANT INTERVIEW GUIDE – MANAGERS/POLICYMAKERS

USAID Jordan Health Service Delivery (HSD)

General Information

This Guide has been designed for key informant interview with mangers and policymakers including partners, collaborators, implementers, and funders of the USAID Jordan HSD project. representatives to be included are: MoH, HCAC, EMPHNET, HAD Directors, HAD Health Promotion Supervisors, RMS Central-level managers and hospital-level managers, NGO's operating clinics (JAFPP, the other one) and those contracted by HSD (Pop Council/ Assoc of Nurse Midwives), USAID, HSD, Professional syndicates, WHO/UNFPA, JMSSR NAG & DAG.

Name and Title	
Relationship to the project	
Gender	Female _____ Male _____
Time interview started:	
Time interview ended:	
Name of interviewer:	

A. (HSD IMPLEMENTING PARTNERS ONLY) We would first like to ask about your involvement in the Integrated Service Delivery Improvement Collaborative (ISDIC) Program.

1. Can you please tell me about your participation in HSD's Integrated Service Delivery Improvement Collaborative (ISDIC) program cycle?
    - How have you specifically been involved in the program cycles and activities? Which ones? [Probe: ISDIC cycle, Training, supervision, etc.]
    - How did you become involved in your specific function/role? [Probe: Were you nominated? By whom?]
    - How long have you been involved in the program? [Probe: how many cycles have you participated in]
2. In your experience as a manager/policymaker, what are the greatest **challenges and gaps identified** by the project through the ISDIC model and other activities of HSD?
3. In your opinion, did the process prioritize the issues that were most important for improving RMNCH+ quality of care? [Probe: In program design, data collection, stakeholder engagement] Why / why not? Can you give me examples?
4. Is the HSD project working to address the most challenging problems?

5. In your opinion, are they well focused and effective?
6. Gender is analysed as a key determinant of RMNCH+, women-centered care, agency amongst women in community. Has **gender** been raised as an issue within the HSD project activities?
7. Have gender barriers to care (i.e. opening times, cost, waiting times, husband/father authorisation/supervision of care) been discussed during the ISDIC program sessions or project reviews as gaps or challenges facing women in accessing care? Were any of the solutions or change strategies aimed at reducing such barriers? How gender responsive do you feel are HSD interventions? [Probe: Is monitoring data disaggregated? Have ISDIC change strategies included gender transformative approaches i.e. trying to change gender norms]
8. Are their specific challenges that Non-Jordanians (Syrians, Palestinians, other] face in accessing care? Please explain.

B. We are now going to ask questions about the extent to which HSD has improved service quality in terms of evidence-based practices (e.g. clinical standard and protocol improvements) for family planning.

1. In your experience, how has HSD contributed to improvements in quality of RMNCH+ care in facilities/ directorates/health service provision in Jordan?
    - Which specific standards, management or organizational improvements have made the most significant difference to the quality of care improvements in your opinion?
    - Do you see a change in client and provider attitudes as a result of the training and support received from HSD through the ISDIC program interventions? Please provide an example.
    - What challenges have you and colleagues encountered with HSD programs and interventions (i.e. implementation programs, training, integration, responsiveness, supervision, communication, etc)
    - Have you or your colleagues received adequate support from the HSD program? Was the supervision received helpful for improving services delivery practice? How? Please provide an example.
    - (for MOH/RMS only) What are the benefits and challenges of MoH/RMS trainers conducting ISDIC Training and Mentoring?
    - Does the current data monitoring and support system (in the current cycle) adequately inform the gaps and solutions of RMNCH+?
    - Do you think the changes will be sustained after the program ends? Which support mechanisms have been the most important for the improvements made and how could these be sustained after the end of the project in your opinion?
    - Has HSD specifically contributed to policy changes that have worked to improve access, availability and quality of FP?

2. In your experience participating in HSD program design and implementation, how well has HSD trained and set expectations for **providers and clinic staff** to counsel all women on all modern methods of contraceptive and family planning? Are there relevant training resources and guidance for facilities to direct women to specific methods?

- Through HSD programming, do you believe women are more comfortable choosing the best methods for themselves? [Probe: Are their decisions influenced by others (e.g. sister, mother, husband, etc.]?
- In your experience, has HSD influenced who decides/chooses family planning method for the woman? [Probe: Is there pressure from anyone to use family planning or types of contraceptives?]

3. Has HSD effectively improved the information that facilities have to give women during their third trimester on family planning´[Probe: for immediate protection post partum?]
4. Has there been an improvement in the quality of FP counselling in facilities? Probe: Link to discontinuation of use within 12 months]

C. Equity/Gender Outcomes

1. In your opinion, are RMNCH+ services accessible and available for marginalised and vulnerable populations in the community?
2. In your experience, are there RMNCH+ barriers and challenges for women in the community? How about for marginalised and vulnerable populations in the community? If so, can you tell me more about those.
3. In your experience, are there specific challenges th some groups have in accessing RMNCH+ services? Why? [Probe: Are there specific subgroups who are less likely to seek care? E.g. low income Jordanians; Syrian refugees; Palestinian, other]
4. Is HSD currently working to mitigate gender related barriers to care in terms of access and availability of services (e.g. opening times, cost, waiting times, husband/father authorisation/supervision of care)?

D. We will now ask questions about RMNCH+ Management Improvements such as MOH and RMS training, facility based supportive supervision.

1. In your opinion, has HSD managerial and provider training contributed to improvements in RMNCH+ service delivery management, organization, or approaches (e.g. in how you provide care and support to clients and community members)? [Probe the following:
   - Client flow (via CSS);
   - Organisation of care (provider time);
   - Community understanding of RMNCH+ services;
   - Awareness of refugees;
   - Materials for IEC;
   - Behavior of providers in addressing clients, particularly Syrian refugees;
   - Other. Explain: _____]
2. In your experience, do the surveillance facilities notify all maternal deaths to the HD according to MMSR system? Is the MMSR system effective?
3. Are you familiar with HSD's Facility-Based Supportive Supervision (FBSS)? If yes, how has FBSS contributed to improvements in RMNCH+ services, organization, or approaches [Probe the following:
   - Managers complete direct observations of clinical care;
   - Review of services statistics and sharing of findings with staff;
   - Records reviewed to verify compliance with protocols;

- Regular meetings are held to review RMNCH+ performance at SDP, HD and central levels.
- Other _____]

4. In your opinion, to what extent does the current data collection system capture and generate data that can be used for policy and programming of FP and RMNCH+? Tell me more about the benefits and challenges.

E. We will now ask questions about Community Health Committees

1. Have you worked with a Community Health Committees or community health workers? If so, in what capacity? [Probe the following:
   - Development and/or Implementation of CHC health promotion plans
   - Promotion of 2 way communication between clients and providers;
   - Awareness raising on RMNCH+ among community members through home visits, health promotion activities or events (tick whichever applies);
   - Support community evaluation of services (Scorecards)
   - Other. Explain _____]
2. To your knowledge, how often are community priorities reflected in HSD priorities for quality of care improvement through the ISDIC Change Package? Could you give examples?
3. How available and accessible are support groups for FP, pregnancy and breastfeeding in the community?
4. To what extent has the CHC /CHWs generated community platforms for feedback and accountability (via scorecards, secret shoppers) in the community? Do the platforms work? How? Please provide an example.
5. Are CHC Information, Education, and Communication (IEC) materials effective in helping raise awareness n the community to promote family planning? YES/NO. Please give examples.

F. Family Planning in RMNCH+ Continuum of Care -- including Contraceptive Discontinuation Surveillance System and Self-reliance

1. (Clinic/Hospital) How well does the current system capture and generate data used at SDPs, HD, MoH and RMS for policy and programming of prevention and service delivery of FP and RMNCH+?
2. (Clinic) Tell us more about policy changes that have worked to improve access, availability and quality of FP.

G. Jordan's maternal mortality Surveillance and response System (JMMSR)

1. Are you familiar with procedures and protocol of the new JMMSR? Tell me a bit more about your experience with the JMMSR.
2. In your opinion, has the MOH's Non-Communicable Disease Directorate provided leadership of JMMSR? [Probe: through policy, procedural changes and accountability]

H. We will now ask questions about the employment of management, operational, and monitoring mechanisms at HSD

1. Has there been sufficient feedback on performance of partners in the HSD program? Tell me about the extent to which HSD has provided feedback and from whom. Please give us examples about the feedback and how helpful it was for improving your work in HSD.
2. Has HSD monitoring data sources and M&E information been provided to you to improve program implementation? Please give examples.
3. Have you been invited to meetings to integrate HSD M&E information into improving your work? If so, how often were the meetings? At the meetings did you:
    - integrate learning to improve the HSD project and your work? Y/N
    - Engage with staff? Other stakeholders
    - Make changes to the program based on your input
4. Do you have a designated manager/contact with regards to the HSD program? If yes, how often did you meet with him/her?
    a. Were they responsive to your needs and give you information/data to support program implementation improvements?
    b. Were they interested in your progress?
    c. Please give examples of how they did/did not engage with your designated program/work.
5. Were there mechanisms in place to engage and collaborate on annual reports, workplans and M&E activities with HSD? Give us examples of how you were involved in this process (clients and partners)
6. Has there been sufficient staff and HSD support to facilitate your participation in the HSD program? Tell us about the extent to which HSD data collection and managers have facilitated your program implementation (e.g., how often you saw them on visits, how supportive they have been to facilitate your program, how responsive they are to your needs).
7. Has the ISDIC model generated momentum and commitment from all of its partners? Please give examples.
8. Where may there be room for improvement to improve partnership and engagement?
9. Do you think the selected partners the most appropriate ones to carry out the program (e.g., NGO partners, EMPHNT, HCAC)?
10. To what extent has HSD strengthened the MOH system and its decision making through its monitoring system? Please give examples. [EQ2.6]

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H. We will now ask questions about HSD's potential for post-investment sustainability.

1. How well do you think your program or work is set up for integrated sustainability? Please provide examples about mechanisms that will support sustainability, or mechanisms that could help improve sustainability.
2. In your opinion, has HSD provided data for decision making to ensure sustainability of the HSD activity? Are current HSD data collection and reporting activities (including training) sustainable over time? If so, can you provide examples about how they have done this?
3. In your experience are current training activities and pedagogical methods to train managers and providers sustainable?

4. To what extent has HSD improved community engagement and ownership around its activities in a sustainable way? If yes, could you provide examples? If no, could you describe why HSD has not been able to effectively engage community?
5. Has HSD succeded in empowering community members to participate in HSD activities as advocates and promoters? Do you think their involvement will be sustainable in the future?
6. To what extent has HSD developed systems and interventions that require the contribution and leadership of important governing bodies and the MOH? [EQ3.4.1]
7. Has HSD encouraged/supported partnership and ownership of the HSD program design, implementation, and M&E from its partners and from MOH? Could you please give examples?
8. How might MOH engage with existing partners in the final years of the program to increase ownership of HSD activities? [EQ3.5.1, 3.6.1]

I. We will now ask questions about the HSD's compatibility with USAID Jordan Country Development Cooperation Strategy (CDCS).

1. To what extent do different USAID health programs in Jordan complement and reinforce each other? Could you provide examples of complementarity or lack of complementarity?
2. To what extent has HSD participated in the design of the PGS (USAID) programme? How could HSD support PGS implementation?
3. Do you think USAID health programming been synergistic/added value with other RMNC +initiatives in Jordan (i.e., MOH programs not funded by USAID)? Please provide an example.
4. Do the different USAID and other donor-supported programs in Jordan work well together? Please provide examples. Is there overlap or redundancy in programming in this area?

We have come to the end of our questions. Is there anything else you would like to add about the effectiveness, efficiency or sustainability of the HSD program that you have been involved with?

Thank you for your time and participation in this interview.

C. KEY INFORMANT INTERVIEW – COMMUNITY HEALTH COMMITTEE MEMBERS

USAID Jordan Health Service Delivery (HSD)

General Information

This Guide has been designed for key infomant interviews with members of Community Health Committees (CHC). It is intended for Heads of the CHC, CHC representativse, and when possible, non-Jordanian representatives from under represented and/or marginalized groups depending on the CHC.

Title	
Role in the project	
Gender	
Time interview started:	
Time interview ended:	
Name of interviewer:	

A. We would first like to ask about the CHC's role in the Integrated Service Delivery Improvement Collaborative (ISDIC) Program.

1. Are you familiar with HSD's Integrated Service Delivery Improvement Collaborative (ISDIC) program cycle?
2. If yes, please tell me about how CHC's participate in HSD's ISDIC program cycle?
    - How have you specifically been involved in the program cycles and which activities have you participated in? (Probe: ISDIC cycle, Training, etc)
    - How did you become involved? (Probe: Were you nominated? By whom?)
    - How long have you been involved in the program? (Probe: how many cycles have you participated in)
3. In your experience as a community member, what are the greatest **challenges and gaps** in your community with regards to RMNCH? (Probe: Challenges faced by the clients/community in terms of their health and care seeking;)
4. In the CHC meetings you attended, were these included in the discussion? Why / why not? Can you give me examples?
5. Did you participate in ISDIC cycle activities (e.g., workshops)? Y/N If so, were these challenges included in the discussion? Why / why not? Can you give me examples?
6. For the challenges you described, have **solutions** been explored to address the challenges?

- If so, can you give me an example of the solutions identified during the CHC/ISDIC process and who came up with the solutions?
- Do you agree with the solutions adopted?

7. Were these challenges and solutions the **focus of the Change Strategy** adopted during the ISDIC process for your facility?
8. During the ISDIC cycle, did your facility achieve the change you aimed for in the CHC?
   - If change occurred through the process, what were the most important catalyst for making the changes?
   - If no changes were achieved, what do you think are the reasons they haven't been addressed?
9. Gender is analyzed as a key determinant of RMNCH+, women-centered care, agency amongst women in community. Has **gender** been raised as an issue within the CHC? In your community, who is making RMNCH+ decisions?
   - Is the woman making decisions on her own, with her husband, or is she influenced by someone else?
10. Have gender barriers to care (Probe: opening times, cost, waiting times, husband/father authorization/supervision of care) been discussed during the CHC program sessions as gaps or challenges facing women in accessing care? Were any of the solutions or change strategies aimed at reducing such barriers?
    - Have any gender-based issues been integrated into ISDIC programs based on CHC activities?
11. Tell us more about how CHC outcomes are relayed to facilities and providers in the facilities.
12. Are their specific challenges that Non-Jordanians (Syrians, Palestinians, other] face in accessing care? Please explain.

B. We are now going to ask questions about the extent to which HSD has improved service quality in terms of evidence-based practices (e.g. clinical standard and protocol improvements) for family planning, ANC, Delivery Care, and Postpartum/postnatal care in your facility.

<u>Family Planning</u>

1. In CHC meetings, is family planning ever discussed as important health priorities? For example:
   a. **Availability of family planning methods** in the clinic
   b. Planning methods are not available
   c. Availability of FP counseling and services
   d. Referrals
   e. Women-centered care
   f. Other _____
2. Are there any particular challenges or barriers to providing the FP counseling and services that women need in clinics?
3. What are they key concerns of community members related to Family Planning? [Scale, choices, or open-ended?]
4. In your experience, do **providers and clinic staff counsel all women** on all modern methods of contraceptive and family planning? Do they direct women to specific methods? On what basis do they make recommendations?

- Are women comfortable choosing the best methods for themselves? (Probe: Are their decisions influenced by others (e.g. sister, mother, husband)?
- In your experience, who decides/chooses family planning method for the woman? (Probe: is there pressure from anyone to use family planning or types of contraceptives?

2. In your experience, what are the **primary reasons women may discontinue use** of a modern method of FP within the first year of use?
    - Do you think access to quality FP counselling makes a difference to continuation of use of FP methods by women? Why?

C. We will now ask questions about Community Health Committee participation and implications on the priority areas for communities, feedback on services; and improved RMNCH+ outcomes.

1. Are you currently working with a specific facility?
2. What specific role does your CHC or Community Health Workers play in promoting RMNCH+ in their directorates?
    - Development and/or Implementation of CHC health promotion plans
    - Promotion of 2 way communication between clients and providers;
    - Awareness raising on RMNCH+ among community members through home visits, health promotion activities or events (tick whichever applies);
    - Support community evaluation of services (Scorecards)
    - Other. Explain _____
3. Has the CHC /CHWs facilitated access and use of community platforms for feedback and accountability (via scorecards, secret shoppers) between your facility and the community? How? Please provide an example.[EQ1.4.1/R1: A2.1]

D. Equity/Gender Outcomes

1. Are RMNCH+ services accessible and available for marginalised and vulnerable populations in the community?
2. In your experience, are there RMNCH+ barriers and challenges for women in the community? How about for marginalised and vulnerable populations in the community? If so, can you tell me more about those.
3. In your experience, which women have the most trouble accessing RMNCH+ services? Why? (Probe: Are there specific subgroups who are less likely to seek care? E.g. low income Jordanians; Syrian refugees; Palestinian, other)
4. Is your facility currently working to mitigate gender related barriers to care in terms of access and availability of services (e.g. opening times, cost, waiting times, husband/father authorisation/supervision of care)?

E. We will now ask questions about RMNCH+ Management Improvements such as MOH and RMS training, facility based supportive supervision.

1. In your opinion, how has CHC g contributed to improvements in RMNCH+ service delivery management, organization, or approaches (e.g. in how you provide care and support to clients and community members)? (Please tick all that apply.) [EQ1.2.2 and 1.2.3/R2:R2.1]
    - Client flow (via CSS);

- Organisation of care (provider time);
- Community understanding of RMNCH+ services;
- Awareness of refugees;
- Materials for IEC;
- Behavior of providers in addressing clients, particularly Syrian refugees;
- Other. Explain: _____

F. We will now ask questions about how you work with community members to be aware of their health needs, seek care, and become engaged in imporving service delivery in their local facility.

1. How well does your CHC represent the diversity and populations in your community? Is the CHC respected in your community?
2. What specific role do CHC or Community Health Workers (CHW's) play in promoting RMNCH+ in your facility?
    - Development and/or Implementation of CHC health promotion plans
    - Promotion of 2 way communication between clients and providers;
    - Awareness raising on RMNCH+ among community members through home visits, health promotion activities or events (tick whichever applies);
    - Support community evaluation of services (Scorecards)
    - Other. Explain _____
3. Do CHC activities benefit service delivery in your facility? YES/NO. Please give examples.
4. To what extent has the CHC /CHWs facilitated community platforms for feedback and accountability (via scorecards, secret shoppers) between your facility and the community? Do the platforms work? How? Please provide an example.
5. Are job aids and Information, Education, and Communication (IEC) materials available for CHC members? In your experience, do the job aids and IEC materials help raise awareness during household and community based activities to promote family planning? YES/NO. Please give examples.
6. In your opinion, has the presence of CHC's improved the health seeking behaviors of clients in your clinic?

F. The following questions ask about HSD employed appropriate and effective management, operational and monitoring mechanisms.

1. Are there mechanisms in place to engage and collaborate on annual reports, workplans and M&E activities with HSD? Give us examples of how you were involved in this process .
2. Has there been **sufficient staff and HSD support** to facilitate your participation in the HSD program (or ISDIC model) through CHC? Tell us about the extent to which HSD data collection and managers have facilitated your program implementation (e.g., how often you saw them on visits, how supportive they have been to facilitate your program, how responsive they are to your needs).
3. In your opinion, have CHC's and the ISDIC model generated momentum and commitment from community members? Please give examples.
4. Where may there be room for improvement to improve partnership and engagement? .

5. To what extent has HSD strengthened the MOH system and its decision making through its monitoring system? Please give examples.

G. The following questions ask about the post-investment sustainability of HSD program activities.

1. In your opinion, has HSD provided data for decision making to ensure sustainability of the HSD activity? Are current HSD data collection and reporting activities (including training) sustainable over time? If so, can you provide examples about how they have done this?
2. To what extent has HSD improved community engagement and ownership around its activities in a sustainable way? If yes, could you provide examples? If no, could you describe why HSD has not been able to effectively engage community?
1. Has HSD succeded in empowering community members to participate in HSD activities as advocates and promoters? Do you think their involvement will be sustainable in the future?

We have come to the end of our questions. Is there anything else you would like to add about the effectiveness, efficiency or sustainability of the HSD program that you have been involved with?

Thank you for your time and participation in this interview.

D. FOCUS GROUP DISCUSSION GUIDE – CLIENTS

USAID Jordan Health Service Delivery (HSD)

General Information

This Guide has been designed for focus group discussions with postpartum women attending primary health care facilities (MoH and NGO) in Jordan for health care within 12 months of pregnancy.

The USAID Health Service Delivery project has been implemented in Jordan to improve access, availability and quality of reproductive, maternal, newborn and child health. [Name of facility] and [Hospital] have received support from the HSD project since HSD was initiated in 2016. We would like to have your opinions about your experience of care in MoH health facilities over the past 12 months. We will ask you about a number of health areas including your impressions of service quality, access to specific services for women, and your experience with the facilities.

A. Service Quality and Experience of Care. We are going to ask questions about your experience of the service you received at your local health facility and hospital. We will be asking about family planning, antenatal care, delivery services and your recent postpartum or postnatal visit.

Family Planning

1. Which **family planning methods have you been offered** at your facility? (Probe: Pills, injectibles, implanon, LAM, Bilateral Tubal Litigation, IUD, Condoms, Other/Specify)
    - If methods are not available, were you referred elsewhere? Where? If yes, for which methods were you referred for?
2. When was the **last time you received counseling** on Family Planning (probe: third trimester of ANC; before discharge)?
    - How was the counseling provided? (Probe: When does it happen? Who did the counseling? How long does it take? Was their confidentiality/privacy during the counselling?)
    - What family planning methods were offered?
    - Did they ask you about your family planning needs or desires? Did they ask you your contraceptive preferences?
    - Did they answer your questions and concerns about side effects??
    - What information were you given in ANC about family planning [Probe: for immediate protection post partum]
    - After delivery, did you receive family planning counseling before being discharged? Were there any particular challenges or barriers to receiving FP counseling before you were discharged? [Probe: Do some women not get the counseling? For those that do, are they tired? Is it a priority for them?]
3. In your **experience**, were you counseled on contraceptive methods and family planning without judgement by providers and clinic staff?
    - Are women comfortable choosing the best family planning methods for themselves? [Probe: Are decisions influenced by others such as a sister, mother, husband, or others]

- Who decides/chooses family planning method for you, and women in your community? [Probe: Is there pressure from anyone to use planning or types of planning?]
- Did you feel the provider respected your opinion, preferences and concerns related to FP? [Probe: Treatment with respect, dignity and humanity]

Antenatal Care

1. Please try to recall the times you attended antenatal care visits during your pregnancy. During the visits, were you **screened for high risk factors**? Which ones?
   [Probe: High blood pressure, anemia, age (under 18, over 35), birth history (first birth, multiparous, past miscarriages, past c-section), vaccination history, preexisting conditions (diabetes and other NCD), genetic predisposition (family history), etc.]
2. What **tests, counselling and services were you offered** during your ANC visits? [Check/Clinical Pathway]
   [Probe: Iron supplementation, Folic acid supplementation, Fasting blood sugar, Urine stick (protein, sugar), Tetanus toxoid (TT) vaccination, Breastfeeding counseling, Family planning counseling]
3. Did you receive **information about how to take care of your newborn** after delivery in ANC?
   [Probe: importance of skin-to-skin contact and early initiation of breastfeeding]
4. Did you feel the **provider respected your opinion**, preferences and concerns related to your pregnancy? [Probe: Treatment with respect, dignity and humanity]

Delivery Care

1. Did the provider **explain how the delivery care would be managed** (i.e. how they would help manage the third stage of labor)? Did they ask for your agreement with their approach?
   - Were you given medication (uterotonic agents such as Oxytocin) to reduce the risk of bleeding (postpartum hemorrhage)?
   - Did the provider support the delivery of the placenta (through controlled cord traction and fundal massage to reduce the risk of post partum hemorrhage)?
2. Did you feel the **provider respected your opinion**, preferences and concerns related to your childbirth? [Probe: Treatment with respect, dignity and humanity]

Postpartum and postnatal Care

1. Before you were discharged from the hospital, did you receive postpartum counseling?
2. Were you assisted to initiate breastfeeding? When were you start breastfeeding? Did the provider help you to maintain proper positioning and latching on? Was further support provided if you had difficulty? Please give an example.
3. If your newborn had health problems at birth, were these explained to you in language that was clear including what treatments they were recommending/doing? Give examples if possible.
4. Did you feel the provider respected your opinion, preferences and concerns related to your immediate post-partum/post-natal period? [Probe: Treatment with respect, dignity and humanity]

B. We will now ask questions about how the health services reach out to communities to engage community members to provide feedback on services; and improve RMNCH+ outcomes.

1. Have you received information at home or in your community about good health practices related to RMNCH+? Where did you get the information? [Probe. CHC, CHW, home visit, public health campaign or event, other]
2. Have you been involved in a community health committee (CHC) or other community health feedback mechanisms to improve the quality of services at your local facility?
    - Do you know anyone who has been engaged in this process in your community?
    - Would you like to be more involved in such activities? Why?

C. Women and some populations have additional challenges in accessing health care services. We are now going to ask you about equity in access to care. [Equity and Gender Barriers]

1. In your opinion, what are the most significant health problems in your community related to RMNCH+? What are the most significant barriers to accessing care for you? Are there barriers for others in the community (please specify)?
2. Are there specific barriers you face in getting information about RMNCH+ and in making family planning decisions?
    a. Are the community health workers helping to overcome these barriers? How?
    b. Is the facility helping to overcome these barriers? How?
3. What are the most significant challenges and barriers facing the more marginalized and vulnerable populations in accessing care?

D. We will now ask questions about how health services at your facility are run and how that has impacted your health care experience.

1. In your last visit during ANC, how long was your waiting time before you saw the provider?
2. Did you speak to someone at a Client Service Station?
    - Did they offer a referral for an additional service?
    - If yes, did you seek the other service during that visit?
    - Did you go back for the additional service? If no, why not?
3. Do you think the CSS improves your client experience? How?
   [Probe: good suggestion and referral; time saving; Awareness raising]
4. Were health promotion materials on RMNCH used/made available to you that were helpful to you? Which ones?
5. Were you offered/referred to participate in a support group for family planning, pregnancy or breastfeeding?

We have come to the end of our questions. Thank you all for your time and participating. Is there anything else you would like to add about your services in MoH/NGO clinics?

Thank you for your time and participation in this interview.

E. FOCUS GROUP DISCUSSION GUIDE – COMMUNITY

USAID Jordan Health Service Delivery (HSD)

General Information

This Guide has been designed for focus group discussions with women in the community of reproductive age with children under 5 who may or may not have attended primary health care facilities (MoH and NGO) in Jordan.

The USAID Health Service Delivery (HSD) project has been implemented in Jordan to improve access, availability and quality of reproductive, maternal, newborn and child health. Your community has received support from the HSD project since HSD was initiated in 2016. We would like to learn about your health care over the past 12 months and your experiences. We will ask you about a number of health areas including your impressions of service quality, access to RMNCH services for women, and areas for improvement.

General Questions

1. Tell us if you have sought health services in a MoH or NGO primary health care facility in the past 12 months. If so, give us an idea of how many of the visits have been RMNCH focused? (Probe: How often have you gone? This will be different for everyone, but we want to understand how many of you use the clinics).
2. For those of you who have **not** gone to the facility for services, what are the reasons you have not gone? Where do you go? Please tell us a bit more about this. (Probe: Were there barriers? Challenges? Other reasons?)

A. Service Quality and Experience of Care. We are going to ask questions about your experience of service you have received at your local health facility and hospital. We will be asking about family planning, antenatal care, delivery services and experiences with any postpartum or postnatal visits.

<u>Family Planning</u>

1. For those of you who have received family planning services, which **family planning methods have you been offered** at the facility? (Probe: Pills, injectibles, implanon, LAM, Bilateral Tubal Litigation, IUD, Condoms, Other/Specify)
    - If methods are not available, were you referred elsewhere? Where? If yes, for which methods were you referred for?
2. For those of you who have received services, when was the **last time you received counseling** on Family Planning (probe: third trimester of ANC; before discharge)?
    - How was the counseling provided? (Probe: When does it happen? Who did the counseling? How long does it take? Was their confidentiality/privacy during the counselling?)
    - What family planning methods were offered?

- Did they ask you about your family planning needs or desires? Did they ask you your contraceptive preferences?
- Did they answer your questions and concerns about side effects?
- What information were you given in ANC about family planning (Probe: for immediate protection post partum?)
- For those of you who have received services, after delivery, did you receive FP counseling before being discharged? Were there any particular challenges or barriers to receiving FP counseling before you were discharged? (Probe: Do some women not get the counseling? For those that do, are they tired? Is it a priority for them?)

3. In your **experience**, has the counselling you have received on contraceptive methods and family planning been provided without judgement from providers and clinic staff?
   - Are women comfortable choosing the best methods for themselves? (Probe: Are decisions influenced by others such as a sister, mother, husband, or others)
   - Who decides/chooses family planning method for you, and women in your community
   - Did you feel the provider respected your opinion, preferences and concerns related to FP? [Probe: Treatment with respect, dignity and humanity]

Antenatal Care

1. Please try to recall the times you attended antenatal care visits during your pregnancy. During the visits, were you **screened for high risk factors**? Which ones?
   [Probe: High blood pressure, anemia, age (under 18, over 35), birth history (first birth, multiparous, past miscarriages, past c-section), vaccination history, preexisting conditions (diabetes and other NCD), genetic predisposition (family history), etc.]
2. What **tests, counselling and services were you offered** during your ANC visits? [Check/Clinical Pathway]
   [Probe: Iron supplementation, Folic acid supplementation, Fasting blood sugar, Urine stick (protein, sugar), Tetanus toxoid (TT) vaccination, Breastfeeding counseling, Family planning counseling]
3. Did you receive **information about how to take care of your newborn** after delivery in ANC?
   [Probe: importance of skin-to-skin contact and early initiation of breastfeeding]
4. Did you feel the **provider respected your opinion**, preferences and concerns related to your pregnancy?
   [Probe: Treatment with respect, dignity and humanity]

Postpartum and postnatal Care

1. Before you were discharged from the hospital, did you receive postpartum counseling?
2. Were you assisted to initiate breastfeeding? When did you start breastfeeding with your last child? Did the provider help you to maintain proper positioning and latching on? Was further support provided if you had difficulty? Please give an example.
3. If your newborn had health problems at birth, were these explained to you in language that was clear including what treatments they were recommending/doing? Give examples if possible.
4. Did you feel the provider respected your opinion, preferences and concerns related to your immediate post-partum/post-natal period? [Probe: Treatment with respect, dignity and humanity]
5. Has your child been screened for anemia?

[Probe: evaluation of nutritional status, nutritional counseling; diagnosis/referral to specialist]

B. We will now ask questions about how the health services reach out to communities to engage community members to provide feedback on services; and improve RMNCH+ outcomes.

1. Have you received information at home or in your community about good health practices related to RMNCH+? Where did you get the information? [Probe. CHC, CHW, home visit, public health campaign or event, other]
2. Have you been involved in a Community Health Committee (CHC) or other community health feedback mechanisms to improve the quality of services at your local facility? Do you know anyone who has been engaged in this process in your community? Would you like to be more involved in such activities? Why?

C. Women and some populations have additional challenges in accessing health care services. We are now going to ask you about equity in access to care. [Equity and Gender Barriers]

1. In your opinion, what are the most significant health problems in your community related to RMNCH+? What are the most significant barriers to accessing care for you? Are there barriers for others in the community (please specify)?
2. Are there specific barriers you face in getting information about RMNCH+ and in making family planning decisions?
    - Are the community health workers helping to overcome these barriers? How?
    - Is the facility helping to overcome these barriers? How?
3. What are the most significant challenges and barriers facing the more marginalized and vulnerable populations in accessing care?

D. We will now ask questions about how health services at your facility are run and how that has impacted your health care experience.

1. In your last visit during ANC, how long was your waiting time before you saw the provider?
2. Did you speak to someone at a Client Service Station? Did they offer a referral for an additional service?
    - If yes, did you seek the other service during that visit?
    - Did you go back for the additional service? If no, why not?
3. Do you think the CSS improves your client experience? How?
   [Probe: good suggestion and referral; time saving; Awareness raising]
4. Were health promotion materials on RMNCH used/made available to you that were helpful to you? Which ones?
5. Were you offered/referred to participate in a support groups for family planning, pregnancy or breastfeeding?

E. We will now ask questions about community engagement and HSD's potential for post-investment sustainability in your community.

1. How can the facilities in your area improve community engagement around RMNCH? Could you provide examples?

2. What are ways in which facilities have been able to effectively engage community?
3. Are community members who are reached by Community Health Workers, CHC's or other MoH/NGO facility programs empowered to engage as advocates and promoters for quality care?

We have come to the end of our questions. Thank you all for your time and participating. Is there anything else you would like to add about your services in MoH/NGO clinics? Thank you for your time and participation in this interview.

TABLET SURVEY TOOL FOR PROVIDERS

USAID Jordan Health Service Delivery (HSD) Activity

General Information

[Note: Informed consent to be read aloud]

The USAID Health Service Delivery (HSD) project has been implemented in Jordan to improve access, availability and quality of reproductive, maternal, newborn and child health and nutrition. This survey is intended for health facility and hospital providers (designated MoH HCs, NGO HCs, RMS Hospital, MoH Hospital) participating in ISDIC program activities through their facility.

ENUMERATOR OR INTERVIEWER NAME:	
Questionnaire #	

FACILITY IDENTIFICATION		
Governorate**:**	Amman [_ | _]	Irbid [_ | _]
	Ajloun [_ | _]	Jerash [_ | _]
	Mafraq [_ | _]	Balqa [_ | _]
	Zarqa [_ | _]	Madaba [_ | _]
	Karak [_ | _]	Tafilah [_ | _]
	Ma'an [_ | _]	Aqaba [_ | _]
Health Directorate:	Amman [_ | _]	Irbid [_ | _]
	Ajloun [_ | _]	Jerash [_ | _]
	Mafraq [_ | _]	Balqa [_ | _]
	Zarqa [_ | _]	Madaba [_ | _]

	Karak [_ | _]	Tafilah [_ | _]
	Ma'an [_ | _]	Aqaba [_ | _]
	Petra [_ | _]	Ramtha [_ | _]
Facility name: _____		Code: [___ | ___]
Facility Type:	01- MoH Hospital 02 RMS Hospital 03 MoH Clinic 04 NGO Clinic	
Type of Provider	01 – Physician/GP 02 – Nurse 03 – Midwife 88 – Other _____	
How many years have you been participating with ISDIC facility?	Less than 6 months	
	6 – 12 months	
	12-24 months	
	More than 24 months	

SECTION A: **Experience with the USAID Health Service Delivery project's Integrated Service Delivery Improvement Collaborative (ISDIC) Program**					
NO	**Respondent Type**	**QUESTION**	**RESPONSE OPTIONS**	**CODE**	**SKIP**
1	Clinic and Hospital	Have you been involved in the HSD's Integrated Service Delivery Improvement Collaborative (ISDIC) program cycle?	Yes	1	
			No	2	Skip to5
			Partially	3	Skip to 5
			Don't know	14	Skip to 5
2		Which activities have you participated in specifically? *(select multiple)*	ISDIC cycle meeting	1	
			Training	2	
			Facility Supported Supervision	3	
			Recognition Program	4	
			Scorecard	5	
			Other	88	Skip to 5
			None	0	Skip to 5
3		How many program cycles have you been involved in?	[number]		
4	Clinic and Hospital	Are the priorities identified through the ISDIC cycle the most important issues to improve access, availability and quality of RMNCH+ services in your facility?	Yes, Strongly Agree	1	
			Somewhat Agree	2	
			Somewhat Disagree	3	
			No, Strongly Disagree	4	
			Don't Know	14	
			Other (specify)	88	

SECTION B: **Contribution to Quality of Care for** family planning, ANC, Delivery Care, and Postpartum/postnatal care in your facility.					
SECTION B1: Family Planning					
5	Clinic only	What family planning methods are currently available in your facility? (Select all that apply)	Oral Contraceptive Pill COC	1	
			Oral Contraceptive Pill POP	2	
			Injectable Contraceptive (e.g. Depo Provera)	3	
			Implant ("Implanon", "rods")	4	
			IUD	5	
			Tubal Ligation referral	6	
			Male Condoms	7	
			LAM (Lactational Amenorrhea Method)	8	

			Don't Know	0	
			Other (specify)	88	
6	Clinic only	If methods are not available, are clients referred elsewhere?	Always		
			Sometimes		
			Rarely		
			Never		Skip to Q9
			Don't Know	14	Skip to Q9
			Not Applicable	99	Skip to Q9
7	Clinic only	Where are clients referred? (Multiple)	1 Another MOH/NGO Health Center 4 Hospital (private) 5 Hospital (public) 6 Private providers 7 RMS Clinic or Hospital 14 Don't Know Other (Specify)		
8	Clinic only	For which methods are clients referred elsewhere? (Multiple)	Oral Contraceptive Pill COC	1	
			Oral Contraceptive Pill POP	2	
			Injectable Contraceptive (e.g. Depo Provera)	3	
			Implant ("Implanon", "rods")	4	
			IUD	5	
			Tubal Ligation referral	6	
			Male Condoms	7	
			LAM (Lactational Amenorrhea Method)	8	
			Don't Know	0	
			Other (specify)	88	
9	Clinic and Hospital	Is FP counseling available to clients at this facility?	Always		
			Sometimes		
			Rarely		
			Never		Skip to Q11
			Don't know	14	Skip to Q11
10		Who provides the counselling? (Multiple)	Nurse	1	
			Midwife	2	
			Doctor	3	
			Don't know	14	
			Other (specify)	88	
11		What are the particular challenges or barriers to providing FP counseling in your facility? (Select all that apply)	Lack of awareness by woman (e.g., misconceptions)	1	
			Lack of interest from woman	2	
			Need to consult family members	3	

			Provider does not have time to do counselling	4	
			Client does not have time to receive counselling	5	
			Lack of family planning guidance materials	6	
			Lack of space/rooms for counseling	7	
			Not a priority for staff	8	
			Staff not trained on FP counselling	9	
			Inappropriate or not needed	10	
			Other (specify)	88	
12		What are the most significant barriers to use of contraceptives for women, based on the women you see in your health center? (Multiple)	Cultural or religious opposition to family planning	1	
			Availability (including stock outs)	2	
			Safety / side effects	3	
			Cost	4	
			Trust in providers	5	
			Lack of information or awareness	6	
			Lack of privacy	7	
			Availability of provider to implement		
			Miscommunication		
			Other (specify)	88	
			Don't Know		
13	Hospital only	Are women usually provided counselling on family planning methods before they are discharged from the hospital after delivery?	Always	1	
			Sometimes		
			Rarely		
			Never	0	Skip to Q16
			Don't Know	14	Skip to Q16
14	Hospital only	If yes, who provided the counseling? (Multiple)	Doctor who delivered baby	1	
			Different doctor	2	
			Same nurse/midwife	3	
			Different nurse/midwife	4	
			Other (specify)	88	

15	Clinic and Hospital	How often are the following family planning issues discussed with new clients?	**Always (1)**	**Sometimes (2)**	**Rarely (3)**	**Never (4)**	**Don't know (14)**

		• Current/prior use of family planning methods					
		• Side Effects					
		• Client concerns/rumors/ misconceptions					
		• Gender based violence					
		• Birth plan					
		• Modern contraceptive methods					

16	Clinic and Hospital	Are job aids/IEC materials available for Family planning counselling?	Yes	1	
			No	2	Skip to 18
			I don't know	3	Skip to 18
17	Clinic and Hospital	If yes, how often are job aids and information, education and communication (IEC) materials used in family planning counseling?	Always	1	
			Sometimes	2	
			Rarely	3	
			Never	4	
18	Clinic only	What is the most significant factor that affect a women's decision to use contraceptive?	Provider's comprehensive FP counselling	1	
			Written materials and health promotion brochures	2	
			Negative past experiences with method	3	
			Positive past experiences with method	4	
			Family members and friends' advice/direction	5	
			Fear of side effects_	6	
			Interest in FP by client	7	
			Spouse advice/direction	8	
			Don't know	14	
			Other _____	88	

SECTION B2: Antenatal Care

Q19: When are the essential ANC procedure provided? (Clinic)

The Procedure	1st Visit	1st Trimester	2nd Trimester	3rd Trimester	Every Visit
Blood Pressure					
Weigh					
High Risk Assessment (Copland Score)					
Anemia Screening					

Folic Acid Supplement					
Iron Supplements					
Nutritional counseling					
Iron administration and counseling					
Family Planning Counseling					
Breast feeding counseling					
1st hour after delivery breast feeding initiation					
FBS					
Blood Group + Rh					
Routine Urine Analysis					
Diabetes Screening					

SECTION B3: Delivery Care					
20	Hospital only	Are women provided 10 units of Oxytocin post delivery?	Always	1	
			Sometimes	2	
			Rarely		
			Never	0	Skip to Q22
			Don't know	14	Skip to Q22
21	Hospital only	If yes, how long after delivery?	Immediate Post Delivery		
			After one hour post delivery		
			1-12 hours post delivery		
			Before discharge		
22	Hospital	How many deliveries did you have during the past week?	[number]		
23	Hospital	How often do you ensure that mothers initiate skin to skin contact immediately after delivery?	Always	1	
			Sometimes	2	
			Rarely		
			Never	0	Skip to 25
			Don't know	14	
24		How many times during the past week did you do it?			

SECTION B4: Postpartum and postnatal care					
25	Hospital only	Is breastfeeding education initiated for postpartum women?	Yes, always	1	
			Yes, but only in some cases	2	
			Yes, but only in few cases		
			No	0	
			Don't know	14	
26	Hospital only	Do you assess and help the mother maintain proper positioning and latching on in breastfeeding?	Always	1	
			Sometimes	2	
			Rarely		

			Never	0	
			Don't know	14	
27	Hospital only	Is CPAP used for respiratory problems with neonates?	Always	1	
			Sometimes		
			Rarely	2	
			Never	14	Skip to 29
28	Hospital	If yes, how often do you monitor the baby on CPAP within the first 2 hours of birth?	Every 5 minutes		Skip to 30
			Every 10 minutes		Skip to 30
			Every 15 minutes		Skip to 30
			Every 30 minutes		Skip to 30
29	Hospital	If no, why not? (Multiple)	Lack of training	1	
			Lack of availability to CPAP equipment	2	
			Lack of availability of other consumable	3	
			Other (specify)	88	

SECTION B5: Client Service Stations (CSS) for integration of care					
30	Clinic only	At facilities, do women receive a "Direction Card" for services for which they are eligible to receive?	Always	1	
			Sometimes	2	
			Rarely		
			Never	0	
			Don't know	14	
			Other.	88	
31	Clinic only	Do these women accept the FP services during the visit?	Always	1	
			Sometimes	2	
			Rarely		
			Never	0	Skip to Section C (Q33)
			Don't know	14	Skip to Section C (Q33)
32	Clinic only	In your opinion, does CSS improve the use of other services for ANC, Child Health Services, Postpartum, and FP clients?	Always	1	
			Sometimes	2	
			Rarely	3	

			Never	0	
			Don't know	14	
			Other	88	

SECTION C: Engagement of the community through the HSD. Community Health Committees seeks to involve community members by helping them to be aware of their health needs, seek care, and become engaged for improving the service delivery in their local facility.					
33	Clinic only	Is your facility currently working with a Community Health Committee?	Yes	1	
			No	0	
			Don't Know	14	
			Other	88	
34	Clinic only	What specific role does the CHC play in promoting RMNCH+ in your catchement area? (Multiple)	Development and/or implementation of CHC health promotion plans	1	
			Promotion of communication between clients' representatives (CHC) and providers	2	
			Awareness raising on RMNCH+ among community members through community events and interactive educational activities	3	
			Support community evaluation of services (e.g., Scorecards)	4	
			Other (specify)	88	

SECTION D: Equity/Gender Outcomes					
35	Clinic and Hospitals	To what extent are RMNCH+ services accessible and available for marginalised (e.g., refugees) and vulnerable populations in the community? Vulnerable populations are those in community who are less likely to have positive health outcomes (e.g., low income persons)	Very accessible	1	
			Somewhat accessible	2	
			Somewhat inaccessible	3	
			Very inaccessible	4	
			Don't know	98	
36	Clinic and Hospitals	What are facility-related barriers and challenges for marginalised and vulnerable populations in the community to access RMNCH+ care? (Please tick all that apply	Transportation challenges	1	
			Discrimination / perceived discrimination	2	
			Cultural / religious barriers	3	
			Not aware of service availability	4	
			Language barriers	5	

			Lack of time (provider)	6	
			Cost barriers	7	
			Long wait times for treatment	8	
			Lack of understanding of the documentation needed to receive services	9	
			Other (specify)	88	
37	Clinic and Hospitals	In your opinion, what are the key gender barriers limiting access and use of RMNCH+ services?	Operating hours	1	
			Cost of services	2	
			Financial barriers	3	
			Waiting times	4	
			Decision-making power	5	
			Husband/father authorization/ supervision of care	6	
			Not comfortable with gender of provider	7	
			There are no gender barriers	0	
			Other (specify)	88	
38	Clinic and Hospitals	Is your facility working to mitigate facility-related gender barriers to access and use of care?	Yes	1	
			No	0	
			Don't Know	14	
			Other (specify)	88	

SECTION E:
RMNCH+ management improvements including MOH and RMS training, guidance, facility based supportive supervision and integrated service stations and data sharing.

39	Clinic and Hospitals	To what extent do you agree with the following statements? *HSD managerial and provider training contributed to improvements in the following areas:*	**Strongly Agree (1)**	**Somewhat Agree (2)**	**Some what Disagree (3)**	**Strongly Disagree (4)**	**Not Applicable (98)**
		• *RMNCH+ service delivery management, organization, or approaches (e.g. in how you provide care and support to clients and community members)*					

		• *Client flow (via CSS)*					
		• *Organisation of care (provider time)*					
		• *Community understanding of RMNCH+ services*					
		• *Materials for IEC*					
		• *Behavior of providers in addressing clients' needs*					

40	Clinic	Have you received the MCH Instruction Booklet for management of RMNCH+ been distributed and used?	Yes, distributed and used	1	
			Distributed, but not used	2	
			Not distributed	3	
			Other (specify)	88	
			Not applicable	99	
			Don't know	98	

We have come to the end of our questions. Thank you for your time and participation in this interview.

SURVEY TOOL FOR PRIVATE PROVIDERS

USAID Jordan Health Service Delivery (HSD) Activity

General Information

[Note: Informed consent to be read aloud]

The USAID Health Service Delivery (HSD) project has been implemented in Jordan to improve access, availability and quality of reproductive, maternal, newborn and child health. This survey is intended for private providers participating in HSD program activities through their facility.

FACILITY IDENTIFICATION		
Governorate**:**	Amman [_ | _]	Irbid [_ | _]
	Ajloun [_ | _]	Jerash [_ | _]
	Mafraq [_ | _]	Balqa [_ | _]
	Zarqa [_ | _]	Madaba [_ | _]
	Karak [_ | _]	Tafilah [_ | _]
	Ma'an [_ | _]	Aqaba [_ | _]
Health Directorate:	Amman [_ | _]	Irbid [_ | _]
	Ajloun [_ | _]	Jerash [_ | _]
	Mafraq [_ | _]	Balqa [_ | _]
	Zarqa [_ | _]	Madaba [_ | _]
	Karak [_ | _]	Tafilah [_ | _]
	Ma'an [_ | _]	Aqaba [_ | _]
	Petra [_ | _]	Ramtha [_ | _]

Primary Workplace: _____		Code: [___ | ___]
Sector:	01- Private Practice 02 Pharmacy 88 - Other ____	[___ | ___]
Type of Provider	01 – Physician/GP 02 – Nurse 03 – Midwife 04 -- Pharmacist 88 – Other _____	
How many years have you been participating with HSD?	[_____]	
How many years have you been in your occupation?	[_____]	
SURVEY DATE (DAY, MONTH, YEAR, EG, 30/01/19) & TIME		[__|__/__|__/__|__]
ENUMERATOR OR INTERVIEWER NAME:		
SUPERVISOR Name_____ Date_____		ENTERED BY Name_____ Date_____

SECTION A: **Experience with the USAID Health Service Delivery project activities**

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NO	Respondent Type	QUESTION	RESPONSE OPTIONS	CODE	SKIP
1		Have you been involved in activities with HSD? (e.g., RMNCH+ training, training follow-up, Clinical Pathways)	Yes	1	
			No	2	Skip 5a
			Don't know	14	
			Other (specify)	88	
1a		How long have you been involved?	[number]		
1b		Which activities have you participated in specifically? *(select multiple)*	RMNCH +Training	1	
			Facility Supported Supervision (e.g., medical record training)	2	
			Job aids and IEC materials	3	
			Meetings or workshops	4	
			None	0	End
			Other	88	
2		Can you tell me specifically any other key priority engagement you have had with HSD? [Open response] _____ _____			
3		Are the priorities identified through HSD activities the most important issues to improve access, availability and quality of RMNCH+ services in your facility?	Yes, Strongly Agree	1	
			Somewhat Agree	2	
			Somewhat Disagree	3	
			No, Strongly Disagree	4	
			Don't Know	14	
			Other (specify)	88	

			Strongly Agree (1)	Somewhat Agree (2)	Somewhat Disagree (3)	Strongly Disagree (4)	Don't know (14)
4		To what extent do you agree with the following statements?					
4a		HSD has contributed to improvements in patient **access** to RMNCH+ services at this facility.					

4b		HSD has contributed to improvements in **availability** of RMNCH+ services at this facility.					
4c		HSD has contributed to improvements in **quality** of RMNCH+ services at this facility.					

SECTION B: **Contribution to Quality of Care for** family planning, ANC, Delivery Care, and Postpartum/postnatal care in your facility.					
SECTION B1: Family Planning					
5		What family planning methods are currently available in your facility? (Select all that apply)	Oral Contraceptive Pill COC	1	
			Oral Contraceptive Pill and POP	2	
			Injectable Contraceptive (e.g. Depo Provera)	3	
			Implant (“Implanon”, “rods”)	4	
			IUD	5	
			Tubal Ligation referral	6	
			Male Condoms	7	
			LAM (Lactational Amenorrhea Method)	8	
			Don’t Know	0	
			Other (specify)	88	
5a		If methods are not available, are clients referred elsewhere?	Yes	1	
			No	0	Skip to Q6
			Don’t Know	14	Skip to Q6
			Not Applicable	99	Skip to Q6
5b		Where are clients referred?	1 Another MOH/NGO Health Center 3 Pharmacy 4 Hospital (private) 5 Hospital (public) 6 Private providers 7 RMS Clinic or Hospital 14 Don’t Know Other (Specify)		
5c		For which methods are clients referred elsewhere?	Oral Contraceptive Pill COC	1	
			Oral Contraceptive Pill and POP	2	
			Injectable Contraceptive (e.g. Depo Provera)	3	
			Implant (“Implanon”, “rods”)	4	

			IUD	5	
			Tubal Ligation referral	6	
			Male Condoms	7	
			LAM (Lactational Amenorrhea Method)	8	
			Don't Know	0	
			Other (specify)	88	
6		Is FP counseling available to clients at this facility?	No	0	Skip to Q7d
			Yes	1	
			Don't know Other (specify)	14 88	
6a		Who provides the counselling?	Nurse	1	
			Midwife	2	
			Doctor	3	
			Don't know	14	
			Other (specify)	88	
6b		What are the particular challenges or barriers to providing FP counseling in your facility? (Select all that apply)	Lack of awareness by woman (e.g., misconceptions)	1	
			Lack of interest from woman	2	
			Need to consult family members	3	
			Provider does not have time to do counselling	4	
			Client does not have time to receive counselling	5	
			Lack of family planning guidance materials	6	
			Lack of space/rooms for counseling	7	
			Not a priority for staff	8	
			Not trained on FP counselling	9	
			Inappropriate or not needed	10	
			Other (specify)	88	
6c		What are the most significant barriers to use of contraceptives for women, based on the women you see in your health center?	Cultural or religious opposition to family planning	1	
			Availability (including stock outs)	2	
			Safety / side effects	3	
			Cost	4	
			Trust in providers	5	
			Lack of information or awareness	6	
			Lack of privacy	7	
			Availability of provider to implement		
			Miscommunication		

			Other (specify)	88	
			Don't Know		

7c		How often are the following family planning issues discussed with new clients?	**Always (1)**	**Sometimes (2)**	**Rarely (3)**	**Never (4)**	**Don't know (14)**
		• Current/prior use of family planning methods					
		• Side Effects					
		• Client concerns/rumors/ misconceptions					
		• Gender based violence					
		• Reproductive plan					
		• Modern contraceptive methods					

7d		Are job aids/IEC materials available for family planning counselling at your facility?	Yes	1	
			No	2	Skip to 8
			I don't know	3	Skip to 8
7e		If yes, how often are job aids/IEC materials used in family planning counseling?	Very often	1	
			Often	2	
			Not often	3	
			Rarely	4	
			Not applicable	5	
8		In your practice, what is the most significant factor that affect a women's decision to use contraceptive?	Provider's cpmprehensive FP counselling	1	
			Written materials and health promotion brochures	2	
			Negative past experiences with method	3	
			Positive past experiences with method	4	
			Family members and friends' advice/direction	5	

			Fear of side effects_	6	
			Interest in FP by client	7	
			Spouse advice/direction	8	
			Don't know	14	
			Other _____	88	

SECTION B2: Antenatal Care					
9a		What tests, counselling and services are women offered during their first trimester? (Tick all that apply)	High Risk Assessment	1	
			Folic acid supplementation	2	
			Anemia screening	3	
			Iron supplentation	4	
			Iron administrative counseling	5	
			Family Planning Counseling	6	
			Breastfeeding Counseling	7	
			Diabetes Screening	8	
			Don't Know	14	
9b		What tests, counselling and services are women offered during their second trimester? (Tick all that apply)	High Risk Assessment	1	
			Folic acid supplementation	2	
			Anemia screening	3	
			Iron supplentation	4	
			Iron administrative counseling	5	
			Family Planning Counseling	6	
			Breastfeeding Counseling	7	
			Diabetes Screening	8	
			Don't Know	14	
9c		What tests, counselling and services are women offered during their third trimester? (Tick all that apply)	High Risk Assessment	1	
			Folic acid supplementation	2	
			Anemia screening	3	
			Iron supplentation	4	
			Iron administrative counseling	5	
			Family Planning Counseling	6	
			Breastfeeding Counseling	7	
			Diabetes Screening	8	
			Don't Know	14	
10		Are women typically screened for anemia during ANC visits?	Yes, always	1	Skip to next
			Yes, but only in some cases	2	
			No	0	
			Don't know	14	Skip to next
		If no, why not?	[Free form]		

SECTION D: Equity/Gender Outcomes					
17a		To what extent are RMNCH+ services accessible and available for marginalised (e.g., refugees) and vulnerable populations in the	Very accessible	1	
			Somewhat accessible	2	
			Somewhat inaccessible	3	

		community? Vulnerable populations are those in community who are less likely to have positive health outcomes (e.g., low income persons)	Very inaccessible	4	
			Don't know	98	
17b		What are facility-related barriers and challenges for marginalised and vulnerable populations in the community to access RMNCH+ care? (Please tick all that apply)	Transportation challenges	1	
			Discrimination / perceived discrimination	2	
			Cultural / religious barriers	3	
			Not aware of service availability	4	
			Language barriers	5	
			Lack of time (provider)	6	
			Cost barriers	7	
			Long wait times for treatment	8	
			Lack of understanding of the documentation needed to receive services (eg mixed messages about what is needed)	9	
			Other (specify)	88	
17c		In your opinion, what are the key gender barriers limiting access and use of RMNCH+ services?	There are no gender barriers	0	
			Operating hours	1	
			Cost of services	2	
			Financial barriers	3	
			Waiting times	4	
			Decision-making power	5	
			Husband/father authorization/ supervision of care	6	
			Not comfortable with gender of provider	7	
			Other (specify)	88	
17d	Clinic and Hospitals	Is your facility working to mitigate facility-related gender barriers to access and use of care?	Yes	1	
			No	0	
			Don't Know	14	
			Other (specify)	88	

SECTION E:
RMNCH+ management improvements including MOH and RMS training, guidance, facility based supportive supervision and integrated service stations and data sharing.

18	Clinic and Hospitals	To what extent do you agree with the following statements? *HSD managerial and provider training contributed to improvements in the following areas:*	**Strongly Agree (1)**	**Somewhat Agree (2)**	**Some what Disagree (3)**	**Strongly Disagree (4)**	**Not Applicable (98)**
18a		• *RMNCH+ service delivery management, organization, or approaches (e.g. in how you provide care and support to clients and community members)*					
18c		• *Organisation of care (provider time)*					
18d		• *Community understanding of RMNCH+ services*					
18f		• *Materials for IEC*					
18g		• *Behavior of providers in addressing clients' needs*					

19	Clinic	Have you received the MCH Instruction Booklet for management of RMNCH+ been distributed and used?	Yes, distributed and used	1	
			Distributed, but not used	2	
			Not distributed	3	
			Other (specify)	88	
			Not applicable	99	
			Don't know	98	

We have come to the end of our questions. Thank you for your time and participation in this interview.

HSD Health Facility Checklist and Observation Guide

Date:

Name of Health Center:

Location:

Person conducting Checklist and observation:

Time:

NOTE: FIND THE PERSON IN CHARGE OF THE FACILITY AND CONTINUE WITH THE CHECKLIST AND OBSERVATIONS

I. General Information

Facility Name	[Note: Integrated to insert facilities; Hazem has facility codes]
Type of facility	Primary Health Center (MoH) Comprehensive Health Center (MoH) NGO Health Center MoH Hospital RMS Hospital Other
Health Directorate	
Number of registered clients: **(White Cards or logbook)**	Jordanians: Syrians: Other:
Number of physicians and specialists	General practitioners (GPs): Family medicine: Pediatrics: Gynecologist: Neonatologist: Other:
Number of nurse & midwives (WCH only)	Nurse: Midwives:
Total number of health center staff (clinic only)	
Length of time facility been supported by HSD	
Community Health Committee (Clinics only)	Yes/No
Community Health Worker Outreach program (Clinics only)	Yes/No

II. HSD Interventions & Achievements

1. Which HSD Interventions has the Health Center participated in?

Checklist questions for facility manager

Activity	Yes/No	Year(s) of activity	How many staff participated in the activity	Are these staff still working at the facility
ISDIC cycles (Collaborative session 2017 or 2018)				
Training				
○ Client Service Station				
○ Implanon Insertion and removal				
○ IUD insertion for Midwives				
○ RMNCH+ management Training (RMNCH+ Manager Certification Program)				
○ Clinical pathways and procedures				
○ Newly Hired GP Training				
○ Comprehensive counseling for Women and Child Health Services (WCH) -- General				
○ Comprehensive counseling for Women and Child Health Services (WCH) -- Family Planning Counselling				
○ Facility based supportive supervision for Health Area Directorates (i.e., Clinical Performance Monitoring Checklists)				
○ Technical capacity for Community Health Committees				
○ Improved clinic development and utilization of new medical records (i.e., Documentation and logbook)				
IEC materials orientation				
Screening CU5 and pregnant women for anemia				
Recognition program				
Other				

2. Has the facility been formally recognized as part of the **USAID HSD Recognition Program**? *(Explanation: The Recognition Program objective is to recognize SDPs that demonstrate improved quality of maternal and child health service provision, focusing on*

the incremental progress of the MOH facilities and NGOs clinics toward achieving improved integrated maternal and child health outcomes) YES/NO

In which areas have you been **assessed** by HSD (via HCAC)? [tick boxes]

- Maternal and child health service provision
- Health care management
- Client integrated services
- Community

In which areas have you been **formally recognized**? [tick boxes]

- Maternal and child health service provision
- Health care management
- Client integrated services
- Community

III. SERVICES ACCESS AND AVAILABLITY

3. Does the Facility have a client service station? YES/NO

Observation related to Client Service Station and flow

Client service station is a stand-alone, visible service entry point	Yes	No	Comments
If no, are CSS services available without visibility			
Do all RMNCH+ clients receive information from the CSS?			
Is the nurse in the CSS welcoming and friendly (tone is respectful, polite, helpful)?			
Are all clients treated equally regardless of nationality, poverty, gender etc. (non-discrimination)?			
Do they receive an guidance for additional services (e.g. FP, vaccination, anemia screen for children, etc.)? Ex. A postpartum woman is offered FP.			
Can their discussion be overheard by others (privacy, confidentiality)?			
Do they appear interested in the additional service suggested to them (i.e. client ask for information/ has questions)?			
Do they receive a Direction Booklet/ card?			
Do they obtain the additional service during this visit?			

4. How many clients (approximately) are in the waiting area when you arrived?

5. How many clients (approximately) are in the waiting area when you left the clinic?

Observation: Less than 5 Between 6-15 More than 15 More than 30

6. Approximately, how long on average is the waiting time for the client to be called for the service?

Observation: Less than 30 minutes 30 mins. to 1 hour 1-2 Hours More than 2 hours

7. What are the opening hours of the facility? _____

8. Are all services offered every day? YES/NO Explain _____

9. Is a doctor available every day? YES/NO Explain _____

10. Does the health facility appear welcoming? YES/NO

Observation: Service Environment specific issues

Which service appears to have the highest client load today?	Drop down menu: 1. Antenatal Care 2. Child health including growth and development and curative care services; 3. Family Planning, 4. Postnatal Care, 5. Immunization 6.Nutrition counselling	Comments
Are some services not available today?	Drop down menu: 1. Antenatal Care 2. Child health including growth and development and curative care services; 3. Family Planning, 4. Postnatal Care, 5. Immunization 6.Nutrition counselling	Explain
Which services appear to be sufficiently staffed?	Drop down menu: 1. Antenatal Care 2. Child health including growth and development and curative care services; 3. Family Planning, 4. Postnatal Care, 5. Immunization 6.Nutrition counselling	Explain
Does the health center appear to be run efficiently (e.g. staff is calm, not overburdened, friendly, informative, clean, in good condition, etc.)	Yes/No	Explain
Is the room where FP, ANC, PP and vaccination clean and welcoming?		
Is the toilet for clients functioning and in good	Yes/No	Explain

condition?		
Are their IEC materials available for clients on family planning, ANC, other topics?	Yes/No	Explain
Are their posters and public health messages in good condition on the walls?	Yes/No	Explain
Are the posters and public health messages readable (font size, text style, bullets, too much information to be understandable, etc)	Yes/No	Explain
Do clients appear to be reading/observing the public messages and IEC materials?	Yes/No	Explain
Are there chairs and benches in the waiting room?	Yes/No	Explain

IV. FAMILY PLANNING

11. Are family planning services and counseling offered? YES/NO

[NOTE: ASK TO SEE THE PLACE WHERE FAMILY PLANNING CLIENTS ARE SEEN BEFORE THEY HAVE THEIR CONSULTATION AND INDICATE WHICH OF THE FOLLOWING ACTIVITIES ARE ROUTINELY CARRIED OUT THERE]

Observation of Family Planning Services

Is there a designated family planning counselor available?	*YES/NO*	Explain
Is there a private, confidential location for FP counselling?	*YES/NO*	Explain
Are job aids used for the counseling?	*YES/NO*	Explain
Are all 5 modern methods available today	Drop down list: (tick all that apply) o Oral Contraceptive Pill (COC/POP) o Injectable Contraceptive (e.g. Depo Provera) o Implant (“Implanon”, “rods”) o IUD o Tubal Ligation referral o Male Condoms o LAM	*Explain stock outs or unavailability*
Is a trained provider on the premises to provide Implanon and IUDs?	*YES/NO*	Explain

V. ANTENATAL CARE, POSTPARTUM

12. Is Antenatal/Postpartum care being offered in the facility today? YES/NO

ASK TO SEE THE PLACE WHERE ANTENATAL CLIENTS ARE SEEN BEFORE THEY HAVE THEIR MEDICAL CONSULTATION AND INDICATE WHICH OF THE FOLLOWING ACTIVITIES ARE ROUTINELY CARRIED OUT THERE

Observation of Antenatal and Postpartum care services

Are there designated nurses or midwives for ANC/PP?	YES/NO	Explain
Is there a private, confidential location for ANC/PP services and counselling?	YES/NO	Explain
Are job aids used for the ANC/PP?	YES/NO	Explain
Are the following selected supplements and screening tests available today?	Drop down list: (tick all that apply) ○ Folic acid supplementation ○ Anemia screening (name test) ○ Iron supplementation ○ Diabetes Screening	*Explain stock outs or unavailability*
Are breastfeeding support groups offered to new mothers?	*YES/NO*	Explain
Is there a functioning laboratory facility in working condition with the consumables necessary to conduct PNC and ANC and delivery (i.e., blood tests, lab tech in, equip/consumable, gloves)? Please check for quality and operability of lab equipment and consumables.	*YES/NO*	Explain
Is there a lab technician available today?	YES/NO	Explain
In PHC, where do you send your lab tests that need to be done?	YES/NO	Explain
How long does it take to get the results of the lab tests?	YES/NO	Explain time it takes to get results on average.

13. Are the necessary equipment, drugs and vaccines available (see table below)?

FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN ADJACENT ROOM.

Observations of necessary equipment, drugs and vaccine that should be functional and available

Functioning exam light for pelvic exam	YES/NO	Explain
Table or bed for gynecological exam	YES/NO	Explain
Sterile and disposable gloves	YES/NO	Explain
Sharps container	YES/NO	Explain
At least five or more 2-ml or 3-ml syringes (with 21 guage needles)	*YES/NO*	Explain

Already mixed disinfectant solution	*YES/NO*	Explain
Blood pressure apparatus	YES/NO	Explain
Stethoscope	YES/NO	Explain
Thermometer	YES/NO	Explain
Adult weighing scale	YES/NO	Explain
Newborn scale	YES/NO	Explain
Vaginal spectrum	YES/NO	Explain
Sonic aid (Handheld Fetal Heart Detector)	YES/NO	Explain
Refrigerator for vaccines	YES/NO	Explain
IUD kit(s) if the center is providing IUD insertion/removal services	YES/NO	Explain
Instrument trolley	YES/NO	Explain
Autoclave (may be in MCH or other section	YES/NO	Explain

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