Assessment of SRH Integration in Selected Arab Countries
"Jordan Country Report"

Expert Group Meeting

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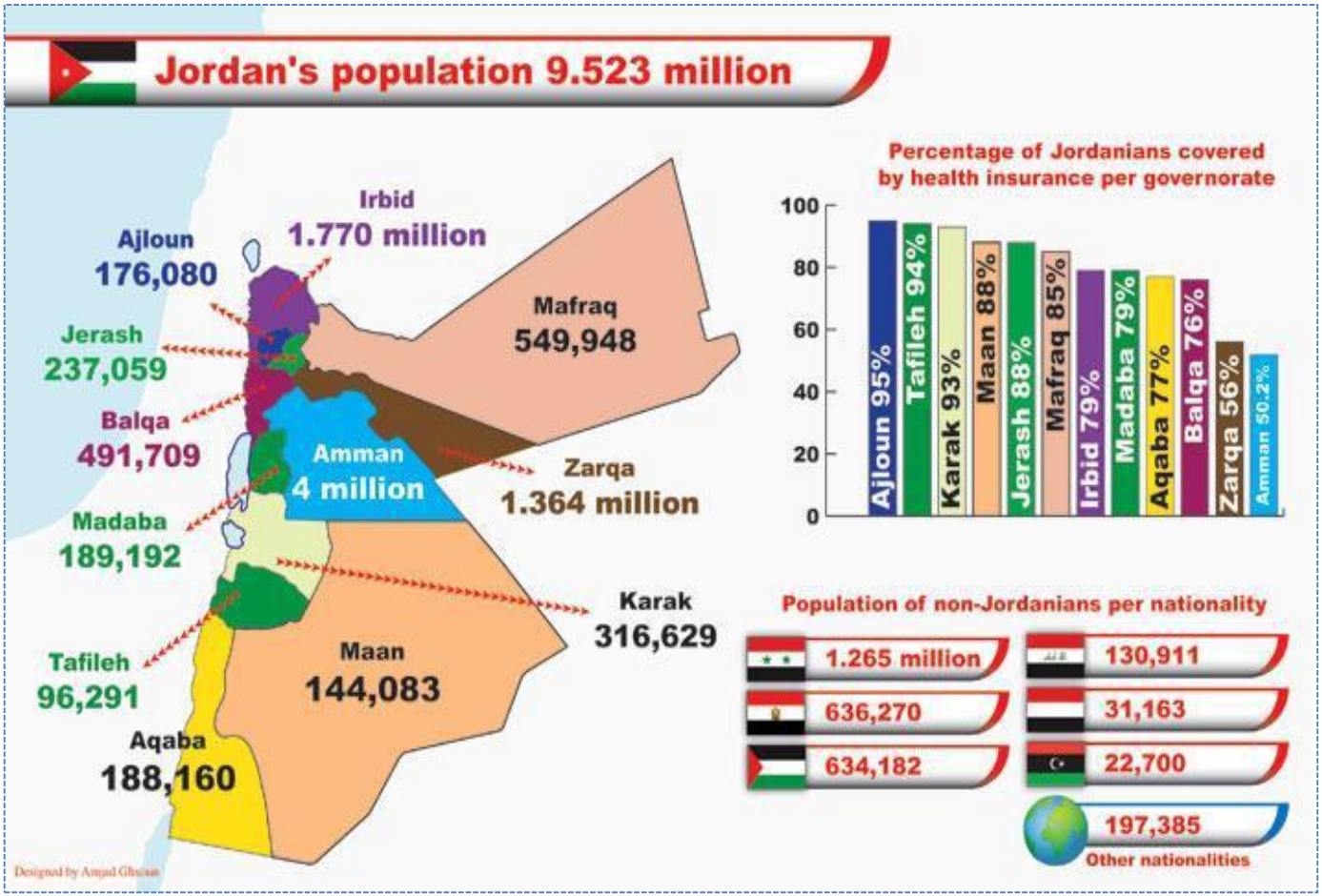
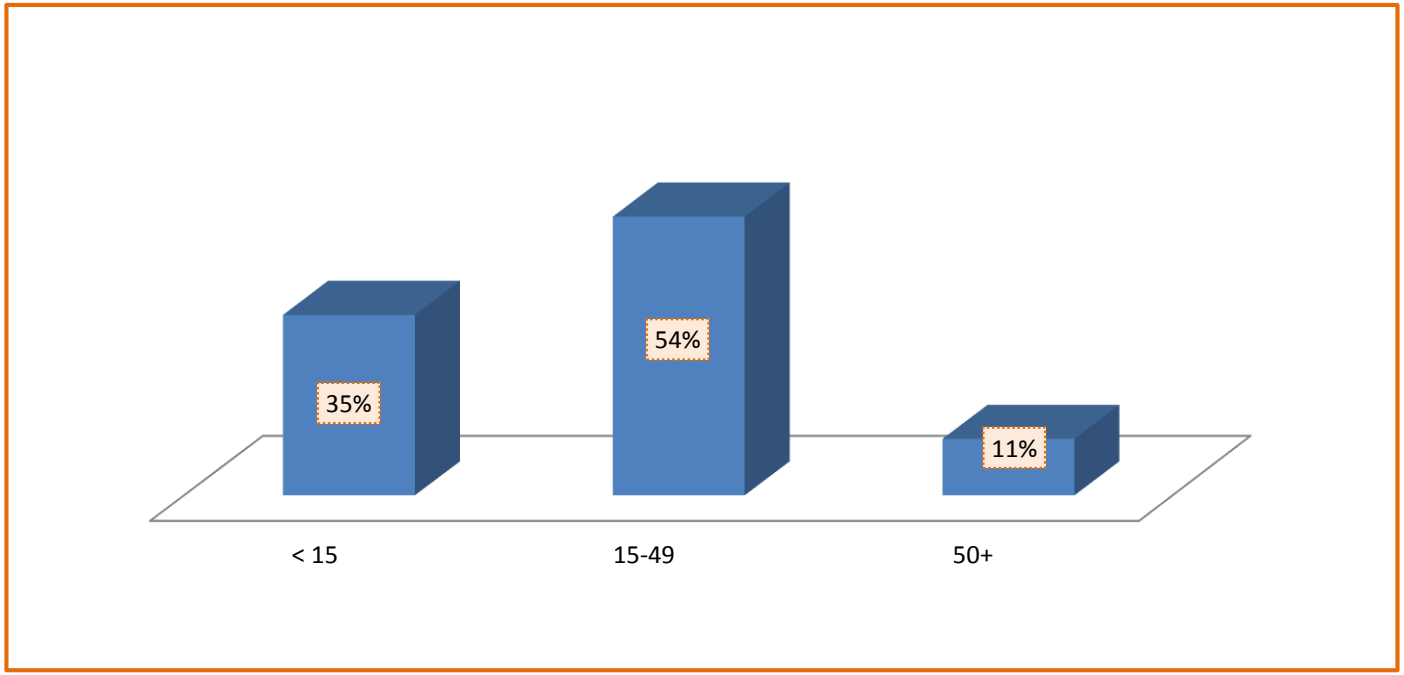
Background

Estimated current population of Jordan at 9.8 million, up from 9.5 million in 2015 census

The 2016 Annual Statistical Report of the Ministry of Health



Background : Age structure



Of the 54% , 2,355,305 females in reproductive age.

Further action to integrate sexual and reproductive health (SRH) in order to :

- Cope with the large proportion of youth and reproductive age population cohorts
- Improve access to comprehensive SRH services and increase coverage to meet the need for quality services.

Health outcomes Indicators

- Life expectancy at birth: stable at **74** years since 2007 through 2015,
- Birth rates: decreased from **29.1** per 1,000 population in 2007 to **23.0** in 2016
- Eradication of infectious diseases such as polio
- Civil health insurance has expanded and to automatically cover the following groups:
  - » pregnant women

    (for free for Jordanian women and for nominal fees of 75$ for non-Jordanians)
  - » children under six years of age
  - » individuals over 70 years of age (*nominal fees, 100$ per year)*
  - » residents of remote areas and the less advantaged (beneficiaries of the National Aid Fund).

SRH and FP indicators

Indicator	Value
Total Fertility Rate (TFR)	**3.38** was the total number of children a woman would have by the end of her reproductive period(MOH statistical report 2016)-3.5 JPFHS, expected to be lower in Jordanians and higher among Syrian refugees **(2.6 !)**
Contraceptive Prevalence Rate (CPR)	**61%** Percent of women of reproductive age (15-49) who are using (or whose partner is using) a contraceptive method
Maternal Mortality Ratio (MMR)	**19** (per 10000 live births) **(Maternal Mortality Surveillance and Response System)**
Antenatal Care Coverage	**99%** of women attended at least once during pregnancy, by skilled health personnel
Percent of Births Attended by Skilled Health Personnel	**100%** of births attended by skilled health personnel
Availability of Basic Essential Obstetric Care	**3.6** facilities with functioning basic essential obstetric care per 500,000 population
Availability of Comprehensive Essential Obstetric Care	**3.1** facilities with functioning comprehensive essential obstetric care per 500,000 population
Perinatal Mortality Rate (PMR)	**17** neonatal /perinatal deaths per 1,000 total births

SRH and FP indicators

Indicator	Value
Low Birth Weight Prevalence	**8.6%** of live infants weighed less than 2,500g
Prevalence of Anemia in Women	**23.7%** (MOH) **33.5%** JPFHS 2012
Knowledge of HIV-related Prevention Practices	**13%** of all respondents who correctly identify all three major ways of preventing the sexual transmission of HIV and who reject three major misconceptions about HIV transmission or prevention
Unmet need for FP	**12%** women with an unmet need for FP at the time of JPFHS 2012.
Method mix Percent of users by FP method at a particular point in time.	At the time of JPFHS 2012. • Modern methods **42%:** IUD **21%,** Pills **8%,** Condoms **8%,**F. Sterilization **2%,** Injectables and implants **1%** • Traditional **19%**
Desire for additional children	**53%** of women reported that additional children are/are not desired at the time of JPFHS 2012.

SRH and FP indicators

Indicator	Value
Positive Syphilis Serology Prevalence in Pregnant Women	NA
HIV Prevalence among Pregnant Women	NA
Percent of Obstetric and Gynecological Admissions Owing to Abortion	NA
Unintended births	NA
Prevalence of Infertility in Women.	NA
Reported Incidence of Urethritis in Men	NA
Reported Prevalence of Women with FGC	NA

National SRH policies and strategies

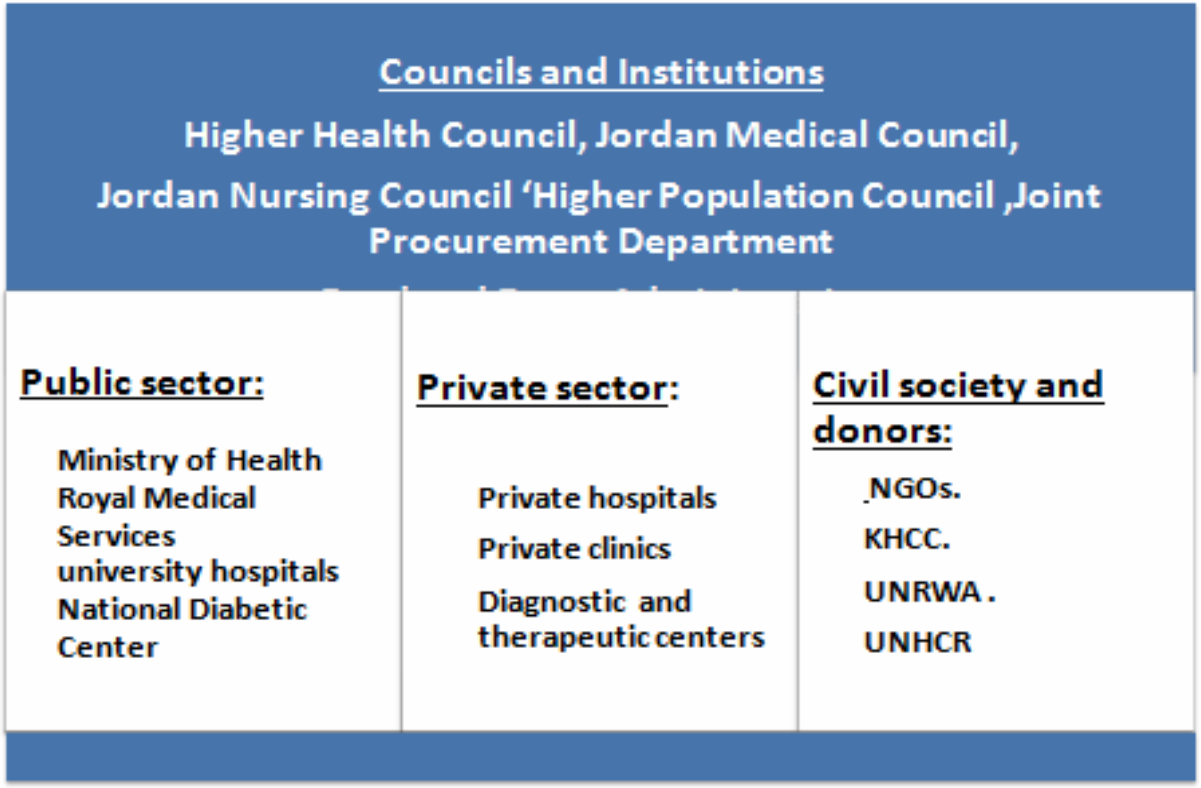
- The **HPC** developed the National Strategy for Reproductive Health/Family Planning was developed for 2013–2017.

- In 2013 **MOH** developed the Strategic Plan for Family Planning, to cover 2013–2017.
- **MOH strategic plan** for 2013–2017where Strengthening FP , reproductive, maternal, newborn, and child health care services were identified as one of the MOH's main institutional objectives .
- **The public health law** :

  antenatal care, delivery, postnatal care, family planning, neonatal care, monitoring child growth and development, vaccination, and curative health care for children under the age of six, in addition to the promotion of breastfeeding and premarital screening according to the relevant regulations.

The concept of sexual health has not been promoted , and other reproductive health components were not explicitly addressed, with only limited preventive and treatment services for infertility, abortion and treatment of reproductive tract infections

Jordan Health System



- Other stakeholders were identified as having roles in health governance including parliament, professional associations, academic, international, and customer representatives.
- **MOH** mandate is to maintain public health by providing preventive and curative health services, as well as regulating and overseeing health services provided by both the public and private sectors.

PHC system

Jordan PHC system includes public, private, and civil society (non-governmental organizations and donors)

- The MOH is the main public provider of PHC services in the county; within the MOH,
- **Central Primary Health Care Administration** and the **Central Health directorates Administration** are the governmental entity responsible for primary health care provision in the country.

- Out of the **8 PHC departments**, the following SRH components are addressed vertically at the three following departments :
  - Maternal and child health; Maternal health , FP services , child health ,and GBV/family violence -
  - Communicable diseases: HIV reporting and treatment and reporting of sexually transmitted diseases -
  - Chest diseases and immigrant health: HIV testing for non-Jordanians

PHC system

Service-provision level

There are **686** Public PHC centers distributed throughout the 12 governorates:

- All provide primary health care services according to MOH standards and clinical guidelines
- Are of three types based on the existence of specialized doctors and laboratory services and subsequently the scope and comprehensiveness of services provided.
  - Comprehensive: **109** (102 MoH, 6 RMS. 1 Public University**)**
  - Primary : **383**
  - sub-centers:**194**
- **464** have semi-independent Maternal and child health centers (MCH) sections within the comprehensive centers, and exist in most primary centers and in a limited number of the sub-centers.

- Regarding SRH specifically ,components are distributed between three programs at the central level , therefore the mandate is way wider than that of the (MCH) which provide RH/FP services mainly for married women of reproductive age.

- Other SRH services, STDs including HIV, post- abortion care, infertility , family planning to males, unmarried women, or youth are not specifically provided at any of the three types of the PHC centers.

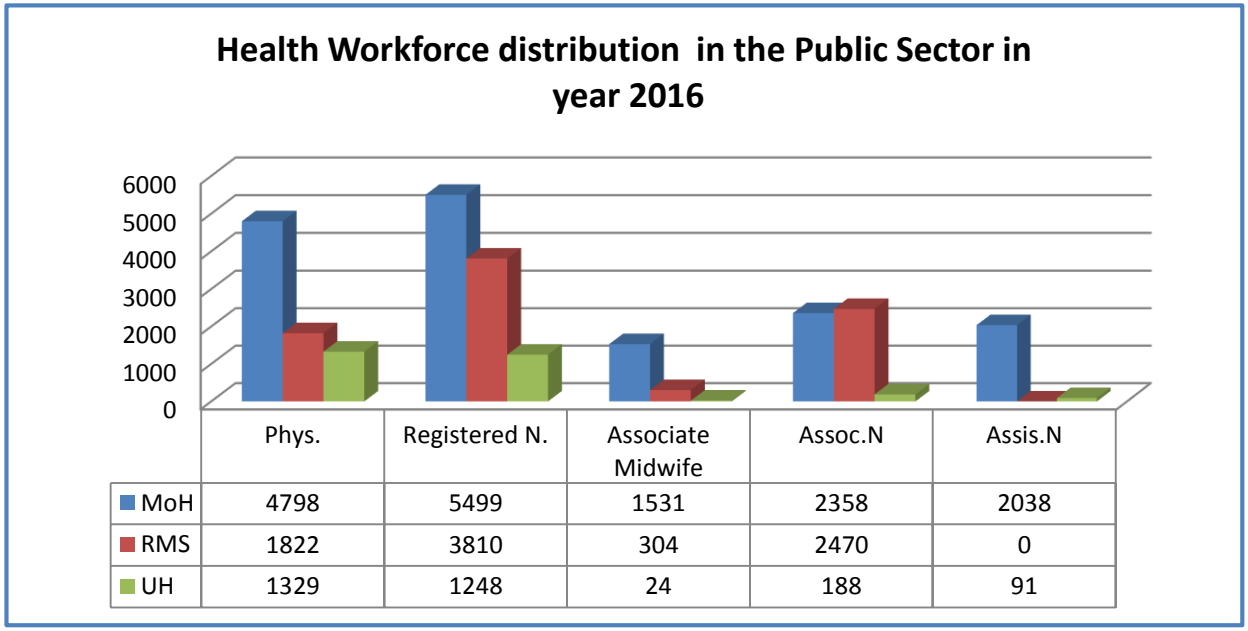
PHC in the Private sector

- There are about **8,000** private clinics in the country
  - Most are general practitioners (GPs), but the number providing or dedicated to the provision of SRH care is not identified in any official document.

- Many civil society organizations are also involved in PHC , but the principal organizations providing SRH are :
  - Jordan Association for Family Planning and Protection (JAFPP) , **20** clinics
  - United Nations Relief Work Agency for Palestine Refugees (UNRWA), **24** clinics
  - Institute Of Family Health-Noor Al Hussein Foundation (IFH-NHF), **18** clinics.

Health workforce

- Human resource is a valuable asset and strategic pillar for the efficient function of the country's health system



	Phys.	Registered N.	Associate Midwife	Assoc.N	Assis.N
MoH	4798	5499	1531	2358	2038
RMS	1822	3810	304	2470	0
UH	1329	1248	24	188	91

Around **669** GPs, **59** family medicine specialists, **652** registered nurses, **742** associate midwives, **652** associate nurses, and **743** assistant nurses currently work at MOH primary health care centers, with the majority engaged in SRH service provision, mainly maternal , child , and family planning services

Gaps/challenges and recommendations

National level	
Challenge	**Recommendations**
SRH is not well articulated in the national development and health related strategies or policies	Advocate for a high-level political commitment and legislative reform to allow the conceptual, technical, administrative support for SRH comprehensiveness and integration in health polices and plans
Lack of sufficient financial allocation for health ,PHC share is only 16% of MOH budget(as compared to 42% for SHC)	Increase PHC allocations and include specific budged allocations for the full range of SRH integration within the primary public-sector, namely MOH and RMS.
Disruptions in international organizations' funding (3.63%) and support of major components of sexual health, such as infertility and STDs (including HIV/AIDS).	Work with funding agencies to ensure more coordination and consistency within the implementation plans, to reduce duplication and ensure coverage of the newly expanded range of services.

Gaps/challenges and recommendations

Central MOH level	
Challenge	**Recommendations**
Organizational resistance \cultural financial barriers at the level is a long and tough process	Facilitate the development and adoption of a cost-effective package containing the full package of sexual health components.
Existing SRH programs are limited to maternal, child health and family planning.	Expand the range of the service package to include infertility, safe sex, post- abortion care , family planning to males, unmarried women and youth, HIV counseling and prevention, STD screening, proper management and reporting .
Existing SRH programs are vertical	Advocate for more coordination and alignment at the central level throughout the planning and implementation , monitoring , data generation and analysis for future planning

Gaps/challenges and recommendations

Central MOH level	
Challenge	**Recommendations**
High staff turnover due to lack of incentives, in addition to the ongoing leakage of qualified providers to neighboring Arab Gulf countries,.	Facilitate and support institutions that train human resources and professional development bodies to provide adequate numbers of trained staff to overcome high turnover, based on continuous needs assessment
	Retain and expand the existing qualified workforce to carry out the anticipated increase in demand and workload requirements.
Current PHC information system is fragmented and does not provide comprehensive information about SRH utilization at the various sections of the PHC centers	Strengthen the SRH information which could be addressed by forging a consensus on relevant sexual health indicators among the main stakeholders to overcome gaps in SRH data collection and reporting (Hakeem e-health program at the PHC and SHC levels).

Gaps/challenges and recommendations

Health directorate/governorate level	
Supervision and data compiling follows the central vertical nature of the existing SRH programs	Adopt longitudinal integration of services and report generation at the governorate and district levels and provide proper supervision at this level
Service delivery level	
PHC centers' readiness varies according to type and geographic location.	Identify and address different governorates ' SRH integration priority needs in terms of infrastructure, manpower, administrative policies \ procedures, and financial allocations
	Scale up the capacity of the existing PHC infrastructure to facilitate application of the approved standards of care (expand woman and child health sections and ensure a male- and youth-friendly atmosphere, including in waiting areas.
The structured Internal referral is limited to FP services	Strengthen the internal referral system within the PHC centers (and sub-centers), and among the deferent types; comprehensive and primary health centers to ensure that the identified SRH are addressed at the designated sections by qualified providers

Conclusion

Integration involves more than a political commitment, regulations, and resources; it is a process and a collaborative efforts that must be implemented over time.