Evaluation Summary

1. **Outline of the Project**		
Country: the Hashemite Kingdom of Jordan		Project Title: Integrating Health And Empowerment of Women in the South Region Project
Issue/Sector: Healthcare and medical treatment		Cooperation Scheme: Technical Cooperation Project
Division in charge: Jordan Office		Total Cost：approx. 389 million JPY (as of end of March 2011)
Period of Cooperation	(R/D): September 2006 - September 2011	Partner Country's Implementing Organization: The Ministry of Health, the Higher Population Council
		Supporting Organization in Japan: Nil
		Other Related Organization: Jordan Hashemite Fund for Human Development (JOHUD)

1-1 Background of the Project

Though the indicators of primary health care in the Hashemite Kingdom of Jordan (Hereinafter referred to as "Jordan") are in better situation in comparison with that in the neighboring countries, Jordan is still facing problems of regional gaps and a slow pace of improvement. Concerning the regional gaps, even though the national average of total fertility rate (TFR) is 3.6, the total fertility rate in three governorates in the south region of Jordan excepting the Governorate of Karak is higher than the national average. The rate of 4.1 in the Governorate of Aqaba is the highest in Jordan. As for the slow pace of improvement of indicators, the indicators over the last two decades was rather slow in Jordan, there was increasing concern about uncertainty of attainment of the Millennium Development Goals (MDGs), specifically MDG 5, which aimed at the improvement of women's health. TFR and contraceptive prevalence rate (CPR) in 2002 and 2007 demonstrated plateau (TFR: 3.7 vs. 3.6, CPR: 55.8 % vs. 57.1%, respectively) and high demands to solve unmet needs were recognized (11.0% vs. 11.9%, respectively). Jordanian women's health, especially for those in childbearing age, is still in needs of further improvement from the aspect of quality reproductive health and family planning (RH/FP) as well as women's empowerment. Under these situations, the Government of Jordan also emphasize the importance of the reinforcement of effort for the issues related to reproductive health, women empowerment, and marital abuse, which are recognized as major factors affecting women's wellness.

To address the issues abovementioned, the Government of Jordan has been working in collaboration with national and international partners for the betterment of the level of wellbeing among Jordanian women, on the basis of "the Reproductive Health Action Plan 2003-2007 (Phase I)" for the improvement of reproductive health and the enhancement of family planning by developing information system, behavioral change and policy development. Subsequently to this, the second phase Action Plan 2008-2012 is focusing on the improvement of environment in reproductive health (RH), family planning (FP) and access to health services via capacity development in health service providers, awareness-raising activities and collaboration with private sector.

Under the circumstances, Japan International Cooperation Agency (hereinafter referred to as "JICA") has been assisting the Government of Jordan to improve RH/FP since 1997 through "The Project for Family Planning and Gender in Development Phase I and II (1997-2003)" and "The Enhancing Self-Empowerment of Rural Women in Karak, Jordan with a Reproductive Health Focus (2003-2006)" under the JICA's assistance schemes of the Technical Cooperation Project and the Community Empowerment Program, respectively. This nine-year cooperation proved the effectiveness of promoting the self-empowerment of

women as well as improving health services for the enhancement of RH/FP in Jordan.

Subsequently to the assistances aforementioned, JICA launched the five-year technical cooperation project entitled "Integrating Health and Empowerment of Women in the South region Project" (hereinafter referred to as "the Project") on the basis of the request of technical assistance by the Government of Jordan to the Government of Japan, in collaboration with the Ministry of Health (responsible for the improvement of environment in reproductive health (RH), family planning (FP)) and the Higher Population Council (responsible for policy making and coordination on population issues) in 2006. The Project was designed to utilize the experiences and lessons learned from the previous JICA' assistances such as involvement of community as well as men and youth, behavior change through home visit, and has expanded the target areas to more remote area in the south region as target sites. Furthermore, the ultimate purpose of the Project is to prepare vital recommendations based on evidence and good practices from the project activities.

1-2 Project Overview[1]

The Project is aiming to make policy recommendations for the improvement of RH/FP based upon the good practices and evidences of improved utilization of RH/FP services through recruitment, training and deployment of Health Educators in the conservative 4 regions in the south. The Project intendeds to establish the foundation of quality RH/FP and women's empowerment in the south four regions as a pilot area for future betterment of policy environment and nationwide deployment by Jordanian self-reliant endeavor (Overall Goals).

(1) Overall Goal

1) Reproductive Health/Family Planning (RH/FP) in Jordan is improved.

2) RH/FP Policy Environment in Jordan is improved.

(2) Project Purpose

Policy recommendations for the improvement of RH/FP are made based upon the good practices and evidences of improved utilization of RH/FP services in the target area.

(3) Outputs

1) A supportive environment for project activities with regard to the improvement of women's health and empowerment is created in the focal area.

2) Men's and youth's attitudes toward RH/FP and women's empowerment are improved in the focal area.

3) Women's knowledge of FP and attitudes towards RH/self-empowerment are improved in the target area.

4) High quality RH/FP services are provided at the target VHCs.

5) Development of Policy recommendations and public relations activities with regard to RH/FP and women's empowerment are implemented for the dissemination of experiences and achievement of the Project.

[1] The Terminal Evaluation Team evaluated the Project based on the PDMe, which was prepared under a shared understanding among the relevant parties, to check ambiguous points in the expressions and logic used in latest version of PDM (version8, October 4, 2010), to make clear what goals the Project intends (or intended) to achieve, and to summarize these goals, outputs and/or activities. The Project Overview was described from the narrative summary of the PDMe.

(4) Input (as of the end of June 2011) (total input: JPY 420 million)

Japanese Side

- Dispatch of Experts: Approximately 155 M/M
- Hiring of Local Consultant: 1 personnel (approximately 58 M/M)
- Provided Equipment: Four vehicles for monitoring and supervision activity, Medical Equipment for VHCs, PCs and Printers, Equipment for community development project (Irrigation machinery and greenhouse, Play equipment in the kindergarten, Community meeting goods/tools)
- Renovation of VHCs: 24 VHCs (38,857.500JD) (approximately JPY 4.43 million)
- Local Cost: Approximately 1,298,000 JD (approximately JPY 0.15 million)
- Training in Japan: 6 counterpart personnel, Training in Jordan: 15 courses, Training in other countries: 24 counterpart personnel (Syria and Morocco)

Jordanian Side

- Counterparts: 42 personnel
- Land and Facilities: Provision of land and facilities including office for the Project
- Local Cost: Approximately 2,150,000 JD (These figures were submitted by the MOH. However, the Evaluation Team could not review and confirm these figures.)

2. **Terminal Evaluation Team**

Members	Dr. Akiko HAGIWARA	Leader/RH	Senior Advisor, JICA Headquarters
	Mr. Mitsuhiro OSAKI	Cooperation Planning	Representative, JICA Jordan Office
	Dr. Yoichi INOUE	Evaluation Analysis	Senior Consultant, Consulting Division, Japan Development Service Co., Ltd.
Period of Evaluation	June 18, 2011 – July 8, 2011		Study Type: Terminal Evaluation

3. **Summary of Evaluation Results**

3-1 Achievements

1. Output 1

OVI 1-1 "80% of people at age 15 and above living in the focal area have participated in at least one project's activity with regard to the improvement of women health and/or empowerment." is not achieved in terms of 80% fulfillment (Achievement: 52% on the average).

OVI 1-2 "At least one community development activity is planned in each focal area by 2011." is achieved since three (3) community development projects were planned and implemented in each focal area.

Therefore the Achievement of Output 1 is limited at the time of the Terminal Evaluation.

Output 1 aimed at creating supportive environment for the project activities among community members in order to facilitate involvement of men in improvement of RH/FP and self-empowerment of women. However, as shown in the following column, delay in activities such as organizing CBOs and implementation of community development projects was caused by various external factors. Delay in these activities might also affect other activities and thus activities for Output 1 have been downsized following the Mid-Term Review team's recommendation to minimize the activities for Output 1. Therefore, the contribution of Output 1 to the achievement of the Project Purpose was limited.

On the other hand, the importance and necessity of involving men in RH/FP and women's empowerment is getting be an international consensus. Although the contribution of Output 1 to the achievement of the Project Purpose was limited, it brought important examples and valuable lessons regarding how to involve men in promotion of women's health in poor rural areas in the Islamic country.

2. Output 2

OVI 2-1 ""Men's attitudes toward RH/FP for women's health" demonstrates improvement with the statistical significance from 2008 to 2011 in the target cohort." was fulfilled since the mean score of 'men's attitudes toward health benefits of RH/FP to women's health' was significantly decreased from 24.8±3.0 to 19.8±4.1 (range: 14-32) in respective year of 2008 and 2011 in the target cohort (paired sample t-test, $p<0.001$, n=31) (The lesser score, the better attitude).

OVI 2-2 " "Men's attitudes toward male involvement in RH/FP" demonstrates improvement with the statistical significance from 2008 to 2011 in the target cohort." was fulfilled since the mean score of 'men's attitudes toward male involvement in RH/FP' was decreased from 38.4±4.3 to 32.8±3.7 (range: 26-44) in respective year of 2008 and 2011 (paired sample t-test, $p=0.001$, n=31) (The lesser score, the better attitude).

OVI 2-3 ""Men's attitudes toward RH/FP service utilization by women" demonstrates improvement with the statistical significance from 2008 to 2011 in the target cohort." was not fulfilled since 'men's attitudes toward RH/FP service utilization by women' did not improve with statistical significance. However, Health Educators were not allocated at 2 out of 3 target VHCs in the focal area, which can explain the reason why men's attitude for RH/FP service utilization by women didn't improve, nevertheless men's attitudes toward RH/FP for women's health. (Mean scores of 'men's attitudes toward RH/FP service utilization by women' were 4.2±1.5 and 3.9±1.3 (range:3-8) in 2008 and 2011, respectively. No significant difference was observed with p-value with less than 0.05 (paired sample t-test, $p=0.221$, n=31).)

OVI 2-4 " "Youth's attitudes toward RH/FP for women's health" demonstrates improvement with the statistical significance from 2008 to 2011 in the target cohort." was not fulfilled since 'youth's attitudes toward RH/FP for women's health' did not improve with statistical significance. (Mean scores of 'youth's attitudes toward RH/FP for women's health' were 19.2±2.5 and 18.3±2.7 (range: 15-25) in 2008 and 2011, respectively. No significant difference was observed with p-value with less than 0.05 (paired sample t-test, $p=0.181$, n=35).) This non-attainment can be explained by (1) Sample size was rather small for analysis, and (2) " Youth" is composed of 2 groups (male and female), which may have different perspectives for women's health.

OVI 2-5 ""Men's attitudes toward women empowerment" demonstrates improvement with the statistical significance from 2008 to 2011 in the target cohort." was not fulfilled since 'men's attitudes toward RH/FP for women's health' did not improve with statistical significance. (Mean scores of 'men's attitudes toward health benefits of RH/FP to women's health' were 9.4±1.7 and 9.2±2.0 (range: 6-13) in 2008 and 2011, respectively. No significant difference was observed with p-value with less than 0.05 (paired sample t-test, $p=0.628$, n=31).) This non-attainment can be explained as the same reason with OVI 2-4.

OVI 2-6 ""Youth's attitudes toward women empowerment" demonstrates improvement with the statistical significance from 2008 to 2011 in the target cohort." was not fulfilled since 'youth's attitudes toward women empowerment' did not improve with statistical significance. (Mean scores of 'youth's attitudes toward women empowerment' were 4.7±1.1 and 4.6±0.9 (range: 3-7) in 2008 and 2011, respectively. No significant difference was observed with p-value with less than 0.05 (paired sample t-test, $p=0.595$, n=35)) This non-attainment can be explained as the same reason with OVI 2-4.

Therefore the Output 2 is partially achieved at the time of the Terminal Evaluation.

Output 2 aimed at improving men's and youth's attitudes toward RH/FP and women's empowerment in the focal area. Since the achievement of Output 1 was limited, there were only limited direct approach toward men and youth for Output 2. While knowledge of men and youth toward women's health improved, attitude toward women' service utilization did not demonstrate significant improvement, which could be attributed to the fact that Health Educators were not assigned in two out of three Village Health Centers (VHCs) in focal areas.

It should be noted that, in Al Ghal, where higher participation of men and youth in awareness raising activities (94%) was observed, CPR of women who received home visit increased from 40% to 80%, which was the highest among all villages where home visit was conducted. This indicated that participation of men and youth in activities related to the improvement of women's health and empowerment might have contributed to the improvement of CPR of women. In addition, interviews conducted by the Team revealed that there was indirect impact to men's attitude toward women's health at the communities where Health Educators are providing services and counseling to women at home and at VHCs. Men's attitude improved such as in improvement spousal communication about FP, or in improvement of husbands' interest in wives' health.

3. Output 3

OVI 3-1 "All the women who have received home visits know all the types of contraceptive methods available in Jordan by 2011." was not achieved in terms of 100% fulfillment (Achievement: 70.7%). However, Ratio of women who knew all contraceptive method in post-test (January-March 2011) was significantly increased in comparison with that in pre-test (August 2009-November 2010) (34.5% vs. 70.7%, $p<0.001$: McNemar test, n=500). Moreover average number of contraceptive that women under home-visit services know is significantly increased from pre-test to post-test by (7.1±2.1 vs. 8.4±1.2 [range: 0-9], $p<0.0001$: paired Student's t-test).

OVI 3-2 "All the women who have received home visits know at least one health facility or one health professional to receive support for access to available contraceptive methods by 2011." was not achieved in terms of 100% fulfillment (Achievement: 99.2%). However, ratio of women who knew at least one health facility or one health professional to obtain contraceptive methods accessible in post-test was significantly increased in comparison with that in pre-test (97.1% vs. 99.2%, $p<0.05$: McNemar test, n=510). Moreover, average number of facilities and providers to supply contraceptive method that women under home-visit services know is significantly increased from pre-test to post-test (3.9±2.5 vs. 5.7±2.7, $p<0.0001$: paired Student's t-test).

OVI 3-3 "All the women who have received home visits know at least two major adverse effects of contraceptive methods available in Jordan by 2011." was not achieved in terms of 100% fulfillment (Achievement: 84 %). However, women who received home visits know more than 3 major side effects of contraceptive methods on average (Mean=3.4±1.9). The statistical analysis of differences in post-test and pre-test in terms of knowledge of adverse effects of contraceptives could not be compared directly since the questions were asked differently in those tests. As many of the participants were not using contraceptives in the pre-test, it was not possible to ask knowledge of adverse effects of current contraceptive methods.

OVI 3-4 "90% of the women who have received home visits feel it important to take RH-related lab tests (diabetics/urine/anemia tests during pregnancy and tests for reproductive tract infection and urinary tract infection) by 2011." was achieved in terms of 90% fulfillment (99.4% at post test), however, ratio of women who have received home visits feel it important to take RH-related lab tests already exceeded 90 %

(97.5%) at pre-test Thus, the Team judged that this indicator doesn't reflect the achievement for Output 3 appropriately, and didn't use for measurement of Output.

OVI 3-5 "90% of the women who have received home visits feel it important to visit village health centers to receive RH-related services available at the centers (FP, antenatal and postnatal care and child care) by 2011." was achieved in terms of 90% fulfillment (93.9% at post test), however, ratio of women who have received home visits feel it important to visit village health centers to receive RH-related services almost reached to 90 % (89 .1% at pre-test). Thus, the Team judged that this indicator doesn't reflect the achievement for Output 3 appropriately, and didn't use for measurement of Output.

OVI 3-6 " (Psychological Wellbeing) "Four major domains of psychological wellbeing represented by self-confidence/self-esteem, autonomy, environmental mastery and se lf-acceptance" demonstrates improvement with the statistical significance from 2008 to 2011 in the target cohort." was not achieved since status of psychological wellbeing was not improved with statistically significance. (Mean scores that represent the status of Psychological Wellbeing were 24.4±2.4 and 24.5±2.5 [range: 9-27] in 2008 and 2011, respectively. No significant difference was observed with p-value of below 0.05 (Wilcoxon signed ranks test, p=0.186, n=690)).)

OVI 3-7 " (Decision-Making) "Perceiving their a bility in m aking decisions" demonstrates improvement with the statistical significance from 2008 to 2011 in the target cohort." can be said to be achieved since status of "Perceiving their ability in making decisions" was improved with statistical significance. (Means score of D ecision Making were 25.8±4.6 and 26.3±4.2 [range: 9-36] in 2008 and 2011, respectively. Significant difference was observed with p-value of below 0.05 (Wilcoxon signed ranks test, p=0.007, n=690).) However, since the difference in the scores was only 0.5, it is considered difficult to say that the status of decision-making was improved in sufficient level.

OVI 3-8 " (Self-Health Care) "Perceiving the importance of self-healthcare" demonstrates improvement with the statistical significance from 2008 to 2011 in the target cohort." can be said to be achieved since status of "Perceiving the importance of self-healthcare" was improved with statistical significance. (Means score of Self-Health Care were 8.96±2.32 and 9.10±1.82 [range: 0-15] in 2008 and 2011, respectively. Significant difference was observed with P-value of below 0.01 (Wilcoxon signed ranks test, p<0.001, n=690).) However, since the difference in the mean scores was only 0.04, it is considered difficult to say that the status of decision-making was improved in sufficient level.

Therefore Output 3 is comfortably achieved at the time of the Terminal Evaluation while some of the OVIs are not appropriate for measurement of OVIs and thus they are excluded from evaluation.

Output 3 aimed at improvement of wo men's attitudes toward RH/FP and self-empowerment. Some indicators concerning RH/FP required 100% achievement, which might have been too ambitious due to the large number of target population. It was not realistic to expect all target population (around 500 persons) improved their knowledge and attitude. Knowledge about types of contraceptive methods and how to obtain contraceptive methods showed firm improvement although the target (100%) was not met. Unfortunately indicators regarding importance of taking RH-related lab tests, utilizing antenatal and postnatal care and child care could not be used for measurement of Output 3 due to reasons described in the following column, yet, field s urvey conducted by the Team confirmed that the utilization of VHC actually increased.

On the other hand, self-empowerment of w omen has been achieved in terms of the achievement of indicators. Although there was a statistically significant improvement in women's empowerment scores, its actual improvement was no t so s ufficient. It could be interpreted that self-empowerment of women was structured with many factors such as interrelation with men and thus it was not so easy to demonstrate

substantial improvement in its scores while the other scores such as knowledge of contraceptive methods and their adverse effects were relati vely independent from the influ ence of men. To confirm the improvement of women's self-empowerment, the Team conducted a field survey and encountered quite a few women who told that their capacity of dec ision making and perception of self-healthcare improved and the Team concluded that overall there was i mprovement in w omen's self-empowerment though the Project activities.

4. Output 4

OVI 4-1 "90% of Health Educators (HEs) at VHCs provides RH/FP services according to the guidelines." was achieved since forty-two (42) out of 43 Health Educators (98%) at VHCs provides RH/FP services according to the Guidelines.

OVI 4-2 "80% of tar get women who use VHCs are satisfie d with the quality of services by 2011." was fulfilled since four hundred and three (403) out of 425 women using VHCs (95%) are s atisfied with service quality at VHCs (full score: 61.2% and 10-13 point: 33.7%).

Therefore the Output 4 is generally achieved at the time of the Terminal Evaluation.

Most of Health Educators provided RH/FP services in line with the Guidelines. Ninety-five percent (95%) of users of V HCs were satisfied with the service. Therefore it can be concluded that RH/FP service was provided with a certain level of quality in targeted VHCs.And Health Educators acted as entry points to the healthcare services including RH/FP services at the community. The effectiveness of service provided by Health Educators at VHCs and at home visit was confirmed.

On the other hand, some problems such as (a) w hat is t he role of male Health Educators in Health Educator system whose TOR covers RH/FP and empowerment of women, (b) what is suitable job title for Health Educators in order to facilitate their activities and (3) how to employ and assign Health Educators to VHCs have been raised.

5. Output 5

OVI 5-1 "At least one policy recommendation is prepared from each output by 2011." is anticipated to be achieved by the end of the project.

Policy Recommendations are being drafted as of the Evaluation Team is dispat ched. It is expected that more than three recommendations would be approved by the Joint Policy/Steering Committee (JPSC).

Although "At least one policy recommendation is prepared from each out put" is t he Objectively Verifiable Indicator, it is not possible to prepare recommendations from Output 1 and 2 because these two outputs did not bring sufficient evidence. However, evidence regarding RH/FP, empowerment of w omen and Health Educator system were extracted from Output 3 and 4 and thus sufficient numbers of Pol icy Recommendations would be drafted based upon the Project outputs.

Furthermore, foundations to sustain Project outputs in the future has been established by conducting international regional workshop to share Project experience and disseminate Project outputs with the participation of Afghanistan, India, Palestine, Sudan and Syria.

6. Project Purpose

The Project Purpose is anticipated to be achieved in general by the end of the project period.

It is expected that draft version of policy recommendations based upon achievements of the Project will be approved by the JPSC within the project period. In terms of improvement of CPR, the target value was not achieved at the target area, while it was achieved among the women who received intervention. Utilization rate of postnatal care did not attain the target value of 63.2%. However, it should be noted that utilization

of postnatal care improved steadily from 25.0 % to 36.6 %, which indicated that the project interventions were effective in improving utilization of postnatal care to the similar level of neighboring countries/regions such as Syria and Palestine, could be praised.

On the other hand, though achievement regarding RH/FP and men's involvement in women's empowerment was insufficient, quite a few information and lessons have been extracted. Moreover, it was remarkable that certain improvements regarding the utilization of RH/FP and women's self-empowerment were demonstrated among target women through service provision at VHCs and home visits conducted by Health Educators, awareness-raising activities in the communities and schools.

It is expected that the Purpose of the Project would be generally achieved by the end of the Project and make significant contribution to the achievement of Overall Goal once the remaining challenges for sustainability and scaling-up were dealt with.

3-2 Summary of Evaluation Results

(1) Relevance

The Government of Jordan emphasizes RH/FP-related efforts. One prominent example is the top listing of raising the utilization rate of RH/FP services among the short-time objectives in the health care sector under the main pillar of social welfare in "the Executive Development Program (2011 - 2013)" announced in December 2010. Meanwhile, in "*the National Reproductive Health Action Plan*" for the year of 2011, the HPC calls for support for and upgrading of the RH/FP policies, wider offer of services and greater accessibility, intensive publicity of and education on RH/FP issues and strengthening of the implementation mechanism of the Action Plan. In "*National Health Policies for Women 2006-2011*", the MOH has indicated that the empowerment of women is one measure to successfully achieve the MDG5 (improvement of maternal health). Moreover, the Project emphasizes the strengthening of health services in rural areas in Jordan, especially areas described as poverty pockets where it is said that a conservative attitude prevails. Against the background described above, the purpose of the Project of aiming to improve women's health through the comprehensive approach of integrating RH/FP and women's empowerment is truly consistent with not only the health policies of Jordan but also the needs of the target group. The Project emphasizes the strengthening of health services in rural areas in Jordan, especially areas described as poverty pockets where it is said that a conservative attitude prevails.

Japan's assistance policy toward Jordan (2008) places emphasis on minimizing social disparities through realizing "Human Security" by extending assistance to rural areas and communities where many poor people reside, helping women and persons with disabilities who are deprived of opportunities of social participation due to religious and traditional reason. The Policy also raises the issue of Gender and mentions the approach of this Project that is improvement of RH and empowerment of women in the south region. On top of that, minimizing gender gap through improving reproductive health and tackling the issue of population and family planning is regarded as priorities in JICA's Country Assistance Implementation Plan.

The Government of Japan has announced "Japan's Global Health Policy 2011-2015" in September 2010. Health Educator system, which has been introduced through this Project, can contribute to creating linkages between communities and facilities by establishing both referral and outreach systems for the continuum of preventive and clinical care, which is mentioned in the Policy. Health Educators are recruited from the community where they are assigned and they play a role of entry point to referral system as they conduct home visit and providing counseling service at VHC. Besides that, the Policy indicates that it is important to promote gender equality and education in order that women and girls can

have greater opportunities to gain knowledge as to seeking appropriate healthcare and life skills including family planning. This conforms to the approach of integrated women's health and their empowerment that the Project has adopted.

(2) Effectiveness

The expected outcomes of the activities designed to involve men were not fully achieved, partly because of the greater than expected conservatism of people in the target areas and partly because of the tribal complexity of local communities. In relation to the activities for Outputs 1 and 2, there was a change of the original arrangement in that the HPC assumed to become the body for the implementation of related activities would concentrate on policy making which is its principal field of work. This change meant the non-existence of a counterpart organization to pursue Outcomes 1 and 2, making the JICA's expert team directly responsible for these activities. In the light of this new situation, the focal areas were reduced from six villages to three villages after the Mid-term Review to enable the effective implementation of the planned activities. Accordingly, the scale of the contribution of Outputs 1 and 2 to the overall project purpose was rather reduced although many of the lessons learned from these activities actually led to the facilitation of activities to produce other outcomes to the extent that the overall Project Purpose was expected to be sufficiently achieved.

It has become clear through the Project that Health Educators can make a tangible contribution to improvement of the health, particularly related to RH/FP, and empowerment of rural women. Because local women were nurtured as Health Educators working at VHCs in their own communities, they are generally well accepted by their communities even in the conservative south region though the level of acceptance shows some variation from one community to another. Many of these Health Educators have gained the trust of their fellow villagers and as many as 6,463 home visits have been made by Health Educators and others health professionals from January 2010 to May 2011. The counseling at VHCs and home visits have improved women's knowledge of and attitude towards RH/FP and their self-empowerment. Such improvement is supported objectively, confirming the effectiveness of Health Educators to improve the health of women. Further evidence of the excellence of Health Educators is their positive impact on the attitude of men towards RH/FP and primary healthcare with an improved RH service (further details are given in the section describing "Impacts"). In addition, it is worth noting that female Health Educators seems to be empowered by self-fulfillment and earning of trust from communities through their duty work of providing healthcare services in the communities as civil servants, and this can be regarded as a success model of female community residents. The successful introduction of Health Educators is believed to have greatly contributed to not only the achievement of the planned outputs relating to improved RH/FP and women's empowerment in the target areas but also to the achievement of the Project purpose by means of the accumulation of positive evidence and the wide dissemination of good practice.

(3) Efficiency

The project activities have been implemented in accordance with the Plan of Operations (PO). However, the progress of individual activities has been affected by several factors. In the case of those activities featuring men in the focal areas, the formulation of a community development plan experienced a substantial delay despite the fact that a lot of time and labor were devoted by the members of the Project. Consequently, activities to follow the PO were also delayed to the extent that the implementation of other activities to produce other Outputs could have been jeopardized. In order to reduce this risk, the scale of the Output 1-related activities was cut back based on the recommendation made at the time of the Mid-term Review. This decision led to insufficient outcomes of the activities designed to involve men.

However, other activities, notably those focusing on the work of Health Educators, have made great progress to ultimately achieve the Project Purpose.

When emphasis is placed on the progress of project activities within a set period stipulated in the PO, it could be argued that the efficiency of the Project is adversely affected by these delays. The truth is that the available time has been used effectively and three sets of guidelines for home visits and service provision at VHCs have been distributed to the relevant organizations and facilities throughout the four governorates. The remaining activities, including the finalization of draft policy recommendations, are anticipated to be completed as scheduled within the project period. This prospect indicates that the various setbacks described above have had little adverse impact on the ultimate achievement of the Project Purpose.

In short, the efficiency of the Project has been generally maintained in terms of the progress management of the planned activities.

(4) Impact

The following positive and/or negative impacts are confirmed and/or expected by the implementation of the Project.

As has been described, the Project demonstrated the efficacy of system and/or concept of Health Educator for the enhancement of RH/FP and women's empowerment at rural areas, especially in the poverty pockets with difficulties in accessing health services. However, it is obvious the number of Health Educators cannot be easily increased since its financial aspect should be taken into account for future deployment of this system to other areas. As for 43 Health Educators at work in VHCs, counseling services at VHCs and home visit activities are nearly embedded, and foundation of the system itself is considered to be founded by setting up guidelines and manuals, supportive supervision system, and means for regular monitoring. Thus, it is expected that the quality of services provided by the Health Educators would be maintained or enhanced after the end of the Project.

Meanwhile, community residents were principally hired as Health Educators and that contributed to favorable acceptance of Health Educators from the communities. Thus, difficulties regarding acceptance from communities should be taken into consideration when unacquainted medical staff were allocated. Moreover, it is considered that Jordanian side can afford monitoring expenses that are major maintenance costs for the system of Health Educator. However, initial investment such as training costs including TOT, arrangement of vehicles for monitoring activities, printing and distributing costs of guidelines, manuals and other printed materials, costs for VHC renovation, etc. should be taken into account for the deployment of the system to other regions, in addition to running costs aforementioned. In particular, in order to expand the system and/or concept of Health Educator, policy recommendations should be based on evidences with high reliability, and analysis results of necessary resources such as human resource, introduction and recurrent costs, and a roadmap for introduction should be accompanied to the policy recommendations.

Predominant role of Health Educators stipulated in the Project is to provide awareness-raising services with regard to RH/FP and women's empowerment. However, understanding of health conditions of family members in addition of targeted women by interviews, direct observations and simple testing (e.g. blood pressure) as well as basic first aid are included to their designated work as a part. Through the counseling services at VHCs and home visits by Health Educators, many community residents, suspected health abnormity such as sexually transmitted diseases in targeted women as well as any acute and/or chronic illness in family members, were referred to health facilities including VHCs and led to the initiation of medical treatment and/or healthcare. In detail, a total of 6,463 home visits were conducted in 4 target

regions from January 2010 to May 2011, and 1,113 cases out of 6,463 visits that were referred. Amongst 1,113 referred cases, 780 actual visits to health facilities were confirmed. From these facts, Health Educators contributes health management of community residents from the perspective of primary healthcare in addition to awareness raising for prophylaxis. Moreover, Health Educator is functioning in the referral system as front line players.

(5) Sustainability

Importance of comprehensive RH/FP is clearly cited in **"***Executive Development Program 2011-2013***"** and **"***Health Sector Strategic Plan 2010-2014***"**, which prescribes the concrete measures and policies for achieving this, and the MOH expressed verbally that the importance and priority would be maintained for many years to come. Moreover, as was stated in the "Impact" section, political proof should be given for official deployment of the system and/or concept of Health Educator to untargeted areas of the Project. Since the political recommendations with certain evidences and good practices are anticipated to be prepared within the project period, it is considered that the political sustainability will be secured to some extent.

Certain mechanisms to sustain monitoring and supportive supervisions for the performance of Health Educators to provide counseling services at VHCs and home visit were established. Since it is expected that travel costs, envisaged as a main running cost, will be affordable by Jordanian side, it is considered that financial sustainability of the Project can be secured from the aspect of maintaining the current project activities even after the end of the project period. However, financial sustainability, from the perspective of self-deployment of current activities to untargeted areas in the southern reasons and/or other central or northern regions, is unpredictable as of the time of the Terminal Evaluation, since certain amount of budget should be allocated as an initial investment for training costs, securing transportation, printing costs, etc. in advance.

Day-to-day activities of Health Educators, such as counseling services at VHCs and home visits, are stipulated in the Guidelines developed by the Project, and ditto with supervisory activities from superagency. And, the Team confirmed that the daily activities are conducted in accordance with the Guidelines. Thus, it is considered that sustainability from technical aspect will be secured to some extent, while the performance of each personnel varies. Furthermore, problems arising from daily duties are discussed amongst Health Educators and supervisors at monthly meetings, and complementary trainings are provided at the meetings, implying that it is expected to some extent that the performance of Health Educators will be enhanced even after the end of the project period. And, since the supportive supervision is highly contributing the reinforcements of practical service provision of Health Educators, sustainability from technical aspect will be consolidated if the supportive supervision were continued regularly.

3-3 Factors that promoted the attainment of the Project

(1) Concerning the project design

No major contributing factor has been observed as far as the project design is concerned.

(2) Concerning the implementation process of the Project

In the course of the Project, home visitors of the community support teams (CSTs) in the Karak Governorate who had been trained during "the Family Planning and GID Project in Jordan" were used as trainers for the OJT for Health Educators after the latter's assignment to VHCs. This arrangement had the positive result of improving the home visit techniques of the Health Educators.

3-4 Factors that impeded the attainment of the Project

(1) Concerning the project design

The decision was taken to make the HPC solely focus on policy making as mentioned earlier. This affected the implementation of the activities designed to produce Outputs 1 and 2 as the HPC was originally expected to become directly responsible for these activities. Because of the fact that policy making is the essential work of the HPC, such work should not be denied for the sake of the Project. Nevertheless, it is a simple fact that this decision necessitated a change of the project implementation system, which was not anticipated at the beginning of the Project. From the viewpoint of producing Outputs to achieve the Project Purpose, this change was an inhibiting factor for the overall effectiveness of the Project. In the light of this new situation, the focal areas were reduced from six villages to three villages after the Mid-term Review to enable the effective implementation of the planned activities.

(2) Concerning the implementation process of the Project

Many of the target communities have a complicated tribal mixture and it was difficult in some of these communities to establish a community-wide collaborative and trustworthy relationship for the Project. Moreover, the level of conservatism varies from one area to another, resulting in different levels of output achievement. In order to tackle this issue, the Project conducted a series of community events to introduce the project activities and promoted better understanding of community people.

3-5 Conclusions

The Team concludes that Outputs are comfortably achieved and Project Purpose could be comfortably achieved by the end of the Project period though due consideration should be paid to the achievement of Overall Goal.

As a result of series of meetings, interviews and surveys involving beneficiaries, organizations, stakeholders, experts and other personnel related to the Project, it was found that the whole set of the results and impacts produced by the Project has been outstandingly valuable in the light of improving RH/FP in Jordan. The Project in the long run may contribute significantly to the improvement of RH/FP in Jordan.

The Project demonstrated the effectiveness of RH/primary health care services provided by community health workers (Health Educators) at VHCs and at home visits for the improvement of RH/FP and women's self-empowerment. Pre-and Post-test evaluation revealed that CPR significantly improved among the women at intervention villages where Health Educators are providing services at VHCs and home-visit counseling program compared with the pre-intervention rate; and particularly women who have received home-visit program increased their CPR from 43.7 to 55.6. The utilization of postnatal care was also improved among women of intervention areas and thus it was concluded that the services provided by Health Educators at VHCs or at home increased the access to basic RH/FP services and improved the RH/FP practices. It was also demonstrated that women with improved self-empowerment and/or when their husbands' attitude toward women's health is supportive, women's utilization of contraceptives and FP/RH services increases.

It was concluded that the RH and primary healthcare services provided by Health Educators in the rural health post (VHCs) or at home are effective in improving women's health particularly their contraceptive utilization and service utilization, and thus they can improve the RH situation in Jordan in the long run. Therefore, it is highly expected that Overall Goals, which are health outcomes, would be achieved later by sustaining and scaling up the project activities. To scale up, it is necessary 1) to sustain the community outreach RH/FP services at project target areas (73 villages in the southern region where MOH VHCs are

functioning), 2) to continue to empower Health Educators through continuous supervision, refresh training and provision of institutionalized support and 3) to scale it up to the other regions of Jordan (middle and north regions).

Moreover, community outreach RH/FP and primary healthcare approach may be applicable to many other Middle-East countries where the human and fiscal resources are limited, problems of inequity in access to the health services exist, and women's health are compromised with the socio-cultural norms. Therefore, the project's approaches and achievements should be fully documented and shared regionally and globally.

3-6 Recommendations

<The HPC >

1. Review and adopt the policy recommendations related to RH/FP programs. Tentative recommendations under preparation are followings:
   - Home visit program should be rolled out to other rural areas in Jordan, ・
   - Self-empowerment of women should be integrated into the awareness-raising program of RH/FP. It should also be included in the training package for health providers and community health workers related to RH/FP, and ・
   - VHCs should provide pill and condoms in other part of Jordan. ・
2. Advocate the adopted policy recommendations by coordinating various stakeholders related to RH/FP.
3. Monitor the MOH to sustain the outreach RH/FP services and empowerment of Health Educators. Following indicators for overall outcomes should be monitored annually by National RH Steering Committee and shared among stakeholders including JICA:
   - National CPR,
   - Provision of RH/FP services, and
   - Utilization of RH/FP services.

< The MOH：Central Level >

1. Continue to provide technical and institutional support such as supportive supervision and refresher trainings for Health Educators to maintain their motivation and quality of services.
2. Sustain the monitoring and supervision system of Health Educators and VHCs. Following indicators should be monitored quarterly, and shared among stakeholders including JICA.
   - Number of monthly meetings conducted in four governorates in South, ・
   - Number of home visit, referral cases, and actual visit cases reported by Health Educators, ・
   - Number of supportive supervision conducted in 4 governorates in South, and
   - Major problems identified by the supervision and counter-measures taken by 4 governorates in South. ・
3. As an option, if it is good for sustainability, consider integrating the existing monitoring and supervision systems piloted by various stakeholders in various areas in the country and develop a unified monitoring and supervision system from central level to the regional health directorates (CHC, PHC, and VHCs) in cooperation with other development partners.
4. Provide certificate of their job description for Health Educators since their current official job title of "Service Worker" does not reflect their certified responsibilities and cause misunderstanding among villagers. In the mid- and long-term, the MOH should continue to request other responsible parties to

change official job title of "Service Worker" to reflect their job description.

5. Support existing efforts to expand the coverage of home visit programs within the rural south region.
6. Scale up the improvement of services at VHCs and home visit programs adapted to the other regions of the country (north/middle). Unit cost for each activities, such as for training, supervision, monthly meetings…etc. should be added in the scale-up proposals so that the decision makers can make decisions.
7. Although it is not practical to recruit new Health Educators due to the financial burden, the MOH should consider it in case that newly graduated nursing carder and midwives are not available in some remote villages.
8. Prepare/Revise a strategy of health human resources development and plan to deploy qualified and motivated midwives and/or nurses fulltime in all the villages. It is meaningful to provide job opportunity for a village woman to be a Health Educator and give her a responsibility to take care of villager's health. This contributed to the empowerment of both Health Educator and client women. However, the employment of the village women to be a Health Educator is not a solution to the shortages of health providers in rural areas.
9. Examine the roles of male Health Educators and guide them to perform effectively in community primary healthcare programs.

< The MOH: Regional Health Directorates >

1. Continue to support Health Educators to exert their maximum capacity by providing technical, emotional and institutional support to them through regular meetings, supportive supervision, protecting their roles and promoting their job satisfaction. Take necessary counter-measures to solve problems associated with Health Educators' activities.
2. Comply with "Operational Manual for VHCs in the South Region" and "Handout of Monitoring and Supervision Process" and conduct monitoring and supervision by utilizing the vehicles procured by JICA.

< The Project / JICA Experts>

1. Submit the policy recommendations to the HPC and the MOH.
2. Disseminate the achievements of the Project through conducting dissemination seminars (national and local).
3. Compile essential information to introduce home visit activities and services at VHCs at other areas of Jordan, which include procedures and initial investment for introductory trainings to nursing carder and midwives in cooperation with the MOH.

< Headquarters>

1. "RH/FP and Gender in development Project (1997-2003)" together with this Project (2006-2011) have accumulated both theoretical and practical knowledge, methodologies, instruments, human resources and networks. Key essences of the Project, such as how to reach out to the most vulnerable women and provide them with reproductive health information and services in rural Muslim society, should be extracted into the document and widely shared with stakeholders including development partners in the region.
2. Consider assisting the HPC and the MOH in near future to facilitate advocating the policies adopted

and monitoring Health Educators' activities in south region.

3-7 Lessons Learned

1. In order to reach the target population, community leader's approval and community's involvement was necessary in the rural areas. The Project conducted a series of community events to introduce the project activities and promoted better understanding of community people.
2. It may be easier to target women individually rather than the community as a unity in supporting the community development program. The community development project in this project was not easy to conduct because the needs and values of the community are not always unified due to the existence of tribalism, internal conflict and individualism. It was successful in Phase 1 and 2 in supporting women's income generation activities at home as an entry point to gain male's approval and community's approval.
3. Women's health behaviors were influenced by 1) women's self-empowerment, 2) availability of health services provided by female health workers and 3) approval from the males in the community.
4. It was not easy to change male's attitude towards women's health and empowerment at rural areas where the socio-cultural norms affect their behaviors.
5. Questionnaire survey may not be suitable to evaluate men's knowledge, attitude and practice in conservative rural areas because men do not express their honest feeling and opinion and their social-desirability is reflected in their answers.
6. Methodology of baseline and end-line survey (sample size, study schedule, data collection method, target population, indicators, and statistical analysis) is needed to be confirmed as a study package prior to the implementation of the interventions as well-designed study can produce stronger evidence. It cannot be helped, however, to make necessary adjustment in the course of implementation when the Project is designed to achieve the purpose. It may be necessary then to formulate a separate research project designed for testing the impact of the intervention.
7. Improvement of both demand side and supply side is important to promote changes in people's attitude and practice related to RH/FP. Men's and Youth's demands for RH/FP information and services are as important as women's and thus their demands should be taken into consideration when promoting women's health in rural areas.
8. Home visit program is effective when it is conducted with assurance of quality and intensity. While quality must meet the needs of the community and standard of MOH guideline, the frequency and intensity of visit is also important. The Project demonstrated the effectiveness of home visit program by conducting it both with quality and intensity (6,463 home visits conduced during January 2010 - May 2011.)

3-8 State of the follow-up