Jordan Association for Family Planning and Protection : Needs Assessment

August 2008

Submitted to:
Dr. Basma Khraisat
Cognizant Technical Officer
USAID/Jordan

Submitted by:
Dr. Rita Leavell
Project Director
PSP for Women's Health – Jordan

Prepared by:
Kevin Kingfield
Dr. Carlos Cuellar
Dr. Nagham Abu Shaqra
Dina Sabbagh

August 28, 2008

Private Sector Project for Women's Health-Jordan
PSP Task number 802
Contract number: GPO-I-802-04-00007-00

ACKNOWLEDGEMENTS

The team would like to thank USAID for their generous financial support for this assessment and the Private Sector Project for Women' Health for its technical and administrative support. In addition the team is very appreciative of the openness of all of the Jordanian Association for Family Planning's board and staff.

This report would not be possible without their time and commitment to facilitate access to data and to visit a number of clinics. The ongoing efforts of JAFPP to maintain quality, affordable services to low income women under very trying circumstances are commendable.

Kevin Kingfield, Consultant, Ohanlon Health
Dr. Carlos Cuellar, VP International Health, Abt Associates
Dr. Nagham Abu Shaqra, QA specialist, PSP Women's Health
Dina Sabbagh, consultant, PSP Women's Health

TABLE OF CONTENTS

EXECUTIVE SUMMARY

INTRODUCTION

A four member team (Kevin Kingfield, Dr. Carlos Cuellar, Dr. Nagham Abu Shaqra, Dina Sabagh) conducted a needs assessment of the Family Planning and Protection (JAFPP) during the period August 1-18, 2008. The assessment was conducted with United States Agency for International Development (USAID) support through the Private Sector Project for Women's Health (PSP). JAFPP is at an important crossroads and today faces a difficult challenge experienced by many other mature family planning non-governmental organizations (NGOs): how to increase family planning/ reproductive health service provision, while at the same time maintaining and improving the quality and efficiency of its services.
USAID requested that PSP help the Mission determine how to support JAFPP through this transition.

The scope of work for this assessment is included in Appendix 4 of this report. The objectives of the JAFPP assessment were to develop recommendations to maintain and improve service quality; expand family planning/reproductive health services and clientele; increase access to quality reproductive health services; and improve JAFPP's financial stability and cost efficiency.

FINDINGS

1) Recent JAFPP events including 3 boards of directors in 3 years; the termination of support from USAID and IPPF; loss of an important income stream from the Ministry of Finance (interest from a local currency fund) and closure of 3 clinics and 2 mobile clinics have sharpened focus on a number of challenges facing the organization. The most important challenges to enhance JAFPP service delivery include:

   a) governance issues that result in too many management/administrative roles and responsibilities resting at board level;
   b) demand for a narrow range of services is flat even though excess capacity is available;
   c) access limited by a lower number of fixed clinics and limited clinic hours;
   d) quality of care and ability to expand access is threatened by low staff morale; and a
   e) Growing financial gap where current costs are exceeding current revenues.

2) At all levels, board, management and staff, there is an openness to consider a wide range of options for the future. The temporary Board of Directors (appointed by the Minister of Social Development) is leading efforts to stabilize and improve the situation. Openness to change is due in part to new faces at the board and General Assembly levels. The General Assembly membership has increased by 150 members and hope is widespread that it will be willing to make significant governance adjustments once elections are held late in 2008.
3) Overall the contribution of JAFPP to the national family planning effort appears significant and is generally exceptionally efficient. Compared to a much larger family planning service delivery system operated by the Ministry of Health (MOH), JAFPP's effectiveness and efficiency is impressive. The estimated 250 female providers at the MOH annually insert about 72 IUDs/provider. The 21 JAFPP providers each insert on average 601 IUDs.
4) One competitive advantage that JAFPP has is an all female staff – critically important for women considering IUD insertion. JAFPP clinics visited are uniformly warm, clean and generally attractive. All clinic staff is well trained and together offer a warm, supportive environment for women. In addition a female social worker provides critical counseling to women making decisions on reproductive health.

5) JAFPP appears to be attracting a very desirable and unique market. Client profiles for public, private and NGO providers in a 2004 study based on 2002 DHS indicate JAFPP attracting an appropriate clientele. 67.7% of clients came from middle income quintiles (middle poor, middle, middle rich). The public sector served a generally lower income mix and the private sector a generally wealthier client base. A follow up study using latest Demographic and Family Health Survey (DHS) figures is due in the near future. Spot checking and JAFPP statistics indicate no reason to suspect any major changes in JAFPP's target clientele.

6) After accounting for income earned from investments and all operating revenues, estimated annual total costs will soon exceed annual revenues by about 250-300,000 JD. If this current gap level continues, the reserve funds could be exhausted in about 10 years. If nothing is done, staff will likely desert the organization causing its demise before the reserve fund is exhausted. In spite of the gloomy nature of current accounts, further financial shocks are likely. In the larger economy inflation is growing at a 13.3% annual rate for the first 6 months according to the Department of Statistics. JAFPP cannot survive without an infusion of funds just to maintain the current levels of services. However, infusion of funds without improving governance will likely be counterproductive.

RECOMMENDATIONS

7) The definition of roles and responsibilities between the board of directors and management need to be redefined in order to establish oversight and accountability. Already in place is a JAFPP commitment to ensure more transparent board elections. The process of delegation of authority from board to staff should begin early. Bylaws need to be rewritten. A formal authority chart with well defined levels and limits should be the framework to operationalize the delegation process while maintaining proper control. As an initial step in this process general agreement on these two items between JAFPP and USAID should be a precondition for support. Early indications from JAFPP board and staff are that agreement can be reached soon.

8) In order to stabilize and maintain the current situation of quality, supply and access the most urgent issue that needs to be addressed is the development and implementation of a rational, transparent salary scale, benefits, and performance based salary system for doctors and staff. Some immediate salary increases are needed just to ensure continued commitment to quality care by the current clinic staffs. A higher salary for doctors will also be important for any expansion of the current 16 clinic system. Consideration should be given to differential salaries for those willing to work in more difficult and remote clinic settings. This implies establishing new policies such as creating a salary scale that accounts for time served and a performance based salary system that encourages higher levels of productivity.

9) On an urgent basis provide all current clinics with new equipment (e.g. ultrasound) and supplies; when purchasing equipment and supplies consideration should be given to the possible expansion in the number of clinics from 16-19.

10) The goals of the support plan should be: a) Ensure that current quality family planning services are maintained; b) Increase the number of family planning clients [a proxy objective would be a rise in the number of IUDs inserted from the current 12,895 units to at least 16,000 units at the end of year 5]; c) Expand the method mix to focus more on providing other long term methods including implants and tubal ligation; and d) Increase the longer term financial viability by decreasing the amount of principal drawn annually from the JAFPP reserve funds.

11) The support plan should be implemented through a cooperating agency. A direct grant is possible but given the wide range of interlinked activities needed, a significant amount of oversight and management would be required.

12) The support plan should provide funds on the basis of agreed upon percentage of approved annual JAFPP budgets. The percentage of budget support should start at less than 100% of needs and grow to a larger percentage in each succeeding year. For example, in Year 1 only 65% of annual operating expenses will be provided; in Year 2 based on the achievement of agreed milestones 75% of the operating budget will be provided. By Year 5 all, or near all, of the entire proposed operating budget will be provided. This approach would limit USAID risk of unforeseen events that could derail progress or as in the case of the Cost Recovery Project result in a premature end of activities. The approach would also provide positive incentives to JAFPP to continue to meet overall objectives.

ACRONYMS

CYP	Couple Years of Protection
DHS	Demographic and Family Health Survey
FP	Family Planning
HPC	Higher Population Council
HR	Human Resources
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
JD	Jordanian Dinar
JSI	John Snow International
JAFPP	Jordanian Association for Family Planning and Protection
MCH	Maternal and Child Health
MOH	Ministry of Health
MOSD	Ministry of Social Development
NGO	Non-Governmental Organization
PSP	Private Sector Project for Women's Health
RH	Reproductive Health
USAID	United States Agency for International Development

Principal Findings and Recommendations

I. Background

1) JAFPP is at an important crossroads and today faces a difficult challenge experienced by many other mature family planning NGOs: how to increase family planning/ reproductive health service provision, while at the same time maintaining and improving the quality and efficiency of its services. USAID has requested that the Private Sector Project for Women's Health (PSP) help the Mission determine how to support JAFPP through this transition and in turn contribute to increased contraceptive prevalence in Jordan.

2) The Jordanian Association of Family Planning and Protection (JAFPP) founded in 1964 has grown over the years to a national health delivery system that today includes 16 primary care clinics.

3) JAFPP receives its clinic licenses from the Ministry of Health but the organization itself is organized under the Charities Law (Law 33 1966) and functions under the auspices of the Ministry of Social Development.

4) Although the initial focus was on family planning an increasing emphasis has been placed on expanding to other reproductive health services. Currently JAFPP clinics split their services on average 58% FP and 42% reproductive health. Over 96% of Couple Year Protection (CYPs) delivered by JAFPP are from IUDs.

5) A new NGO law governing the organization has been passed by Parliament and is set to take effect soon. The major change will be to grant the Minister of Social Development (MOSD) authority over new grants and loans to NGOs.

6) A long affiliation as a chapter within the International Planned Parenthood Federation (IPPF) was ended in 2006. Funding from IPPF had been declining for years and at the end there was a conflict between IPPF policy on abortion and Jordanian laws and culture.

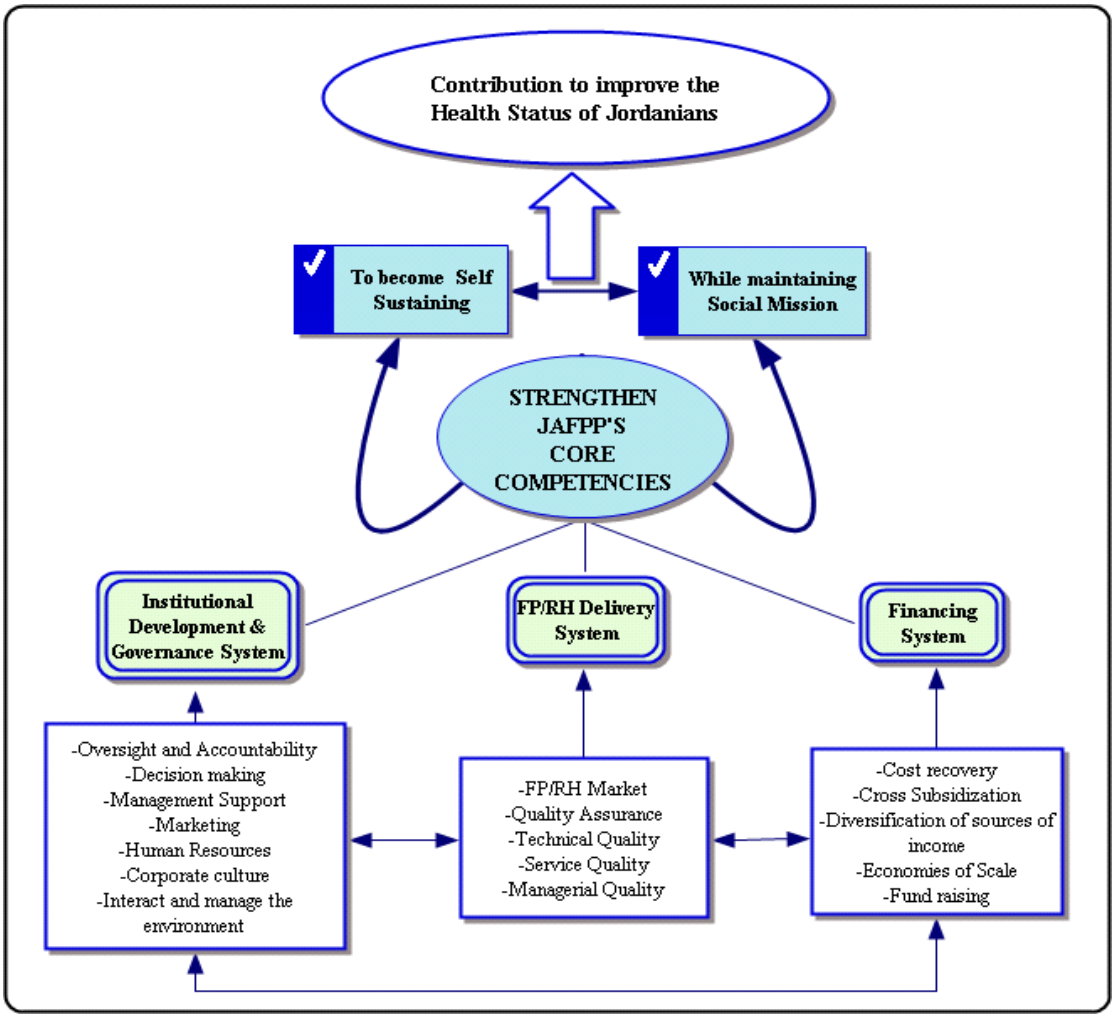
7) All stakeholders interviewed (JAFPP board and staff, USAID and cooperating agencies, Higher Population Council (HPC) Ministry of Health/Maternal Child Health Division(MOH/MCH) indicated that JAFPP has played and should continue to play an important role in the national family planning program. Affordable services of high quality by an all female staff are attracting an important clientele. An all female staff; clean, professional clinics: high quality IUD insertions; and excellent counseling are key features of JAFPP clinics. Further, JAFPP provides FP/RH services to a unique clientele that serves a market segment with socio economic characteristics different from the public and private sectors.

8) Stakeholders look forward to a strong and vigorous JAFPP that is able to meet the FP needs of its target market of low income clients across the country during the coming decade.

9) Under the USAID Strategic Objective of Improved Social Sector Development and Guidance is the most applicable Intermediate Result that this assessment addresses: Improved health status for all Jordanians through improved quality of and access to health care services and information.

10) The assessment team organized its review of JAFPP using the following broad approach focusing on the three major pillars of Governance/Institutional Development, Service Delivery/Quality and Access and Financing System :

Chart 1



11) Recent JAFPP events including 3 boards of directors in 3 years (a current temporary board will carry on until new elections by the end of 2008); the termination of support from USAID and IPPF; loss of an important income stream from the Ministry of Finance (interest from a local currency fund) and closure of 3 clinics and 2 mobile clinics have sharpened focus on a number of challenges facing the organization. The most important challenges to enhance JAFPP service delivery include:

a. governance issues that result in too many administration/management roles and responsibilities resting at board level;
b. demand for a narrow range of services is flat even though excess capacity is available;
c. access limited by a lower number of fixed clinics and limited clinic hours;
d. quality of care and ability to expand access is threatened by low staff morale; and a
e. Growing financial gap where current costs are exceeding current revenues.

II. Current Operations

A. Governance

12) At all levels, board, management and staff, there is an openness to consider a wide range of options for the future. The temporary Board of Directors (appointed by the Minister of Social Development) is leading efforts to stabilize and improve the situation. Openness to change is due in part to new faces at the board and General Assembly levels. The General Assembly membership has increased by 150 members and hope is widespread that it will be willing to make significant governance adjustments once elections are held late in 2008.

13) Another key factor in the change in attitude is the financial pressure being felt by JAFPP (see below **C. Financial Gap – Viability**).

14) The institutional mission as a family planning organization serving low-income Jordanian women appears to be clear in minds of the Board of Directors, executive team and employees in the clinics.

15) The type of prevalent culture is in between a power-centered and a role-centered organization. Power is highly concentrated at the board level where members believe that their role is to manage and not to govern the organization. The board monopolizes decision-making using a top-to-down approach. In consequence, the Executive Director and executive team mere executers of decisions that are not based on information. A clear example of this is the decision to close the Al-Ashrafieh clinic, a highly populated zone of East Amman.

16) Delegation practices could be more formalized. The Senior Executive Team is not empowered to make decisions and manage day to day operations. As an example, the Executive Director has no authority to sign checks regardless of the amount.

17) Most policies are implicit and trend to enforce a centralized and uniform system across the board. Most of these policies do not take into account the socio-economic differences among the populations served. Pricing list and strategies are the same in all clinics, staffing patterns are almost the same.

18) A new board with new roles and responsibilities is likely before 2009. In spite of the new optimism and openness, resistance to change may not have disappeared. Imbalances in roles and responsibilities will likely continue after elections.

19) Current bylaws are unsuitable for JAFPP future success. Current bylaws were amended by a resolution of the JAFPP General Assembly in July 1998 and approved by the Ministry of Social Development in August of the same year. The Board of Directors' powers are a mix of policy and management. There is no definition of the roles and responsibilities for either the board or Executive Director. As an example, board has the hiring and firing power not just of the Executive Director but all employees (Article 29). Powers assigned to the Executive Director are not defined at all. Article 30 describes some tasks that he/she has to perform to support the board.

20) No procedures or plans have been agreed upon by the current board to change governance to meet new challenges. However, the current board president is clear in his support for change. An example of this commitment is his offer to consider changes to the bylaws by the current temporary board.

21) The capabilities of the current staff will need close monitoring at an early stage. Senior staff has not had much experience in actually managing the organization. With training and support they will likely be able to grow into their new roles successfully, but if not, speedy replacement will be required.

22) The combination of years of board turmoil and interference, funding gaps, and external shocks (rising costs, female doctor shortage) has left staff feeling vulnerable.

23) New bylaws and an openness to delegate authority to the management will provide a base from which JAFPP can promote increased family planning access and coverage to Jordanian women. A formal authority chart with well defined levels and limits should be the framework to operationalize the delegation process while maintaining proper control.

24) The organizational structure is composed of a General Assembly(376 members), a Board of Directors, and an Executive Office supported by the following: an Information Services Unit, a Marketing Unit (vacant), a Fundraising Unit (vacant), a Finance and Administration Department, a

Community Services Program Division, and a Clinic Services Division. Activities under the Community Services Program Division include the youth program, male involvement, advocacy and women's empowerment. The Clinic Services Division manages the network of 16 clinics, including the Model Clinic located in the headquarters. Current staff totals 102: 15 at headquarters and 87 in 16 clinics.

25) There is no Human Resources (HR) department. Personnel are managed on an ad-hoc basis. Procedures for planning, selection and recruitment of staff do not exist. No formal salary scale for employees and employee benefits, like Social Security exist. These two factors are the main cause of employee dissatisfaction and low morale. The board holds the power to appoint and terminate employee services "after consulting with the executive director" (Article 29, 13, JAFPP Charter). Because of all these, JAFPP's ability to attract and retain talented staff is extremely low. One critical issue is the scarcity of female doctors, which is the most important resource to deliver the FP/RH services to the population. The Central Office discontinued appraisal reviews. Currently there is no is performance based system for clinic employees, which stopped after the end of the JSI's Cost Recovery project. Training opportunities are very limited and is another cause of dissatisfaction of employees. Turnover is high and has increased significantly in 2006 and 2007. During these years 44 employees left JAFPP being 6 doctors, 3 nurses, 7 social workers, 5 clinic clerks, 5 cleaners, , and 16 employees from the central office including the HR manager, the Marketing manager and 5 marketing representatives.

26) The current Management Information System is collecting both clinical and financial information. However, information produced is not used in decision-making. Reports are neither oriented to decision making nor structured to respond to the needs of three different audiences: board, senior executive team, and clinics.

27) The Marketing Department positions are not filled. During the USAID supported Cost Recovery Project (2001-2006) the marketing interventions demonstrated the potential positive impact of actively promoting the organization. However, the Community Services/Programs Division is still staffed and budgeted to implement a general public relations function. The current level of activity is low due to lack of budget.

28) Based on review by USAID the Administration and Finance Department appears to have adequate financial controls in place. *This report will be attached at a later date.*

B. Service Quality, Client Demand and Access

29) Overall the contribution of JAFPP to the national family planning effort appears significant and is generally exceptionally efficient when compared to the MOH. An indicator of JAFPP's efficiency is the number of IUDs inserted per outlet. The MOH with over 400 outlets inserts about 18,000 IUDs per year or less than 5 per outlet; JAFPP with only 16 clinics inserts almost 13,000 IUDs annually or over 800 insertions per outlet. This is somewhat misleading because some MOH units are not staffed by female providers. When the figures are adjusted for available providers the effectiveness and efficiency of JAFPP is still impressive:

Table 1

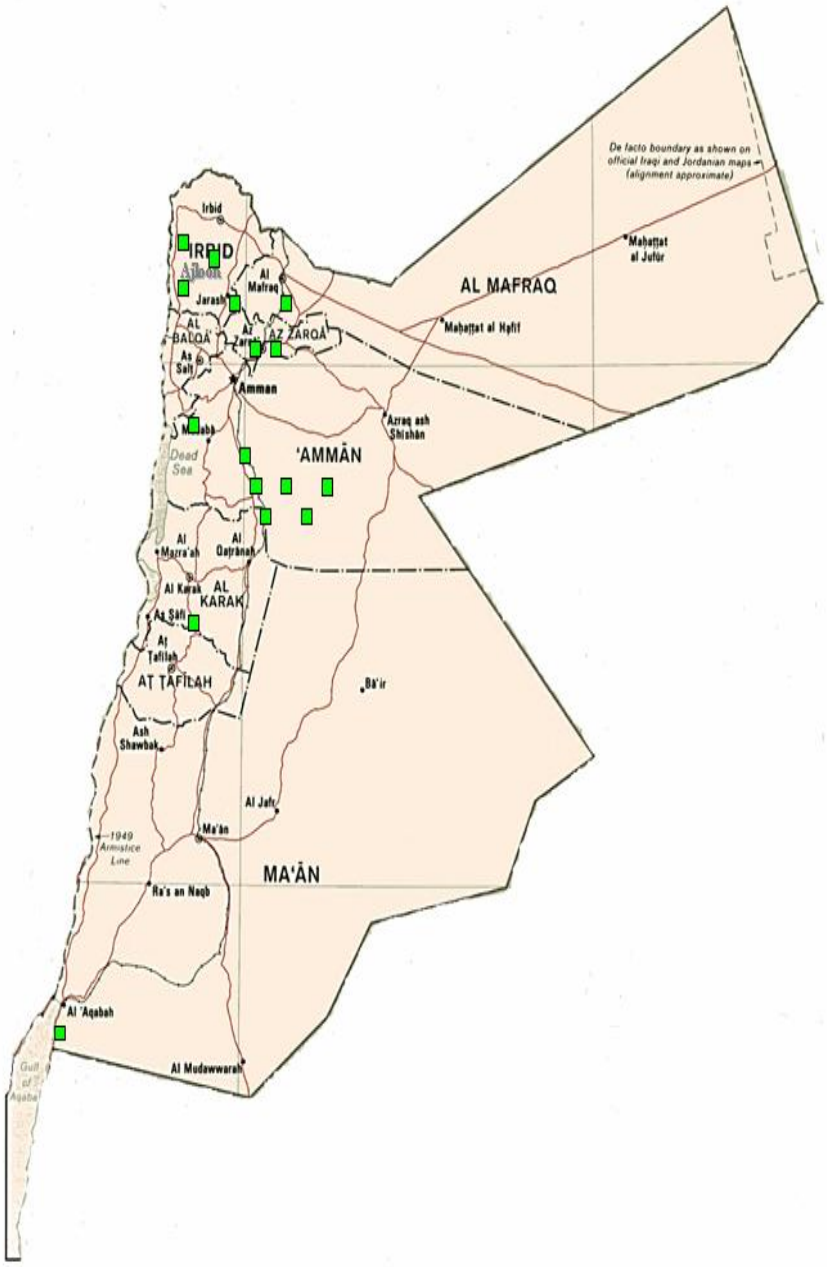
Average number of IUD inserted in MOH and JAFPP units, 2005-2007

	2005	**2006**	**2007**
# of IUD inserted in the MOH	16,715	17,358	18,032
# of estimated MOH IUD providers*	250	250	250
Average annual insertions/provider	***67***	***69***	***72***
# of IUD inserted in JAFPP	14,581	13,256	12,627
# of JAFPP IUD providers	23	23	21
Average annual insertions/provider	***634***	***576***	***601***

*MOH doctors =100; IUD trained midwives = 150

30) One competitive advantage that JAFPP has is an all female staff – critically important for women considering IUD insertion. All clinic staff is well trained and together offer a warm, supportive environment for women. In addition a female social worker provides critical counseling to women making decisions on reproductive health. The MOH has not been able to staff all outlets with females and do not generally offer counseling. It is not surprising that even when MOH female doctors are working in a nearby outlet, JAFPP is the center of choice for family planning services. In JAFPP's Sweileh Clinic neighborhood a busy MOH clinic staffed by a female doctor is well located with easy access. The MOH family planning clients are running about half the level of the JAFPP clinic, and the number of IUD insertions is about 7 per month at MOH vs. almost 30 per month at JAFPP.

31) JAFPP operates 16 clinics distributed in 9 out of the 12 Governorates. Eight of them are located in the Amman-Zarqa area. The geographic distribution by Governorates is the following:



a) 6 in Amman: Sports City, Wadi Essir, Sweileh, Hussein, Mahatta, and Qwaismeh (Central Region)
b) 2 in Zarqa: Zarqa and Rusayfa (Central Region)
c) 2 in Irbid: Irbid 1 and Irbid 3 (North)
d) 1 in Ajloun (North)
e) 1 in Jerash (North)
f) 1 in Mafraq (North East)
g) 1 in Karak (South)
h) 1 in Aqaba (South)

32) The package of services is standardized across a one-tiered clinic network. The package focuses on Family Planning services and secondarily in Reproductive Health Services. FP services offered are counseling and provision of FP methods (IUDs, oral contraceptives, condoms, injectables) and premarital counseling. Non-Family Planning services include: gynecological exam, general exam, antenatal care, infertility check up, breast exam, and Pap smear. The package also includes basic lab tests as pregnancy test, routine urine test, hemoglobin, fasting blood sugar, cholesterol and triglycerides. FP products are obtained through the MOH's supply system where JAFPP is an important and integrated part of it. FP commodities are sold to clients at reduced nominal prices. JAFPP clinics do not sell other pharmaceutical products.

33) JAFPP has developed over the years technically sound procedures and provided the necessary training in providing FP services and counseling. Current quality of care appears to be high. The Private Sector Project (PSP) and the MOH/MCH have assessed JAFPP clinics recently and generally are very satisfied. The PSP assessment was quite a rigorous process (approved by the Jordanian Medical Council) and included a Quality Assurance and Certification program for JAFPP physicians for family planning, breast cancer, and reproductive health/sexually transmitted infections. The assessment included an evaluation of the facilities readiness to provide quality services. The main problem observed during this assessment is insufficient technical supervision at the clinical level. The director of medical services is currently focused on coordination and has no leverage to perform supervision activities because of low morale. Finally, the current low level of staff morale has the potential to affect quality of care without speedy action to address staff concerns about organizational viability, board authority/governance and salaries.

34) The payment of providers is based on a fixed salary. Fixed salaries make costs predictable but can generate risks in quality and the capacity to respond to demand fluctuations. This is probably the case in JAFPP. There is no performance based salary system. A reward system was used and discontinued during the Cost Recovery Project (2001-2006). Providers appreciated the system but we found no evidence of a linkage to performance. Furthermore, the way rewards were calculated was only known by the board and perhaps by the Executive Director. Employees who received this benefit found the system lacked of transparency and was illogical.

35) The current JAFPP core service remains FP and particularly IUD insertion. In 2007 IUDs accounted for over 96% of CYPs generated.

36) The relative decline in market share illustrated by the last Demographic and Family Health Survey 2007 (DHS) does not appear to indicate a declining contribution to the national family planning effort but rather the positive result of a growing market that is shared with other important players from public and private sectors. This dynamic is compounded by the nature of the JAFPP delivery system: a fixed and relatively small number of primary care clinics.

37) Recent declines in client demand reflect the static nature of a clinic based delivery system that has not expanded but in fact has contracted. JAFPP is currently functioning well at field level delivering high quality services to a stable number of clients. The closure of 3 clinics (plus 2 mobile clinics) since 2006 account for most of the recent decline in client base.

38) Actual demand figures from recent years illustrate a recent stabilization of the client base after the recent board turmoil and resignations, the early end to the Cost Recovery Project and the 2006/07 clinic closures:

Table 2

Annual Client Increase (Decrease)

	FP	RH	Total
2004	5.8%	9.2%	7.4%
2005	(7.8%)	6.7%	(0.9%)
2006	(8.1%)	(4.5%)	(6.2%)
2007	(8.3%)	(9.1%)	(8.7%)
2008*	2.7	(2.3%)	(0.2%)

*January-June 2008 compared with same period 2007

39) Clinics in Ashrafiya and Irbid 2 were closed because they appeared unlikely to meet cost recovery goals; Tafila clinic could not recruit a female doctor. These closures plus the discontinuance of the 2 mobile clinics have effectively reduced access to care in the past 2 years.

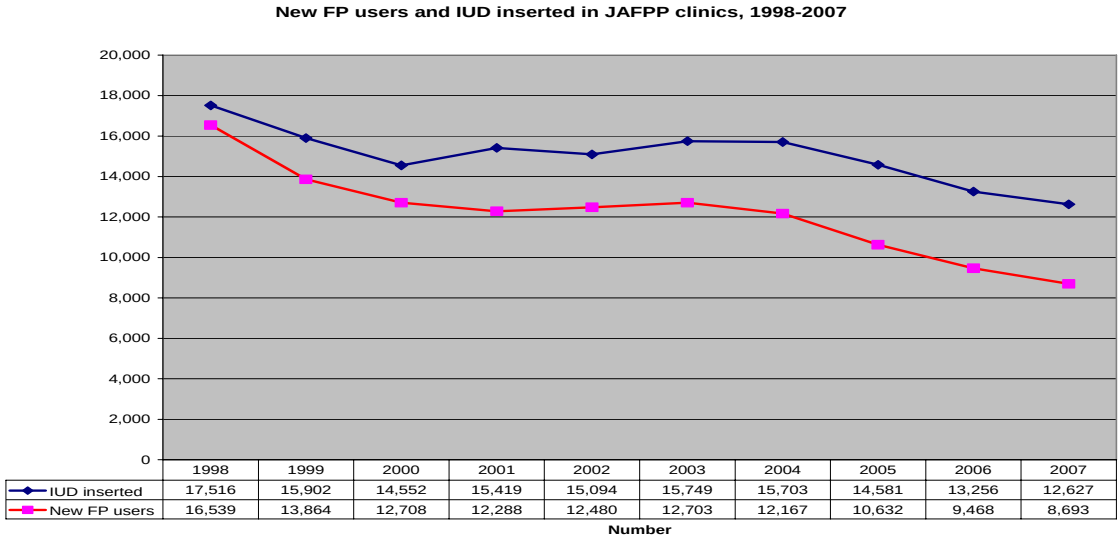
40) A key factor in an individual clinic's utilization statistics is the availability of the clinic's female doctor. Illness, injury, and other long term absences negatively affect a clinic's demand figures.

41) Mobile clinic vehicles are still available but need some work. In general the mobile clinics can increase access for rural and hard to reach clients. The Irbid 1 clinic serves such a market and has used the mobile clinic in the past to improve reach and access. However, the costs of such efforts might not be worth the return in actual demand. Such an investment could have a higher impact if directed at more populous but still underserved urban markets.

42) JAFPP is currently investing in the Aqaba Complex that would result in the opening of 1 new clinic plus create a new income stream from rentals.

43) As an indication of what JAFPP is capable during better years the number of new FP users and IUD inserted over time can be illustrative. Although no adequate description of why performance was the way it was prior to 2003 is available, some earlier statistics from 1998 are:

Chart 2



44) The above indicates that in 1998 JAFPP was inserting over 17,500 IUDs annually. After falling significantly from the peak in 1998 through 2002, demand stabilized. The stabilization and improvement coincides with the start up of the Cost Recovery Project. Although the cause in the drop in demand is not known, the 1998 care levels indicate a much healthier contribution to the national family planning effort. Of some interest is that demand did not drop because of the MOH expansion; that expansion started during 2003/04 during a time of JAFPP growth. The 2001/02 period was also a time when JAFPP increased it prices somewhat to meet cost recovery objectives.

45) The range of clinic services is somewhat limited although they have increased over the years. A larger range of services should increase both the client and revenue base. Ultrasound, pap smear, breast exams and lab are among the most popular services. Increased revenues have resulted. One client is increasingly buying multiple services/visit. New services that fit JAFPP competencies and mission easily would incorporate include premarital counseling, tubal ligation referrals, Implanon implants, post abortion counseling/care and menopause services.

46) Tubal ligation is another area of opportunity for JAFPP. Currently no formal referral system exists that adequately supports a women's transition from the clinic network to a more specialized facility. Patients that are eligible for tubal ligation are directed to the MOH hospitals with no referral form or other formal document. Eligibility criteria applied in MOH for sterilization are very restricted and discouraging for users. In 2007, about 74% of the 527 tubal ligations reported in 22 MOH hospitals were performed during a cesarean section.; 18% through laparotomy and only 8% through laparoscopy, the gold standard for tubal ligation. About 25% of all procedures are being done in the Al Bashir hospital.

47) Current tubal ligation prevalence in Jordan is low when compared to other countries and is likely a contributing factor in the current plateau in total fertility rate reductions. Women with a medical need for the procedure are facing strong provider barriers to care. Women who are fortunate enough to get as far as admittance to hospital have been discouraged /frightened from going through the procedure by hospital staff.

48) JAFPP has the space to establish a tubal ligation facility at the headquarters building. A detailed proposal to do this was made in 2001. However, the costs of such an effort are very high. Another option is to enhance the current referral system to better ensure a women's transit through the system. This could include a formal agreement with a current outside provider(s). Prices would be established with appropriate subsidies and payment mechanisms. A tubal ligation passport would be originated by JAFPP. The passport would guarantee safe transit through to the procedure and could include a personal guide where appropriate.

49) The incidence of IUD removals is high. In 2007 12,895 IUDs were inserted; 7,583 IUDs were removed during the same period. Major reasons given for removal include desire to get pregnant (35.9%); 'rest' (24.6%); change of method not medically indicated (13.3%); any medical reason (17.7%). This may indicate that many women are using the IUD as a short term method. A lower incidence of IUD removal would have an impact on the total fertility rate by reducing the intervals of time where protection is lower.

50) JAFPP clinics visited are uniformly warm, clean and generally attractive. Locations of some clinics are not easily accessible because they are hidden away in the upper stories of larger buildings. This is complicated, in Amman at least, by a new government regulation limited the use of outdoor signage to help clients find an individual clinic.

51) Excess capacity exists at most clinics. Three clinics are running at near or full capacity given current staffing and operating policies. Other clinics would benefit from marketing interventions at the individual clinic level. Although clinic staff (especially social workers) is directed to spend a fixed amount of time among the community they serve, this does not appear to be a high priority activity. Social workers are one of the keys to the excellent quality reviews of JAFPP services for the high standard of counseling they provide. It may be difficult for individual clinics to encourage such a key player to spend sufficient time outside the clinic. Also in at least one clinic social worker has discontinued community mobilization because she has been assigned to cover for a long unfilled position in her clinic. However, more importantly, in recent years the social worker has received little or no direction or support from headquarters. This is especially so after the departure of all marketing department staff. Without support and direction many social workers have tended to focus less on community outreach and instead focus only on counseling.

52) Another barrier to individual clinic marketing and outreach is lack of resources. No budget or staff is available at headquarters or clinic levels. No one is responsible for developing strategies, messages and implementation tools/activities. At the clinic level petty cash is limited to 100 JD making the purchase of small, basic supplies for the clinics a challenge let alone reaching out to the clinic neighborhood.

53) PSP currently operates the only effective community outreach efforts on behalf of JAFPP. The PSP outreach is referring about 2,487 women or 11% of its total annual family planning referrals to JAFPP. Importantly, most (2,300) were for IUD insertion or about 15% of the total IUDs inserted

by JAFPP that year. By establishing a linkage with a staffed JAFPP Marketing Division, a better understanding of individual clinic service areas could lead to an improved level of referrals to JAFPP.

54) However, the individual clinic is the key to increasing demand for current and new services are desirable. Over and above reducing current excess capacity, access and reach could be increased in the current 16 clinic system by expanding the operating hours (current hours are 8-2PM six days a week) and/or adding doctors in clinics where demand is already high.

55) Clinic expansion would contribute to increased access. The number of clients served in areas where recent clinics were closed (Tafila and East Amman) indicates the potential demand. In East Amman's Hashimi district a large, underserved Iraqi population would benefit from a new JAFPP clinic. Establishment of other, new clinic sites where underserved clientele are located is also possible. Prior to any clinic expansion further analysis will be required.

56) The keys to increased access (current and new clinics) are successfully retaining current female doctors and effective recruitment of new doctors.

57) Recruitment of new and retaining current female doctors in Jordan is hampered by a limited supply of female physicians. This in turn limits the ability of the organization to quickly expand the number of clinics. The lack of JAFPP resources and outdated personnel policies are also serious barriers to quick expansion.

58) Previous female doctor recruitment has been possible due to a sufficiently large pool of eligible candidates. Competition from the public sector for female doctors has made recruitment much harder; MOH is trying to rapidly fill about 150 open positions for female staff. Salary plus benefits offered by the MOH recruits now are higher than JAFPP can offer. The private sector also competes for female provides and also offers very attractive benefits. This is leading to staff turnover (8 doctors or about 30% have left JAFPP since in 2005) because the competition's better offer. The strong competition for a limited number of female doctors also makes it more difficult to recruit physicians for more remote areas. In 2006 the clinic in Tafila was closed because no female doctor could be recruited.

59) MOH has addressed the female doctor shortage in recent years by a pilot project which permits trained midwives to insert IUDs. Over 150 midwives have been trained. The future of this pilot is very uncertain; resistance within the MOH is strong. However, if some arrangement could be made for JAFPP to contract the trained MOH midwives, an immediate bottleneck in supply would be possible for this specific service.

60) No salary scale for physicians or staff has been formally established by JAFPP. Policies for annual increases appear unsatisfactory; increases are given as flat sums (50 JD) to all doctors regardless of current salary, years worked, or performance achieved. This has led to untenable situations. One example is the physician with JAFPP for over 10 years is earning less than others with less experience.

61) In January 2006 the Ministry of Health issued guidance that doctors working full time in NGOs are entitled to a 750JD/month minimum salary. Annual raises are authorized at 10% per year for the first 15 years worked and 12%/year thereafter. Even after a 50JD increase given by JAFPP in 2007, the average physician salary is 650 JD.

62) The current low level pay combined with turmoil at the board and feeling of powerlessness has led to a high level of job dissatisfaction and low morale. Talk of protests and legal action to ensure salary guidelines are met has already occurred.

63) Prices (and in general all current functions/activities) of JAFPP appear to be attracting the desired market. Client profiles for public, private and NGO providers in a 2004 study based on the 2002 DHS indicate JAFPP attracting an appropriate clientele. 67.7% of clients came from middle income quintiles (middle poor, middle, middle rich). The public sector served a generally lower income mix and the private sector a generally wealthier client base. A follow up study using latest 2007 DHS figures is due in the near future. Spot checking and JAFPP statistics indicate no reason to suspect any major changes in JAFPP's target clientele. For example according to JAFPP data the last price adjustments in 2004 did not affect the client profile.

64) Price adjustments in the past have been few and minor in substance. The JAFPP social mission to serve the poor has kept all price adjustments minimal. Historically, donor contributions have been important to ensure coverage of any financial gap resulting from insufficient client revenues. Four years have passed since the last minor price adjustment.

65) Some price adjustment is indicated to support medical policy and as a consequence would allow an immediate impact on contraceptive prevalence. For example the price for IUD removals is

40% less than the insertion price. Removal of IUDs appears too easy resulting in high numbers of removal. As a barrier to a seemingly large number of IUD removals, a price increase that matches insertion is indicated. Other barriers could also be considered including limiting removals to one day per week or asking the client to return during her menstruation. Many IUD removals could be a contributing factor in a slower decline of the national fertility rate. If so a lower ratio of removals would be a positive development.

66) Further, some clinics are located in higher income areas where prices across the board appear to be too low in relation to ability to pay. Other price increases are indicated to cover inflation.

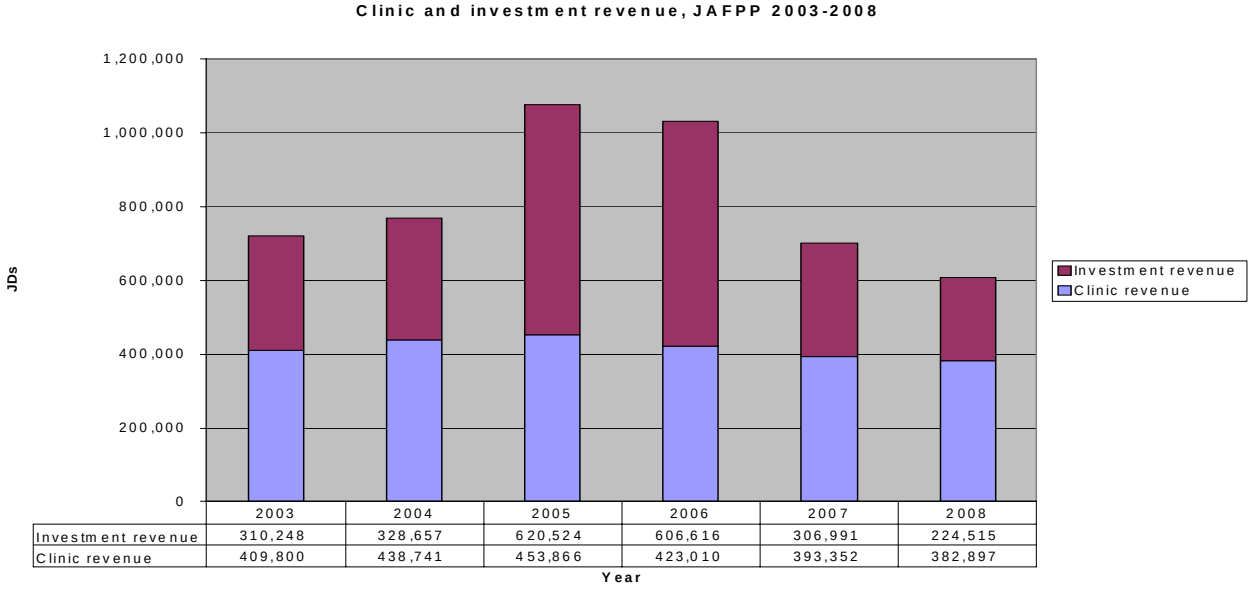
C. Financial Gap – Financial Viability

67) On a global basis, NGOs whose mission is delivering family planning services have rarely been able to match revenues with costs. JAFPP has come closer than most IPPF affiliates in attaining full sustainability. In 1996 income from its training center generated significant income. However, although the current training facility is excellent competition from hotels and other venues offering a better combination of security, food, and general convenience has left the JAFPP center mostly unused today.

68) During the effort to attain sustainability under the Cost Recovery Project early progress was documented but governance issues derailed the process. Today financial sustainability appears a long ways off.

69) JAFPP revenues can be divided into two major categories: Clinic Revenues and Returns on Investments. The returns from investments come from more than one fund but for simplicity sake are referred to throughout this report as the investment fund. Chart 2 below illustrates the contributions of each over the past several years:

Chart 3



	2003	2004	2005	2006	2007	2008
Investment revenue	310,248	328,657	620,524	606,616	306,991	224,515
Clinic revenue	409,800	438,741	453,866	423,010	393,352	382,897

70) The data show an increase in both investment income and clinic revenues to 2005. The investment income varies somewhat more by year. Its recent drop after 2005 is due in part to the loss of one income stream from the Ministry of Finance (local currency fund interest); also in 2006 JAFPP began dipping into the fund principal to pay for operations. The drop in clinic revenue is due primarily to the closure of 3 clinics 2006/07.

71) In 2008 capital expenditures for the Zarqa Villa (30K JD) and Aqaba Complex (400K JD) together with an anticipated shortfall in operating revenues (70K) will further draw from the investment fund principal.

72) The current and projected cost and revenues at the clinic level are illustrated below:

Table 3

	Total Clinic Costs	Total Clinic Revenues	Gap
2003	523,472	409,806	113,672
2004	559,125	438,741	120,384
2005	558,370	453,866	104,504
2006	553,240	423,009	130,231
2007	575,252	393,351	181,901
2008	598,711	388,125	210,586

73) A more complete picture of JAFPP's total revenues and total costs are as follows:

Table 4

	2003	2004	2005	2006	2007	2008 estimated
Direct cost	524,332	568,665	563,811	555,842	576,921.00	598,711
Indirect cost	490,097	376,295	305,902	298,500	201,130.00	751,134
Total Cost	1,014,429	944,960	869,713	854,342	778,051.00	1,349,845*
Clinic revenue	409,800	438,741	453,866	423,009	393,351.73	382,897
Investment revenue	310,247	328,656	620,523	606,616	306,991.27	224,515
Total Revenue	720,048	767,398.	1,074,390	1,029,626	700,343.00	644,316
Net Income	**(294,381)**	**(177,562)**	**204,677**	**175,284**	**(77,708)**	**(705,529)**

*Includes 600K JD for Aqaba Complex

74) The above shows that the USAID funded effort to attain financial sustainability resulted in some early success. The most lasting effect of that effort is an ongoing focus on finances and willingness to consider new options/solutions by current stakeholders.

75) However, the gap at the clinic level (direct costs vs. direct revenues) is already large and growing. To close the gap implies an annual increase of over 50% in client revenues. Increased revenues of any magnitude, however, would require significantly increased investments/costs. In fact even maintaining the current gap will require attention to costs which have been restrained over many years.

76) The large gap in 2008 (total costs vs. total revenues) is due in part to one time investments needed to complete construction of Aqaba Complex and Zarqa Villa. The current temporary board has taken the initiative to finish these two major projects in 2008.

77) End of year financial gaps are financed by JAFPP reserves. JAFPP reserves from all sources total about 3.8M JD. Annual return on these funds is estimated at 7% or about 273,000 JD.

78) After accounting for income earned from investments and all operating revenues, estimated annual total costs will soon exceed annual revenues by about 250-300,000 JD. If the current gap level continues, the reserve funds could be exhausted in about 10 years.

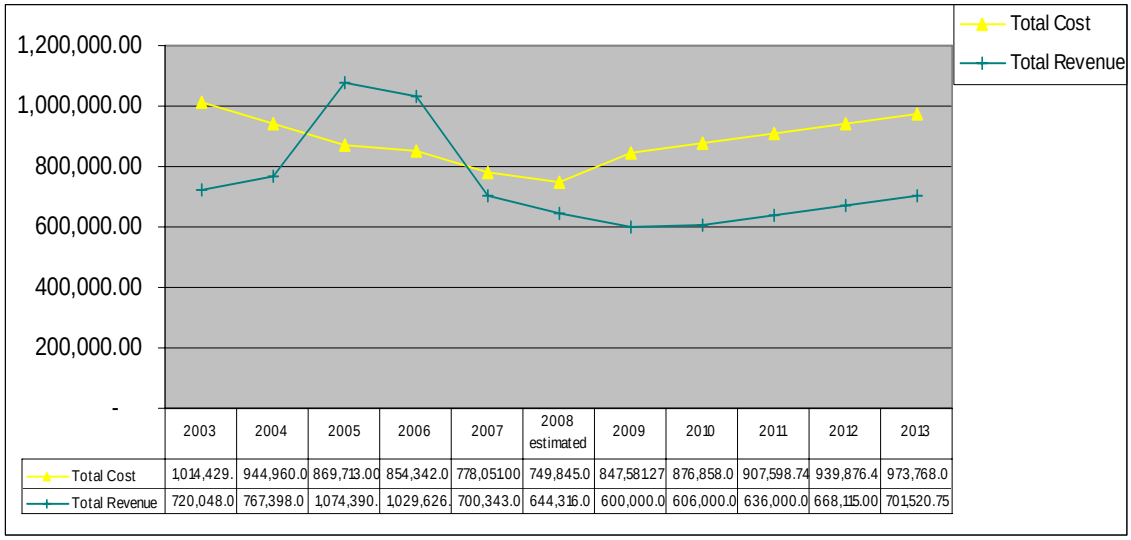
79) If nothing is done, staff will likely desert the organization causing its demise before the reserve fund is exhausted. In spite of the gloomy nature of current accounts, further financial shocks are likely. In the larger economy inflation is growing at a 13.3 annual rate for the first 6 months according to the Department of Statistics. Costs within JAFPP have been restrained over the history of the organization. The policy has been to hold annual salary increases to 3%. This has been successful in other times perhaps due in large part to JAFPP's social mission, a 36 hour work week, historically low inflation and investments in clinic upgrades at critical times.

80) In January 2006 the Ministry of Health issued guidance that doctors working full time in NGOs are entitled to a 750JD/month minimum salary. Annual raises are authorized at 10% per year for the first 15 years worked and 12%/year thereafter. Even after a 50JD increase given by JAFPP in 2007, the average salary is 650JD; seniority is not recognized.

81) In order to comply with MOH guidance the average physician salary would have to be increased by about 30% to 850 JD. This implies an annual cost increase of about 60,000 JD.

82) If physician salaries are increased, other staff will require an adjustment as well. A 15% increase would cover official inflation rates. This would imply an annual cost increase of about 42,000 JD. The following chart illustrates the impact on cost for the next five years assuming a constant 5% annual salary increase after a major adjustment in 2008:

Chart 4



	2003	2004	2005	2006	2007	2008 estimated	2009	2010	2011	2012	2013
Total Cost	1014,429.	944,960.0	869,713.00	854,342.0	778,05100	749,845.0	847,58127	876,858.0	907,598.74	939,876.4	973,768.0
Total Revenue	720,048.0	767,398.0	1,074,390.	1,029,626.	700,343.0	644,3 16.0	600,000.0	606,000.0	636,000.0	668,115.00	701,520.75

83) In addition to recurring costs there are capital cost items that need attention. They are ultrasound units and general equipment/supplies. Ultrasound units are over 10 years old and many are difficult to maintain. Based on JAFPP estimates, investment in all clinics may be required to maintain quality care and to guarantee future revenue. If all new equipment is purchased in Jordan, the total cost could exceed 290,000 JD.

84) Rent control is due to end in 2010. Rents could increase by 30-65% at that time. The range is due to questions on how the new system will be implemented and the supply of space available vs. demand. An indication of the impact the end of rent control is illustrated at the Irbid 1 clinic. Irbid 1 is the only clinic where full cost recovery has been attained. This is due in large measure to a large client base. However, an important factor has been low rent. As one of the oldest clinics in the system rent is only 500 JD per year. Nationally the average rent is over 3000 JD per year. Based on JAFPP estimates, immediate increases in rent could reach a range of 120,000 – 240,000 JD. JAFPP is considering purchasing at least some key clinic locations as an insurance against future rapid increases in rent.

85) Currently all contraceptive supplies are provided free of charge by the MOH. The system is operating very well even during the current period where USAID is withdrawing financial support to MOH for contraceptive supply.

86) Contraceptive supply security is enhanced because of an effective MOH logistics system. Further the MOH has formally recognized JAFPP as governate within the administrative structure of the Jordanian government. This classification permits legal access to public supplies by JAFPP. Still there is concern that the current arrangement could be changed at any time (e.g. should government budget constraints become severe)

87) Because increased access and service reach is a priority new clinics should be (re)opened. The cost of each new clinic is estimated as follows:

Table 4

Clinic Establishment costs	
Medical equipment	20,000
Rent	3,000
Utilities	1,000
Furniture	6,000
Salaries & benefits	30,140
Stationary	200
Supplies	2,530
Other running expenses	4,200
Total	**67,070**

88) Summarizing the impact of the all above costs to increase the JAFPP service capacity :

Table 5

Physician Salaries	60,000
Other Salaries	42,000
Rent	120,000
Equipment/Supplies	243,000
3 New Clinics	201,000
Total	666,000 JD

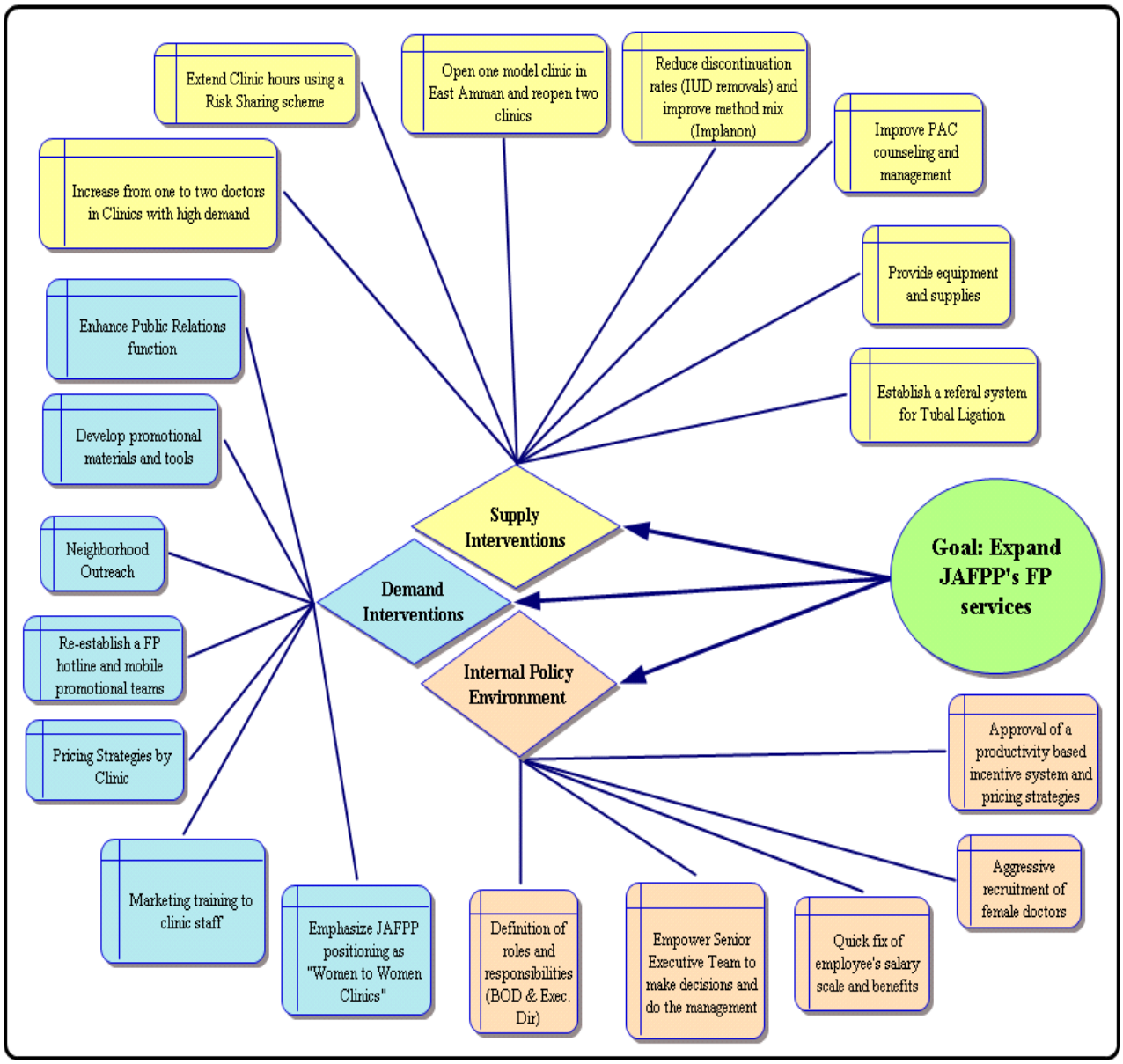
89) Another capital cost expenditure to be studied is the purchase of clinic locations. Purchase of key clinics could help cash flow over the long term by reducing/eliminating current and increasing rent payments.

90) In summary JAFPP cannot survive without a rapid infusion of funds just to maintain the current levels of services. However, infusion of funds without improving governance will likely be counterproductive.

III. Recommendations

91) Recommendations are designed to stabilize the current JAFPP situation and lay the foundation for future growth. The main goal is to expand JAFPP's family planning services while allowing time for annual income from clinic revenues and investment fund income to match annual costs. A summary of the recommendations are presented visually as follows:

Expanding Access, Coverage and Scope of JAFPP's Family Planning Services in Jordan



A. Recommendations – Governance and Internal Policy Environment

92) The current division of roles and responsibilities between the board of directors and management needs to be redefined. Already in place is a JAFPP commitment to ensure more transparent board elections. The process of delegation of authority from board to staff should begin early. Bylaws need to be rewritten so the Board of Directors is focus in government, policy making and oversight, whereas the executive team do the management and administration and are accountable to the Board of Directors. As an initial step in this process general agreement on these two items between JAFPP and USAID should be a precondition for support. Early indications from JAFPP board and staff are that agreement can be reached soon.

93) Based on an initial agreement a quick fix of salaries and benefits (Social Security) should take place. Very low staff morale threatens the immediate effectiveness of JAFPP. In conjunction with or prior to any initial salary adjustments technical assistance should be provided to begin developing, with clinic staff, an reward system based on performance.

94) Technical assistance (TA) should be provided to ensure initial training of the new board and current management. Thereafter, TA will be necessary to 'coach' or empower both management and board members during the first 2-3 years to deal with governance issues and questions as they arise. This is required because the current environment has been in place for so long that attitudes and actions of both board and management could tend to revert to 'traditional' practices.

95) The positions of marketing and human resource management should be filled in the first year. TA will be required to assist in the development/implementation of a marketing strategy as well as new personnel policies and procedures. In the former an immediate focus on a new pricing policy including approval of flexible pricing policies based on clinic location; the economic status of the clientele served; competitive factors; and the need to increase financial barriers to easy IUD removal.

96) A new strategic direction that focuses on quick stabilization and increased access through productivity enhancements, broader service range and the establishment of new clinics should be adopted by the board and implemented by management. This will include a strategy of aggressive recruitment of doctors. This may require additional benefits to recruit doctors in more remote areas.

97) Strong management is required to ensure a smooth transition from the current strong board role. The current management may be able to accomplish this with adequate TA. However, early evaluation of the management team's progress/capability will be required.

B. Recommendations – Supply, Access and Quality

98) In order to stabilize and maintain the current situation of quality, supply and access the most urgent issue that needs to be addressed is the development and implementation of a rational, transparent salary scale and performance based salary system for doctors and staff. Some immediate salary increases are needed just to ensure continued commitment to quality care by the current clinic staffs. A higher salary and better benefits for doctors will also be important for any expansion of the current 16 clinic system. Consideration should be given to differential salaries for those willing to work in more difficult and remote clinic settings. This implies establishing new policies such as creating a salary scale that accounts for time served and a merit system that encourages higher levels of productivity.

99) As part of the salary adjustments JAFPP should develop a productivity arrangement where doctors and staff are rewarded for attaining a clear set of productivity objectives.

100) Increase client access by expanding clinic hours. To expand hours and encourage use, one option would be to use risk sharing schemes. For example, current doctors would be allowed to keep a portion of the fees earned during these extra hours. Alternatively, new non-salaried doctors could be recruited to operate the clinic after closing hours of 2PM. Fees earned would be split with JAFPP.

101) Access would also be enhanced by adding doctors to clinics that are already experiencing high demand. Some clinics such as Irbid 1 have unused consulting rooms.

102) Increased access would also be achieved by (re)opening clinics. Initially open the proposed clinic in Aqaba Complex and one model clinic in East Amman. The current Aqaba clinic is reaching its current capacity and completion of the new complex could be completed within a year. East Amman, with its dense population of target market clientele could be tapped further. A new clinic with a ground level entrance and more adequate space would be well positioned to tap this market without negatively affecting current clinics in East Amman. Also there appear to be underserved Iraqis in the Hashimi district of East Amman that fit JAFPP's target market of lower income families. Further market analysis is required before investment in new or reopened clinics. The opening of new clinics other the Aqaba Complex can be delayed for at least a year or two pending progress on stabilizing the current situation.

103) On an urgent basis provide all current clinics with new equipment (e.g. ultrasound) and supplies; when purchasing equipment and supplies consideration should be given to the possible expansion in the number of clinics from 16-19. A list of equipment needs is presented in Appendix 1.

104) Reduce IUD discontinuation rates by discouraging IUD removals. Options include a combination of price increases for removals; limiting the number of days removals are done; counseling; and insisting the no removals are done until after the women is menstruating. Testing of different approaches could be done on a pilot basis at individual clinics by Year 2. Besides, there is a need to study in detail the issue of high removals. Research questions might include: source of IUDs removed, time elapsed between insertion and removal, IUD removals' policy and practice between the JAFPP and other providers such as MOH and UNRWA.

105) Evaluate the current pricing structure of not only IUD removal but all services. Differential pricing for individual clinics should be tested. Research pricing by private sector outlets in a clinic's service area to determine potential acceptability of higher prices

106) Establish a referral system for tubal ligation. More formal referral documentation is a first step. This implies a more formal relationship with referral centers for each clinic. A more supportive system would also include more direct (and personal) support for women after a referral is made and she navigates entry into a referral center.

107) If resources are available, consideration should be given to the establishment of a JAFPP tubal ligation center at its headquarters building where space is available. A closed tubal ligation system with JAFPP would better ensure a supportive environment for women with medical indications for the procedure.

108) Add new services such as Implanon implants. Training of one JAFPP doctor is already complete and supplies from the MOH are forthcoming. Other possible services include premarital, post abortion, and menopause counseling and the addition of cycle beads as a new product. One clinic, Qwaismeh, has started a diet counseling program that shows signs of success.

C. Recommendations – Demand

109) A 16 clinic system of JAFPP has a number of key features and benefits for women that are often going unrecognized and thus unused by lower middle income women. A well trained, all female staff working in a clean, warm and supportive environment offers a unique affordable service to women of modest means. These are Women to Women Clinics. A missing ingredient is a sustained, organized campaign to make the target market more aware of the availability of such a service in their own neighborhood. Currently clinics rely almost entirely on word of mouth to generate demand.

110) As a priority, the vacant positions in the Marketing Department should be filled. Headquarters staff would be responsible for developing a marketing strategy, messages, tools and processes for implementation. Separately, the department would assist in the development of new project that would attract new funding from other donors including the government of Jordan. TA will be helpful to manage all of these tasks during Year 1 and evaluating impact and making adjustments in subsequent years.

111) Marketing plans should be clinic specific and developed in collaboration with each clinic's staff.

112) The initial focus should be on the primary target audience of each individual clinic. Presently, clinic staffs have a basis idea of where their current clientele live. However, by formalizing a mapping strategy more precise data would confirm the current primary service area (80% of actual clients). By visualizing the location of current clients, gaps in service and opportunities for new interventions can be developed.

113) A series of focus group discussions with a cross section of the neighborhoods target clientele could also provide insights on how to reach new women. Market research companies can help in this as well as in the development of effective intervention strategies.

114) TA combined with contracted market research could help provide special training for clinic staff on messages development and campaign execution.

115) A systematic review and mapping of primary service area institutions, businesses (e.g. hairdressers, beauty shops), transportation (taxis, buses) and other points that serve the target market for each clinic. This can be done by clinic staff. Currently very little interaction occurs between clinic staffs and their primary service area. The social worker and sometimes the physician make presentations to community groups such as schools and parent/teacher organizations. This is often passive exercise and presently is a rare occurrence; time, resources, support and morale are limited. The overall theme for a new effort might be: *Get to know your neighborhood and your neighborhood will get to know you*.

116) Messages for each clinic should be developed that include the overall JAFPP promise of high quality, affordable service by a skilled team of women together with individual clinic pictures and maps that clearly explain how to find the clinic.

117) In addition to clinic staffs' efforts in the neighborhood, a dedicated promotional team can spend additional time in the primary service area with target clientele. Linkages with the PSP Outreach program would also help outreach workers understand where the JAFPP individual clinic's primary service areas are. This coordination should lead to increased focus on generating more referrals to JAFPP.

118) In special instances the use of a refurbished mobile unit could help in the dissemination of information in more remote areas. The Irbid 1 clinic is a good example of how this was done previously.

119) Increasing the sense of loyalty within the current clients through providing preferential prices, free services for new attracted clients and coupons.

120) Getting the primary target market to visit the clinic can be facilitated by special events in the clinics themselves. Past experience using Mothers Day Celebration inside the clinic was viewed as a very effective way of getting new clients to visit. In the future special events might include inauguration of new equipment or clinic refurbishing. Invitations and event promotion would be disseminated though neighborhood businesses scheduled presentations by clinic social workers, serving women, telephone calls to past clinic users, or even door to door visits in promising households.

121) Establish a JAFPP interactive website. Many women have questions about family planning and general health issues but do not know where to go. JAFPP can help fill this gap and at the same time direct potential clients to clinics near the callers home.

122) After the situation at the clinic level is stabilized, focus on expanding awareness of JAFPP at a more global level. The image of JAFPP has no doubt suffered during the recent turmoil. As a pioneer of family planning in Jordan new respect and recognition needs to be earned. Success at the clinic level can provide the basis for this respect. Improved staff morale, refurbished clinics, better governance, and increasing use by satisfied clients should be communicated to a broader national audience of influential leaders. This can be done primarily through the Community Services/Programs Division at headquarters. A newsletter should be developed to keep board members and other key audiences (professional associations, government authorities) abreast of important JAFPP events.

123) A plan to mobilize the Friends of the Association should be developed. This network needs to be informed of developments and trained on ways to support the clinics near them.

D. Recommendations – Support Plan

124) Financial issues comprise the most significant pressure for change at JAFPP. A growing financial gap between annual revenues and costs threaten the viability of the organization. Although significant reserves (about 3.8M JD) are in hand, the interest earned is not enough to fill the gap. Starting in 2006 the principal has been used to cover escalating costs. Annual costs will have to increase even more to retain staff and maintain inventory. The organizational at all levels appear willing to try new approaches to stabilize the situation and ensure continued family services to a growing number of women. Therefore, it is timely that a new relationship with USAID is possible. A financial package is proposed that would extend over 5 years.

125) The current temporary board president has committed publicly to making all recommended changes in governance. He has already worked to increase the number of General Assembly delegates to ensure a transparent election process for the new board. He has declared that delegation of authority to empower management is required. And he has even offered to try to start on appropriate bylaws changes prior to the election of the new board in order to get off to a quick start. If these points can be formalized for USAID acceptance, then implementation of a support plan should proceed.

126) The goals of the support plan should be: a) Ensure that current quality family planning services are maintained; b) Increase the number of family planning clients [a proxy objective would be a rise in the number of IUDs inserted from the current 12,895 units to at least 16,000 units at the end of year 5]; c) Expand the method mix to focus more on providing other long term methods including implants and tubal ligation; and d) Increase the longer term financial viability by decreasing the amount of principal drawn annually from the JAFPP reserve funds.

127) The support plan should be implemented through a cooperating agency. A direct grant is possible but given the wide range of interlinked activities needed, a significant amount of oversight and management would be required.

128) The support plan should provide funds on the basis of agreed upon percentage of approved annual JAFPP operating budgets. The percentage of budget support should start at less than 100% of needs and grow to a larger percentage in each succeeding year. For example, in Year 1 only 65% of annual operating expenses will be provided; in Year 2 based on the achievement of agreed milestones 75% of the operating budget will be provided. By Year 5 all, or near all, of the entire proposed operating budget will be provided. This approach would limit USAID risk of unforeseen events that could derail progress or as in the case of the Cost Recovery Project result in a premature end of activities. The approach would also provide positive incentives to JAFPP to continue to meet overall objectives.

129) Under this plan Year 1 direct support to JAFPP (at 65%) would total about $900-950,000. This sum is based on estimated operating expenses only (and includes increased salary costs and capital for equipment and supplies); that is, revenues from clinics and the reserve funds are not included. The implication is that these revenues would be placed directly into the JAFPP reserve funds for long term viability (see **126 d**.). This was the system under the Cost Recovery Project. By

Year 5 the direct support for the operational budget could exceed $1.6M. First year JAFPP priorities include salary adjustments, filling Marketing and Human Resource Departments, and equipment purchases.

130) Technical assistance and project management by a designated cooperating agency would be in addition to the above sums. A total 5 year budget is estimated in the range of $12-15M. This is similar to the budget allocated for the Cost Recovery Project.

131) Priority technical assistance areas for Year 1 include: a) one time training on governance and delegation of powers for the board and management staff; b) a full time coach or mentor to advise board and staff on governance and management issues that arise; this person can also institutionalize a broader use of data for decision making; c) a full time marketing advisor once JAFPP marketing positions are filled to develop pricing strategies as well as marketing strategies, messages, tools and training; d) a market research firm on retainer to do feasibility studies and qualitative research; e) human resource advisor to develop salary policies and a performance based salary program; f) a part time medical advisor to assist the Clinical Services Division on quality issues including discouraging IUD removals, general support in management/supervision and training.

Appendix I

List of Needed Equipment and Supplies

Item	Quantity
Speculum (Medium and large)	200
Tenaculum (25 cm fine teeth)	160
Sound (32 cm rigid) معكوف	160
Forceps (thin teeth) 26 cm مستقيم	160
Forceps 23cm معكوف	160
Ovam Forceps (Sponge holder 25 cm)	100
Scissors (22 cm)	300
Shettle Forceps	30
Instrument Containers	20
Jars Long + Short	20/20
Kidney cup	20
Iodine Cup	20
Alligator Forceps	16
Scales/BMI & Fat	21
Scales	6
Double basin	16
Sphygmomanometers	16
Side lamps	21
Calculators	16
Steps	5
Stethoscope	16
Papsmear Jars	16
Sterlizers	6
Lab Instruments – Hemocue –B Hemoglobin	6
Lab Instruments – Accutrend – GCT Roche	6
Ultrasound machines	21
Couches	6
Fridge	6
Heater	16
Fans	6

Appendix II

CONTACTS

Organization	*Person*	*Title*
Ministry of Social Development	**H.E. Hala Bsaisu Lattouf**	***Minister of Social Development***
Ministry of Health	**Dr. Ruwaida Rashid**	***MCH Directorate Director***
	Abeer Mowaswas	***Head of Information and Logistic Department***
Higher Population Council	**Dr. Raeda Al-Qutub**	***General Secretary***
USAID	**Laura Slobey**	***PFH Team Leader***
	Dr. Basma Khraisat	***Project Management Specialist***
	Amal Madanat	***Financial Analyst***
	Kathryn Stevens	***Director Office of Program Management***
	Hugh Winn	***Acting Office Director Social Sector Office***
	Dr. Ali Arbaji	***Project Management Specialist***
JAFPP	**Mohamad Ebdah (MoSD)** **Dr. Makram Enshiwat** **Dr. Mai Al-Hadidi** **Khetam Shnikat**	***Board of Directors***
JAFPP	**Bassam Anis**	***Executive Director***
	Dr. Salma Al Zobi	***Medical Services Director***
	Hakem Qarioti	***Finance and Administrative Manager***
	Islam Alkam	***Chief of Information Services Unit***
	Wafa Nafe	***Director of Programs and Community Services***
JAFPP Doctors (Visits)	**Dr. Natalia Sweileh** **Dr. Sawsan Nahawi** **Dr. Manal Hussein** **Dr. Wafa Tahbob** **Dr. Farida Omar** **Dr. Songol Abd Al Wahed** **Dr. Zoya Al Batrawi** **Dr. Salam Irshidat** **Dr. Fadwa Hmoud**	***General Practitioners***
Health Systems Strengthening Project /HSS	**Dr. Ayman Abdel Mohsen**	***Project Director***
	Nesreen Al-Bitar	***Performance Assessment Task Manager***
	Dr. Sabri Hamza	***Safe Motherhood Team Leader***
Private Sector Project for Women's Health (PSP)	**Dr. Rita Leavell**	***Project Director***
	Dr. Maha Shadid	***Deputy Project Director***
	Dr. Tara Abdulrahman	***Q/A and outreach program Technical Specialist***
	Mays Zaneh	***Communications and Marketing Coordinator***
	Mays Halassa	***Health Market Research Coordinator***

Appendix III

Reference List

- Jordanian Associations Law for the year 2008
- JAFPP Bylaw, 1998
- JAFPP Financial Statement 2003
- JAFPP Financial Statement 2004
- JAFPP Financial Statement 2005
- JAFPP Financial Statement 2006
- JAFPP draft financial statement 2008
- Jordan Medical Syndicate Law, article 35 for the year 2006
- PSP Cumulative Outreach Report, March 2005-2008
- Jordan Population and Family Health Survey 2007, Department of Statistics, Measure DHS, Macro International
- Barriers to Improved Reproductive Health Programs and Required Policy Reform in Jordan, by Policy Project
- An Analysis of the Family Planning Market in Jordan to Develop an Effective and Evidence-Based Strategic Plan for Attaining Contraceptive Security, Suneeta Sharma and Issa Almasarweh, March 2004
- USAID/Jordan Strategy 2004-2009, Gateway to the Future.
- Cost Recovery and Sustainability for JAFPP, 2001-2006, JSI Final Report

Appendix IV

Scope of Work

Assignment: Conduct a needs assessment of the JAFPP and develop recommendations to:

1) Maintain and improve service quality
2) Expand FP/RH services and clientele
3) Increase access to quality RH services
4) Improve JAFPP's financial stability and cost-efficiency

Level of Effort: Approximately 2 to 3 weeks in country

Dates: On or about August 1 -15 or 18, 2008

1. BACKGROUND

The Jordanian Association for Family Planning and Protection (JAFPP) is an important source of family planning information and services in Jordan. JAFPP, one of the largest NGO providers, serves 13.7% of modern method users and 22% of IUD users (DHS 2007) in the Kingdom through its network of 16 clinics throughout the country.

Data from the 2007 DHS indicate that with a TFR of 3.6, fertility is still high in Jordan and that contraceptive use has leveled off at about 56 percent. USAID is addressing barriers to increased use of modern contraceptive methods, including expansion of FP/RH information and services through the private/NGO sectors.

In the 1990s, JAFPP was responsible for almost 30% of all family planning users in the country, but in the last decade its contribution to contraceptive prevalence has declined. See figures 1 and 2. There are a variety of probable factors contributing towards this decline in contraceptive share: 1) declining external funding including withdrawal of USAID support in 2006, 2) increased support by international donors to strengthen the public sector's ability to provide family planning services, 3) instability in its Board management and governance and 4) a focus on cost recovery that may have affected levels of FP clientele.

Figure 1: Source Mix Among Users of Modern Methods in Jordan (2002)

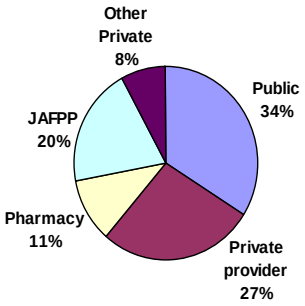
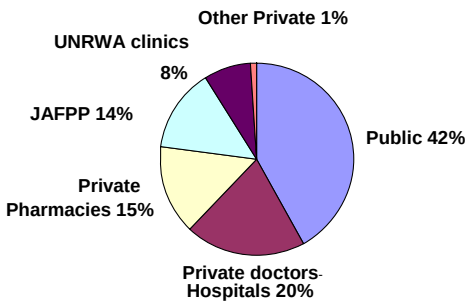


Figure 2: Source Mix Among Users of Modern Methods in Jordan (2007)



JAFPP is at an important crossroads and today faces a difficult challenge experienced by many other mature family planning NGOs: how to increase family planning/ reproductive health service provision, while at the same time maintaining and improving the quality and efficiency of its services. JAFPP would also benefit from exploring more creative and entrepreneurial approaches to financing which do not compromise or diverge from JAFPP's original purpose as a provider of family planning services, even as it expands its portfolio of services.

PSP Women's Health is committed to improving the service quality and potential contribution of JAFPP to FP/RH services in the country. PSP's conducts outreach to women in their homes to generate demand for RH/FP and other women's health services and to refer them to quality service points. JAFPP is the service provider for over 10% of outreach clients and its medical staff are enrolling in the QA programs for FP, Breast cancer and RTI/STI's. In addition, JAFPP could conduct outreach for FP/RH information and services and possibly be a provider or referral service for VAW services.

Overall Objective

PSP therefore proposes to conduct a comprehensive assessment of JAFFP to make recommendations that will strengthen JAFFP's core competencies in order to become a self-sustaining organization while maintaining its social mission. As a result, it is expected to improve JAFFP's ability to respond to the needs and opportunities of a dynamic environment.

The assessment will examine core issues such as

- Is JAFFP reaching the appropriate segment of the population to help Jordan achieve its overall goals of reduced fertility and increase contraceptive use?
- What is JAFPP's market share and potential for expansion?
- What are strategies and mechanisms to expand and upgrade JAFPP'S FP/RH services, both in quantity and quality?
- What are strategies and mechanisms are available to JAFFP to expand services (e.g. enter new areas, introduce new services such as ultrasound, laboratory) which could potentially increase cost recovery?
- What is JAFFP's overall business viability and governance capacity to determine the best strategies and mechanisms for long-term financial and organizational sustainability

Proposed Activities

To address many of the questions raised, the PSP team will conduct the following analyses during the TDY to Amman, Jordan:

1. Assessment of JAFFP's current and potential FP market
    a. Current client by socioeconomic status, location, and characteristics
    b. JAFFP's range of health services
    c. Pricing of health services and products
    d. Target population and cross subsidization
    e. Market size/trends, distribution of facilities, and utilization patterns
    f. Policy, legal, financial and operational constraints

2. Assessment of external environment and target opportunities of collaboration
    a. Central government and local governments
    b. Professional associations
    c. Community organizations representing the users
    d. Private sector actors such private insurance companies, pharmaceutical distributors, others
    e. Other donors and cooperating agencies.

3. Assessment of marketing strategies to help JAFFP's increase FP market share
    a. Current strategies to expand coverage FP
    b. Possible new strategies
    c. Steps and technical assistance needed to expand FP

4. Assessment and anticipation of JAFFP's management systems' present and future needs. Possible areas may include:
    a. Planning and Monitoring, Supervision
    b. Resource Mobilization capability
    c. Human Resources/Training
    d. Quality Assurance and accreditation

e. Marketing
f. Procurement and Logistics
g. Financial Management
h. Accounting (including cost accounting)
i. Management Information Systems

5. Assessment of JAFFP's governance mechanisms
    a. the governance structure
    b. the division of powers and authorities
    c. financial oversight mechanisms

Profile of international consultants and areas of expertise needed
PSP proposes to field a two- person team to travel to Amman for two to three weeks in August 2008. A local Jordanian medical consultant will complement the two-person team and provide a more in-depth analysis of clinic operations requirements for FP service needs. Additionally, the PSP COP or deputy COP would provide oversight and additional TA to ensure continuity and follow-up to the team's recommendations. Finally a second local consultant may be needed (eg, clinical or business). USAID will also conduct a financial assessment of systems.

Health Services Management consultant (Carlos Cuéllar - confirmed)
One team member will have strong clinical services and operations management skills and will be responsible for reviewing JAFFP's services, together with the local consultant, including:

- Health service organizations
    - Quality assurance and related capacity building mechanisms
    - Communications and counseling
    - Commodities – procurement and logistics, availability
    - Infrastructure and operational capacity - equipment and facilities
    - Client information system and follow up
- Management support systems
    - Planning
    - Management
    - Monitoring
    - Supervision
    - Quality
    - Health Information
- Human Resources Management
    - Staffing
    - Salaries
    - Skill mix
    - Training needs
    - Staff turnover

Organizational and Marketing Management consultant
The second team member will have a strong business development and marketing background and will focus his/her efforts on market study, organizational review and financial analysis, including:

- Strategic thinking of FP market
    - JAFPP's current and potential market role in Jordan
    - Possible reasons for decreasing clientele and strategies to reverse this trend
    - Identification of potential FP segment for JAFPP expansion
    - Articulation of marketing strategies to reach this market segment
- Board and governance structure as NGO
    - the governance structure
    - the division of powers and authorities
    - financial oversight mechanisms
- Analysis of marketing and financial opportunities
    - Costing and pricing of health services
    - Financial planning and management

- Resource gaps
- Current status of and potential cost recovery schemes

1.1 DELIVERABLES:

The assessment will provide recommendations for two primary target audiences:

1) JAFFP senior management and Board of Directors: This set of recommendations will provide JAFFP senior management with strategic directions for JAFFP's growth, strategies to improve quality and access to services, expand to new clientele while retaining current clients, establish financial objectives and propose different cost recovery schemes. The recommendations would also help articulate the Board's role and responsibilities in governing and guiding JAFFP to meet the recommendations.

2) USAID and the GOJ/Higher Population Council (HPC): The assessment would confirm JAFPP's current and potential contribution to CPR, identify and prioritize technical assistance and financial support needed to help JAFPP expand or improve services, and provide a scenario of different funding options to support and strengthen JAFFP.

The assessment team's deliverables will include:

- Debriefing for USAID and HPC with preliminary findings and recommendations
- Summary report and consultant trip reports as required. Details and content of report to be developed with clients while on TDY.
- Final draft of the report for Mission comment will be available by late August/early September, 2008.

APPENDIX V

JAFPP Proposed Organizational Structure