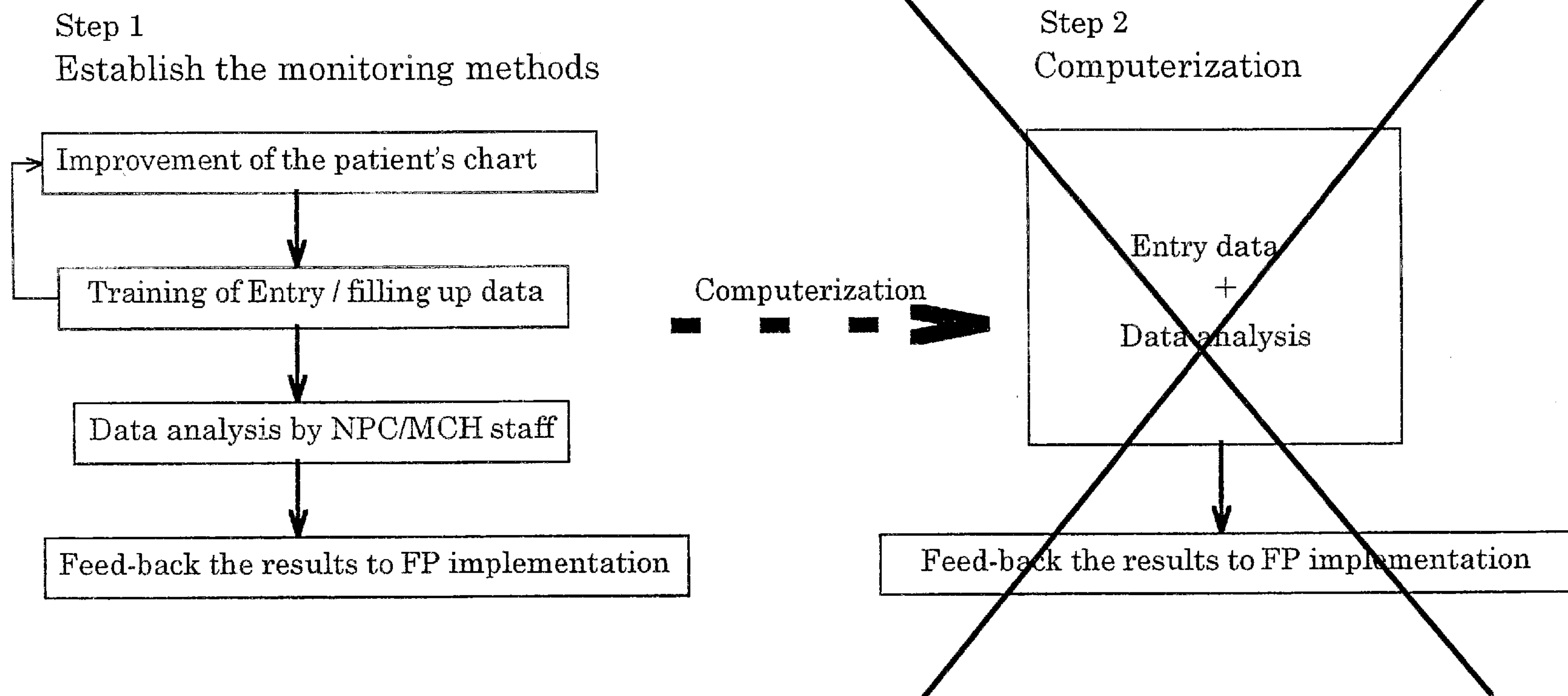
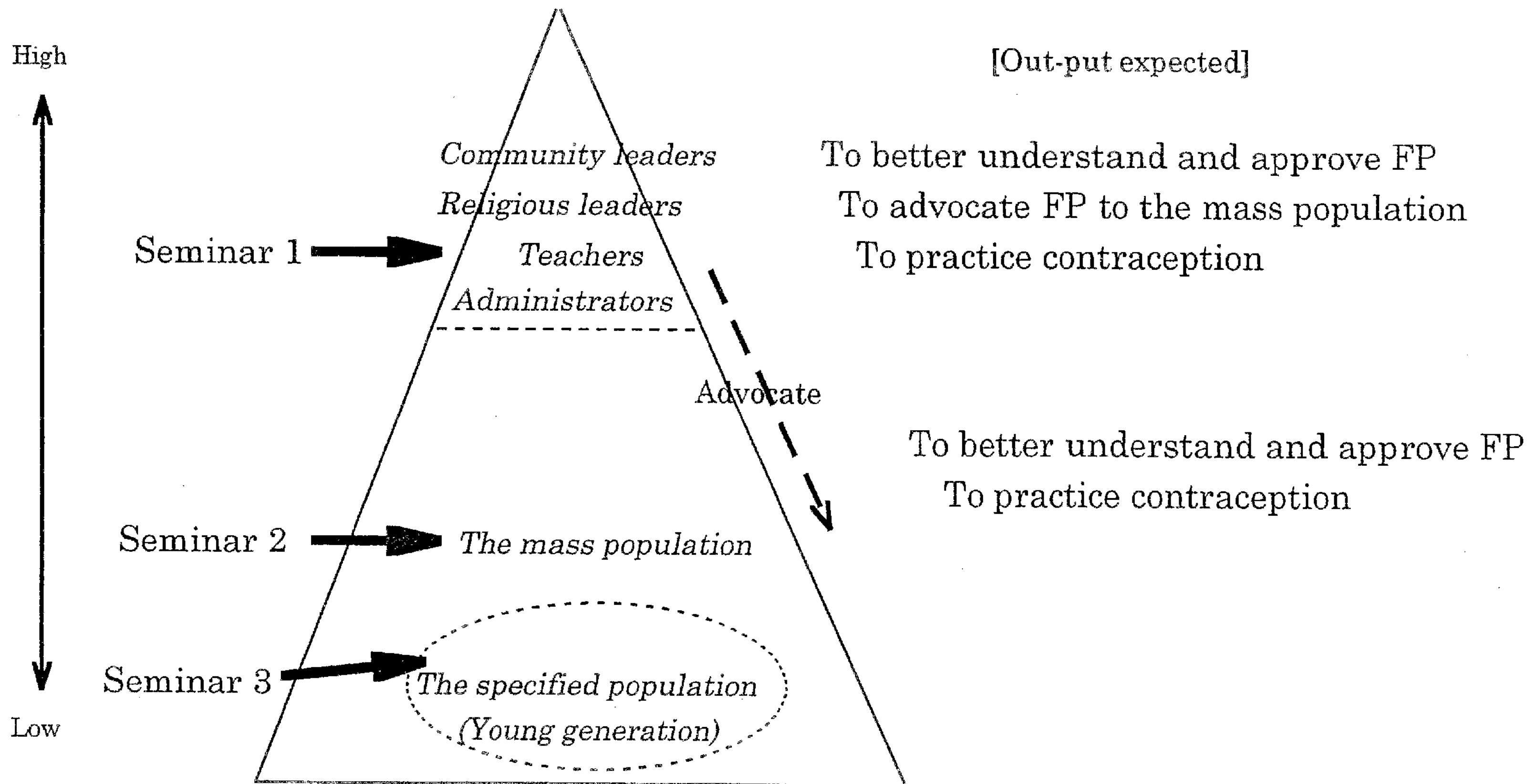
④ 活動フレームワーク図（モニタリング、男性セミナー）

モニタリングフレームワーク

Framework for monitoring the transition of the effects of contraception and CPR



Framework of seminars (1-3) for men, according to target groups and out-put expected



⑤　ＭＣＨ／ＦＰ短期専門家活動計画

短期専門家　丹野かほる　(MCH／FP)

１．プロジェクトサイトのある地域の各施設、病院、Maternal and Child Health Center（以下M.C.Hセンターと略す）、Primary Health Center（P.H.Cと略す）における医療、看護サービスの情況を把握する。とくに、助産婦、看護婦、看護助手の業務内容および看護上の問題点を把握する。

１）Ghor-safi Hospital
２）Ghor-safi P.H.C& M.C.Hセンター
３）Mazraa P.H.C& M.C.Hセンター
４）Hadithe P.H.Cブランチ
５）Mamura P.H.C
６）Fifa P.H.Cブランチ

２．具体的活動内容

１）教育活動の普及とその支援

（１）Ghor-safi hospitalにおける教育活動を開始する（家族計画を含む母子保健）
（２）Ghor-safi M.C.Hセンター及びMazraa M.C.Hセンターにおいて家族計画指導の開始、妊婦教育の充実が図れるように支援する。

トレーニングの実際

（１）教育活動の実際を体験することにより、そのプロセスを理解させ教育活動の重要性を学ばせる。反復実施することにより、教育活動の質を高めていけるように動機づけを行なう。また、教材の制作も実施させる。
テーマ：妊娠中の管理、産後の管理、母乳栄養、家族計画
（２）助産婦、看護婦、看護助手対象の基礎看護技術指導（集団指導）
テーマ：包帯法、血圧測定、注射法
（３）助産婦対象の妊婦管理の実際（個別指導）
テーマ：妊婦観察の実際、教材使用による妊婦教育および家族計画指導

２）家族計画の普及に関する活動

（１）助産婦、家族計画に関る看護婦のトレーニング（集団指導）
テーマ：①家族計画におけるカウンセリング

（２）男性対象セミナーへの参加（講義）
母子保健における家族計画の重要性について…エジプトの体験から…
（３）地域開発推進員対象のセミナーへの参加（講義）
コミュニティにおける推進員の役割と重要性について

３）男性参加型の家族計画の啓蒙促進についてニーズの把握

男性対象のUNMET NEED に関する調査

*以上、活動計画を実施するにあたり、プロジェクトのR/Dの内容、、ベースライン・サーベイの結果・提言、プロジェクトのねらい、P.C.Mの内容等に留意しながら実施する。

家族計画・母子保健サービスの強化

問題点

1. 家族計画サービスは母子保健センターで提供されているが、助産婦による家族計画・母子保健に関する教育活動は実施されていない。
2. 家族計画・母子保健サービスの強化に向けて、助産婦だけではなく医療従事者においても意欲が乏しく、また関心も薄い。
3. 避妊法の種類は首都において 8 種類の選択肢があるが、プロジェクトサイトにおいては 4 種類(ピル、注射法、コンドーム、IUD のみである。しかし、IUD に関しては挿入できる医師が一人しかいないので、利用者にとって選択の幅が狭められている。
4. 家族計画・母子保健サービスの強化に関して、住民に対する情報伝達の手段であるポスター、パンフレット等教材が不足している。(無いに等しい)
5. セミナー、トレーニングで提供した教材が利用されていない。使用方法はわかるが説明する内容について知識が乏しい。

活動計画の説明

1) 病院における妊婦教育の実施
   ・テーマ;妊婦管理、産後の管理、母乳栄養、家族計画
   ・形態;集団指導
2) 母子保健センターにおける産後教育、家族計画指導(助産婦)
   ・テーマ;産後の管理、家族計画指導
   ・形態;個別指導
3) プライマリーヘルスセンターにおける教育活動の実施(プラクティカルナース)
   ・母子保健・家族計画
4) その他

1. 家族計画啓蒙活動のターゲットグループ
   啓蒙活動と同時に<u>必要とする人に</u>、<u>必要とする時期に</u>、<u>必要とする避妊方法を</u>提供できなければならない。したがって妊婦や産婦への家族計画指導は重要である。ターゲットをしぼる。
2. 地域の特殊性
   閉鎖的、受け入れ態勢がない、協働姿勢がない、傍観者的、意欲がない
3. マグネル教材について

⑥　９月９日ＷＩＤセミナー議事録

Female Education in South Ghors

The Beginning of The Education

The first school at Safi for example, was established in 1947. Before that date, teaching was traditional sample which was called "The egg and the loaf". This kind of teaching was achieved by a man called "Sheikh Subri", who was teaching his students reading, writing and maths and his students gave him some eggs and bread. The seats were bricks of clay and the board was a traditional wood.

The main aim of this kind of teaching that time, was to recognize only how to read and calculate in order to read or write a letter to the friends.

In 1947-1948 the official and the compulsory teaching has begun since then. As a result, about thirty-eight male students entered the school in the first class in Safi for example, but at Al-Mazra'a the number was less than in Safi.

It was thought that the teaching of the female students was shameful and ignored by the whole of the community.

As a result, girls didn't enter the school until the academic year 1950-1951.

50s decade

In this decade sympathetic feeling were aroused by same families especially who came from areas outside Ghors. They believed that their girls must have their value of teaching. In 1950-1951 the first girl entered the first class among some male students. This girl was from Egyptian origin.

In the year 1953/1954 only one female among fifty-three male students entered the first class, in 1956/1957 six girls joined the first class but nine girls joined in the next year.

In the same year six girls entered the second class, six girls in the third class and seven in the fourth class.

Here is a name list of some female students in Safi as example.

Name	Class	Academic year
KHALELEIAH SUIAYMAN	1st	57/58
HAMDAH HMOOD	〃	
KAMELAH SULAYMAN	〃	
MOYASSAR MA'ANI	〃	
SEHAM AL-MOSELI	〃	
SEHAM DIEFALLAH	〃	
ABLAH DIEFALLAH	〃	
MALAK ATTAR	〃	
EFTEKAR FARIS	2nd	〃
JAMILA ABED	〃	
KHADEJAH AU	〃	
DAIAL ABED	〃	
RABI'A EZZAT	〃	
SAMEERA MOH	〃	
ZOHEIR KALAF	3rd	〃
WASFEIAH MAHMOUD	〃	
MAHA MOBREK	〃	
NEAMAT MA'ANI	〃	
NAWAL ABED	〃	
HAFIDAH AHMED	4th	〃
FERYAL AHMED	〃	
ZAREEFAH ABED	〃	
AFAF JOWEEHAN	〃	
FEKRAT AL-MA'ANI	〃	
FOWZEYAH KALEB	〃	
HEND SULAYMAN	〃	

Unfortunately, most of these girls failed to continue their school or learning for social and economical factors especially, those in the Ghors. But the girls who were from outside the Ghors managed to continue their education. We remember two of them, named "Khaulah and Nawal Al-Masri".

The higher class that they reached was the sixth, such as "Zohair Khalaf, Khaleileih and Kameleh Al-Khliefat."

-Advanced Look about Education-

This area has suffered so keenly and faced hard conditions as a result of the Israeli occupation upon Ghors in general. This has led to a political unstability in this region which conflicted the social and the economical sides which the education depend upon generally.

As a result, we haven't seen any kind of positive success during the 1960s and the 1970s. Finally, in 1978, the sunshine for the first time in Ghor Al-Mazra'a, teacher Eiatedal Al Doghaimat graduated and became the first girl who got a high degree of teaching. In 1980 about eight female teachers graduated and since that time up to now the number has been increasing rapidly.

In the present decade the struggle and the need for teaching girls has been increasing because of the programs of the mass media. This encouraged people to look after their girls and allow them to join the school without hesitation for many reasons: First girls can earn a good income which in turn improve the condition of their families; second, the men are looking for qualified wives. This made the girls' fathers be sure that there aren't reasons to prevent them from teaching their daughters.

These factors and others basically changed the community concept/ideas about teaching the girls.

In the past decade a large number of girls joined the university and now there are some of them in school, others in hospitals. We have Sa'ada AL-Hoshosh and Amal Maradet, for example.

Some girls joined the intermediate institutes and they are now working in hospitals as nurses, or govern employments at Jordan valley authority, telecommunication and other departments. At the same time girls begin to participate in social affairs. They can elect as well as the men. This is clear now when we can see a woman called "Ebtisam Al-Hoshosh" work as an assistant of the Municipality headquarters. Girls now are shiring men with some kind of voluntary projects.

The number has been increasing in 1990s and we are looking for a large number of girls to graduate and participate in serving their community in all aspect of life in order to reach the self-dependence especially in teaching and nursing fields.

Future look

People of Ghors, after they got rid of barriers to educate the girls, are expecting balanced and perfect future mothers who are aware of their children, especially if they are educated.

All the people here emphasise to make women in the first class, but we need more open lectures for the level of the old people. Basically we can say that there is a wide improvement between the beginning and the present and we see from time to time that more girls who enroll school than the boys. This is a positive point that the teaching is going in the right direction.

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20 - 24 April 1998, New York
Item 4 of the provisional agenda
UNFPA

UNITED NATIONS POPULATION FUND
PROPOSED PROJECTS AND PROGRAMMES

Recommendation by the Executive Director
Assistance to the Government of Jordan

Proposed UNFPA assistance: $4.5 million, $4 million from regular resources and $500,000 from multi-bilateral and/or other, including regular, resources

Programme period: 5 years (1998-2002)

Cycle of assistance: Fifth

Category per decision 96/15: B

Proposed assistance by core programme areas (in millions of $):

	Regular resources	Other	*Total*
Reproductive health	2.8	0.5	3.3
Population & development strategies	0.4	-	0.4
Advocacy	0.4	-	0.4
Programme coordination & assistance	0.4	-	0.4
Total	4.0	0.5	4.5

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JORDAN

INDICATORS RELATED TO ICPD GOALS*

		Thresholds*
Births attended by health professional (%)[1]	87.0	≥60
Contraceptive prevalence rate (15-44) (%)[2]	35.0	≥55
Access to basic health services (%)[3]	97.0	≥60
Infant mortality rate (/1000)[4]	36.0	≤50
Maternal mortality rate (/100,000)[5]	48.0	≤100
Gross female enrolment rate at primary level (%)[6]	98.0	≥75
Adult female literacy rate(%)[7]	72.7	≥50

* AS CONTAINED IN DOCUMENT DP/FPA/1996/15 AND APPROVED BY THE EXECUTIVE BOARD IN DECISION 96/15.

[1] *WHO, Coverage of Maternal Care, 3rd ed., 1993. Data cover the period 1983-1993.*
[2] *United Nations Population Division, World Contraceptive Use 1994, ST/ESA/SER.A/143. Data cover the period 1986-1993.*
[3] *UNICEF, The State of the World's Children, 1995. Data cover the period 1985-1993.*
[4] *United Nations Population Division, World Population Prospects Database 1950-2050, 1994 Revision. Data are for 1992.*
[5] *UNICEF, The State of the World's Children 1995, which is based on data compiled by WHO. Data cover the period 1980-1992.*
[6] *United Nations Statistical Division, Women's Indicators and Statistics Database, Version 3 (CD-ROM), 1994, which is based on data compiled by UNESCO.*
[7] *UNESCO, 1996, Education for All: Achieving the Goal: Statistical Document. Two dashes (--) indicate that data are not available.*

Demographic Facts

Population (000) in 1995	5,373
Population in year 2000 (000)	6,330
Sex ratio (/100 females)	105.0
Per cent urban	72
Age distribution (%)	
Ages 0-14	43.3
Youth (15-24)	21.3
Ages 60+	4.4
Percentage of women aged 15-49	46.8
Median age (years)	18.0
Population density (/sq. km.)	55

Annual population growth rate (%)	3.28
Urban	4.06
Rural	1.20
Crude birth rate (/1000)	37.5
Crude death rate (/1000)	4.8
Net migration rate (/1000)	0.0
Total fertility rate (/woman)	5.13
Life expectancy at birth (years)	
Males	67.7
Females	71.8
Both sexes	69.7
GNP per capita (U.S. dollars, 1994)	1,390

Sources: Data are from the Population Division, Department of Economic and Social Information and Policy Analysis (DESIPA) of the United Nations, World Population Prospects: the 1996 Revision; Annual population growth, including urban and rural data are from DESIPA, World Urbanization Prospects: the 1996 Revision. GNP per capita is from UNDP. Two dashes (--) indicate that data are not available.

1. The United Nations Population Fund (UNFPA) proposes to support a population programme over the period 1998-2002 to assist the Government of Jordan in achieving its population and development objectives. UNFPA proposes to fund the programme in the amount of $4.5 million, of which $4 million would be programmed from UNFPA's regular resources, to the extent such resources are available. UNFPA would seek to provide the balance of $500,000 from multi-bilateral and/or regular resources to the extent possible, consistent with Executive Board decision 96/15 on the allocation of UNFPA resources. This will be UNFPA's fifth programme of assistance to Jordan.

2. The proposed programme of assistance was developed based on the outcomes of a Programme Review and Strategy Development (PRSD) exercise that included a mission to Jordan in June 1997. The PRSD was conducted in close cooperation with the Government and national non-governmental organizations (NGOs) as well as with other donor organizations. The Government fully subscribes to the PRSD findings and recommendations. The programme cycle is harmonized with those of UNDP and UNICEF, as well as with the country's Economic and Social Development Plan for 1998-2002.

3. The overall goal of the proposed programme is to contribute to sustainable development in Jordan through securing quality universal reproductive health services and information as well as promoting gender equity and equality. The reproductive health subprogramme, in particular, will focus on densely populated, poor rural and urban areas. Jordan is a category "B" country according to UNFPA's resource allocation system, and the proposed programme will focus on the area of greatest need – reproductive health. The main subprogramme will be supported at the national level by a population and development strategy subprogramme to facilitate the implementation of the plan of action for the National Population Strategy and by an advocacy subprogramme to create an environment conducive to the mobilization of political, human, and material resources in support of these action plans. The proposed programme will be implemented in close collaboration with other United Nations agencies, especially those that are members of the United Nations Development Group, as well as with bilateral donors.

4. All activities under the proposed programme, as in all UNFPA-assisted activities, will be undertaken in accordance with the principles and the objectives of the Programme of Action of the 1994 International Conference on Population and Development (ICPD), which was endorsed by the General Assembly through its resolution 49/128.

Background

5. Jordan is a lower middle-income country with an annual per capita income of $1,400 Jordan's economy experienced a steady growth in the 1970s until 1983. By 1988-1989, growth in the gross domestic product (GDP) became negative, inflation soared and unemployment reached 25 per cent. Currently, unemployment is reported at 15 per cent, and the proportion of the population falling below the national poverty line ranges between 15 to 20 per cent.

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6. Jordan's population grew seven-fold during the period 1952-1994. The population more than doubled between 1979 and 1994. The average intercensal rate of population growth was estimated at 4.4 per cent. The high population growth rate was due in part to the Gulf crisis in 1990-1991, which caused the return of some 220,000 persons to Jordan. If current levels of fertility and mortality remain unchanged, the population is projected to more than double within 24 years.

7. The current overall population density is about 49 persons per square kilometre, but it is unevenly distributed across the country. Three governorates -- Amman, Irbid and Zarqa -- accounted for about 72 per cent of the total population, with Amman alone containing 38 per cent. The country has urbanized rapidly. In 1950, the proportion of the urban population was around 35 per cent; the comparable figure in 1994 was more than 70 per cent.

8. Compared to most developing countries, Jordan has gone a long way towards meeting the ICPD goals. Infant and child mortality rates (36 per 1,000 and 39 per 1,000, respectively) are well below the corresponding ICPD target levels. Jordan's latest reported maternal mortality rate is between 40-43 per 100,000 live births. However, there is concern over the high total fertility rate (5.1) and its implications for population growth and sustainable development, in general, and women's health in particular. There is a need to strengthen reproductive health and communication programmes that address the sociocultural determinants of high fertility rates in Jordan.

9. The contraceptive prevalence rate in Jordan rose from around 23 per cent in 1976 to 49.3 per cent in 1996, according to the most recent national statistics. Contraceptive practice is higher among urban, older, higher parity and more educated women than among their rural, younger, lower parity and less-educated counterparts. A 1996 survey found that around two-thirds of contraceptive users were using modern methods. In order to consolidate the achievements in this area, the quality of the existing services needs to be improved to address the issue of high discontinuation rates and the need for a wider method mix. Furthermore, despite the vast network of primary health care facilities which covers more than 95 per cent of the population, most of the reproductive health services are greatly underutilized due to their limited responsiveness to the needs of the population. The efficiency of the public health care system as a whole is currently being reviewed under the health-care reform initiative.

Previous UNFPA assistance and lessons learned

10. In its fourth country programme, for the period 1992-1996, which was extended at no additional cost until the end of 1997, UNFPA provided $5 million from regular resources. Of this amount, approximately 67 per cent was allocated to activities in the area of reproductive health, including information, education and communication (IEC). During the programme, UNFPA assistance focused on national capacity-building; increasing access to reproductive health services by supporting expansion of the service delivery system to different parts of the country; enhancing institutional capacity for training by establishing four model training centres; developing comprehensive reproductive health training materials; producing IEC materials for the use of service providers and clients; and implementing intensive training programmes for health-care providers.

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11. In terms of population and development strategies, UNFPA support in the previous programme included assistance for conducting the 1994 census and its accompanying survey; strengthening the capabilities of the National Population Commission (NPC); and, most importantly, the development of the National Population Strategy for 1995-2005. Advocacy efforts initiated and supported by UNFPA have significantly contributed to a greater awareness of population issues. These activities included the sensitization of community leaders, politicians and religious authorities; integration of population education concepts into the basic education system; and support for advocacy efforts for gender carried out by national NGOs and women organizations. Moreover, UNFPA advocacy activities contributed to the establishment of the National Parliamentary Committee on Population and Development in 1996.

12. In promoting gender equity, equality and the empowerment of women, UNFPA provided assistance to the Jordanian National Committee for Women (JNCW), which includes representatives of those public and private bodies concerned with improving the status of women in Jordan. In 1996, the Cabinet designated JNCW as the focal point for all women-related issues and delegated it to represent Jordan in regional and international women's forums. Jordan ratified the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1992, and JCNW is responsible for monitoring its implementation. Further assistance will be needed to fully address the effects of civil laws and the impact of customary practices such as early marriage, son preference and polygamy and child custody, inheritance and property rights.

13. The reproductive health component of the previous programme focused on a general plan to improve competencies of service providers, upgrade selected maternal and child health and family planning (MCH/FP) facilities, meet contraceptive needs, and raise awareness about the importance of reproductive health and family planning. The approach limited the capacity of the programme to focus on the reproductive health needs of the high-risk poor population with high mortality and morbidity indicators who represent 20 per cent of the total population. Limited attention was given to the impact of the programme on the quality of the reproductive health services and their level of utilization by this target group. Given the wide disparities that exist in Jordan and the emerging patterns of poverty, as well as the impact of poverty on the reproductive health status of men and women, the proposed programme will mobilize a significant proportion of its resources for the priority regions, where the majority of the underserved, poor population is located.

14. The past country programme supported activities to improve the quality of services primarily through in-service training. However, a more sustainable strategy would dictate strengthening pre-service education to improve teaching of reproductive health at medical, nursing and midwife schools in the country. There is a need to provide assistance to upgrade pre-service curricula and improve the technical and teaching skills of the medical and nursing faculty.

15. The previous programme succeeded in bringing to the forefront a general awareness of the importance and necessity of adopting a comprehensive reproductive health approach that takes into consideration the needs of women, men and youth. At the policy level, a national strategy for reproductive health is under development, and it will continue to be supported in the new country

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programme. At the implementation level, UNFPA's previous programme succeeded in introducing reproductive health contents, including HIV/AIDS screening and prevention, into the training curricula of service providers. It is important to strengthen and expand these efforts to ensure that quality reproductive health services, including counselling, are more accessible and better utilized.

16. The previous programme was very successful in mobilizing national NGOs to inform and educate the public and raise their awareness about the importance of family planning and the link between improved reproductive health and an enhanced quality of life in general. The intensive IEC efforts of the NGOs made a significant impact. The development of the national IEC strategy during the last year of the programme was an important step towards enhancing the effectiveness of NGOs in reaching the target groups and demonstrated the benefits of assisting NGOs to plan, design, implement and evaluate IEC activities. However, for these efforts to be more effective, UNFPA needs to ensure that they respond specifically to identified family planning and reproductive health morbidity issues, have clearly set behavioural objectives for their target groups, maintain frequent and regular contact with individual clients, address cost-effectiveness issues in the design and dissemination of IEC products, and are directly linked to reproductive health services in the selected underserved areas. There is also a need to strengthen the institutional structure necessary to maintain cost-effective IEC activities, including the increased participation of the Health Education Directorate of the Ministry of Health in the planning and development of reproductive health IEC programmes.

17. Among the main achievements of the past country programme was the institutionalization of population education in the curricula of primary and secondary schools in Jordan. Reference materials and a textbook have been developed, and teachers have been trained using interactive instructional techniques. Future UNFPA assistance needs to focus on strengthening out-of-school programmes and the design of IEC materials that promote a gender-sensitive approach and that empower parents to raise awareness among young people about sexual and reproductive health issues.

18. Following the ICPD, the previous country programme assisted a number of NGOs to conduct ground-breaking awareness-raising campaigns for youth to improve their understanding of population and development issues, sexual health and the prevention of sexually transmitted diseases (STDs). To increase the effectiveness of these efforts, formative research that explores the needs, tastes, preferences and culture of young people needs to be conducted and used to tailor the content of IEC messages and to determine the most effective channels of communication.

19. UNFPA assistance during the last programme cycle was instrumental in mobilizing political support and commitment to address the highly sensitive population issues at all levels, within and outside the Government. The development of the National Population Strategy was a necessary step to assist policy makers in all sectors to deal with the implications of population variables in the achievement of their sectoral development goals. However, many questions surround the institutional structure of NPC and its ability to sustain a systematic and ongoing process of policy analysis and review without foreign assistance. In the next cycle, the Government will need to augment its resources for the NPC, with UNFPA providing assistance to strengthen its capacity.

20. The previous country programme supported a number of gender advocacy activities that had significant impact on the policy formation and analysis processes and proved to be critical for setting a positive climate for the development of the National Population Strategy and the related women's strategy. However, the gender perspective needs to be reflected in the design and planning of activities in each of the main programme areas. Substantive training will be needed to promote a gender perspective among professionals in both the public and private sectors. Given the particular characteristics of family life in Jordan, improvements in the quality of services is directly linked to an increased awareness by service providers of risk factors that affect the reproductive health of women and girls.

21. One of the main lessons learned from the previous programme is the need to increase the level of technical assistance and support to programme management, monitoring and impact evaluation, particularly in the area of reproductive health. Such capacity-building needs to be incorporated into the proposed programme.

Other external assistance

22. Among the United Nations agencies, UNICEF, WHO, UNDP, UNRWA, WFP provide significant assistance to Jordan. The UNICEF programme of 1993-1997 allocated over $5 million to cover health education, social mobilization and advocacy sectors. The health programme included MCH activities, safe motherhood, child nutrition, control of diarrhoeal disease and immunization. WHO continued to focus on health systems research, primary health care, support to training of health personnel, protection and promotion of adolescent health, occupational health, school health, nutrition and environmental health. UNRWA allocated $10 million for a 1993-1997 reproductive health programme. It continued to provide primary health care for around 1.3 million Palestinian refugees in Jordan. Through its family health programme, UNRWA provides comprehensive MCH/FP services. UNRWA operates 23 clinics, of which 10 are outside of its camps. All of the clinics provide family planning services.

23. The World Bank has been the major donor providing loans in support of health management (1993-2000) in the amount of $20 million. The loan components include upgrading of Ministry of Health facilities and services, training, financial planning and budgeting, and development of a comprehensive and integrated management information system.

24. The United States Agency for International Development (USAID) is a major contributor to the family planning programme in Jordan. USAID assistance in the amount of $20 million (1992-2000) covers eight projects, primarily focusing on family planning. USAID provides most modern contraceptives except for oral methods. Among the other bilateral donors and international NGOs, the European Union provided $1.8 million (1992-1996) in support of reproductive health and gender activities. Japan has recently approved a project to strengthen four Ministry of Health clinics as well as launching awareness-creation activities on reproductive health and initiating income-generation schemes. Canada provided assistance in the amount of $1.4 million (1994-1996) for women-in-development activities. The International Planned Parenthood Federation (IPPF) continued to

provide support in the amount of $1.7 million (1992-1996) to assist its national affiliate to establish eight family planning clinics and two mobile units. It also launched a number of IEC activities in support of reproductive health and gender issues targeting youth, women and men.

25. Taking into consideration the leading role of USAID and its continued contributions in the area of family planning, UNFPA's chief areas of responsibility will be: support for the ratification and implementation of a national policy for a comprehensive reproductive health programme; support for the provision of quality reproductive health information and services to selected poor urban and rural areas; special IEC programmes for men and young people; and promotion of advocacy for reproductive rights and the empowerment of women.

Proposed programme

26. The proposed programme is designed to contribute to the goals of the national population strategy that aims to reduce the high population growth, alleviate poverty, and manage the impact of population growth on socio-economic development, the environment and natural resources. The purposes of the programme are to contribute to universal access to quality reproductive services and information and to promote gender equity and equality. To achieve these purposes the programme will help to: (a) improve the quality and increase the utilization of reproductive health services by both men and women in the primary health-care facilities of target areas; (b) increase access to reliable reproductive information and counseling for men, women and youth; (c) strengthen the national capacity to manage, monitor and evaluate reproductive health services delivered in the public, private, and NGO sectors; and (d) increase the political commitment as well as the technical capacity for implementing, monitoring and updating the National Population Strategy.

27. Reproductive health. In the area of reproductive health, the programme will have a capacity-building component at the national level and a service improvement initiative at the subnational level. By the end of the five-year cycle the UNFPA-supported programme will have delivered the following outputs at the national level: (a) ratification and gradual implementation of the plan of action for the reproductive health strategy; (b) improvement in the quality and content of pre-service education in medical schools, midwife programmes and diploma nursing programmes; and (c) upgraded capability of the Ministry of Health to develop IEC programmes and materials. In addition, UNFPA will collaborate with other donors, primarily USAID, to assist the Government in developing a strategy to achieve self-reliance in the provision of contraceptives. UNFPA and USAID would continue the arrangements made to meet the requirements for certain contraceptives over the next five years to ensure accessibility and affordability of a wide choice of modern methods. The Fund will also contribute to efforts to strengthen a decentralized training system. Finally, UNFPA will support efforts to implement quality assurance measures.

28. At the subnational level, the subprogramme will concentrate its service improvement and expansion efforts on the 28 primary health-care facilities in the 14 high priority areas selected in consultation with the Government according to the following criteria: (a) high infant and maternal mortality rates; (b) low contraceptive prevalence rates; (c) high poverty and population density; (d)

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low utilization of existing health centres and a high level of unmet demand; (d) commitment and support of administrative authorities; and (e) avoidance of overlap and duplication with other donors. The expected outputs include the expansion of the scope of reproductive health services to include early detection and treatment of reproductive tract infections (RTIs), screening and counseling for STDs, including HIV/AIDS; improved quality of existing prenatal, postnatal and family planning services; and increased utilization of services in the target areas. UNFPA's efforts will be designed to upgrade selected primary health-care facilities and improve their management, increase the clinical and counseling skills of the service providers, and improve the outreach capacity of the health centres to become more pro-active in providing information and education to clients in their community settings. The findings of a situation analysis that is currently being conducted on the quality of services in Jordan will guide the design of the quality improvement interventions in the selected health centres.

29. On the demand side, IEC campaigns and activities would be conducted in the target areas to support service improvement efforts, enhance the image of services and service providers, increase public awareness about how to prevent common reproductive health mortality and morbidity, increase acceptance of modern family planning methods by addressing specific client concerns and, in general, empowering clients to make their own responsible reproductive health choices. These efforts will be designed to increase knowledge and foster more positive attitudes towards reproductive and sexual health among men, women and youth. The programme would support sociocultural research to add to the growing stock of information on the cultural and social barriers hindering utilization of reproductive health services and to improve understanding of the persisting patterns of preference for large families.

30. A further output of the subprogramme will be improved access of youth, mainly out-of school youth, to reliable sexual health and reproductive health information. Technical assistance will be given to conduct research and to design multisectoral IEC programme components that are specifically tailored to youth. To enhance gender sensitivity among youth, the programme would provide support to develop appropriate training materials on gender equality.

31. The subprogramme will help to increase accessibility of reproductive health information and services for men. In addition to the IEC campaigns that will target the male population, technical assistance will be provided to develop reproductive health counseling and services tailored to the needs and concerns of male clients, with a special emphasis on screening and treatment of STDs as well as on increasing contraceptive choices for men. This will be a pilot activity that will be preceded by research on the prevalence of STDs in selected communities and that will explore the ways to organize these services in such a manner that they will be acceptable to men.

32. Of the $2.8 million allocated to reproductive health, 78 per cent ($2.2 million) will go to support for improving the quality of services and for IEC in the target areas. Initial discussions with the Government and potential donors indicate the feasibility of mobilizing $500,000 in multi-bilateral assistance, which would be allocated to securing reproductive health equipment needed to improve the quality of reproductive health services.

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33. Population and development strategies. In the area of population and development strategies, the proposed subprogramme will be designed to enhance the implementation of the national population policy, with emphasis on three of its seven domains, namely, gender, IEC and reproductive health. To this end, assistance will be provided for technical assistance and training to upgrade the capabilities of the concerned staff in ministries and institutions involved in implementing the National Population Strategy.

34. Advocacy. UNFPA assistance in the advocacy area aims at assisting the Government to mobilize national support for population and reproductive health programmes, including male reproductive health services, for the provision of reproductive information and counseling for youth, and for the empowerment of women. This will include launching advocacy activities at the national and subregional levels for such key groups as policy makers, programme managers, parliamentarians, religious leaders, service providers and organized community groups. UNFPA will continue its support to advocacy activities of national institutions. The programme will also support the National Parliamentary Committee on Population and Development in its advocacy efforts to revise and pass legislation in support of the goals and objectives of the National Population Strategy.

35. In the area of the reproductive rights of women, the programme will launch advocacy activities to promote awareness about the sociocultural norms and practices that negatively affect their status and well-being. In this context, these activities will stress the implications of specific customary practices that are not in conformity with the laws. The outputs would be: (a) strengthening of the efforts of the JNWC and of other NGOs in the area of legal reform; and (b) influencing policy change, including through undertaking studies on specific areas of concern.

36. Implementation, coordination, monitoring and evaluation. The Ministry of Planning is the official coordinating agency for all United Nations assistance, and the NPC is designated as the focal point for population activities. The proposed programme will be primarily executed by national governmental and non-governmental institutions. It will make full use of available and appropriate national expertise. UNFPA will continue to provide training to project personnel in substantive aspects of programme management and implementation. Technical backstopping will be provided by the UNFPA Country Support Team based in Amman, Jordan, as well as by Technical Support Services mechanisms and short-term international consultants, as needed. UNFPA will provide on-site management and technical support through national professional project personnel as necessary.

37. Programme monitoring and evaluation activities will be strengthened. Baseline data on major indicators related to service utilization, quality of services and the contraceptive prevalence rate will be made available at the national and subnational levels through a number of national surveys and studies. All project evaluations will be integrated during the project development phase to ensure that not only process evaluations are done but also that indicators of impact are identified and means of collecting data to measure the changes in these indicators are identified. Evaluation training will be conducted as necessary to enhance the quality of the evaluation design and data collection.

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38. Activities will be subject to progress reports, monitoring field visits and annual and final reviews. In addition, a mid-term programme review will take place in the year 2000, and a final review is anticipated by the end of 2002. The programme will be managed by the UNFPA Representative supported by a senior programme officer, a senior programme assistant, a finance assistant, a senior secretary and a driver.

Recommendation

39. The Executive Director recommends that the Executive Board approve the programme of assistance to the Government of Jordan as presented, in the amount of $4.5 million over the period 1998-2002, of which $4 million would be programmed from UNFPA's regular resources to the extent such resources are available, and the balance of $500,000 would be sought from multi-bilateral sources and/or other resources to the extent possible, consistent with Executive Board decision 96/15 on the allocation of UNFPA resources.

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⑧ 企画調査員報告書（抜粋）

家族計画

（1）背景

ジョルダンの人口増加率は3.7%と現在、世界で最も高く、このまま続けば、2015年には1997年の人口450万人の倍となると試算されており、人口増加による天然資源不足が懸念されている。これに対するジョルダン政府の雇用や社会保障制度は、最近導入された社会生産性向上計画（Social Productivity Programme）が既に財政的困難に陥っていることが証明しているように、問題化してきており、早急な対応が必要となっている。

（2）USAIDの戦略

USAIDの保健医療・家族計画に関する長期戦略は、1997年春にワシントンにおいて策定されて以来、大きな変化はなく、避妊知識普及、家族計画改善、医療費補助制度合理化の3点を重点項目としている。

（イ）近代的避妊知識の普及

1995年に開始された、厚生・医療省によるテレビ・ラジオを通じた家族計画に関する啓発活動及びUSAIDの支援により、避妊知識の理解率は増加したものの、USAIDは引き続き、以下を活動目標として、向こう4年間に実施していく予定である。

（a）少なくとも受講者の6割がわかりやすい言葉で言い換えれることを目標とした、マルチメディアを利用した避妊、夫婦関係、産後ケアに関する知識の普及

（b）配偶者の安全を考慮した正しい避妊方法を理解した男性の増加（経口避妊薬47.6%から67.7%、IUD60.4%から80.4%）

（c）人口保健調査結果のアップデート及び男女差別問題に関連した国家人口計画の修正

（d）国会議員及び政府、閣僚、知事、宗教関係者に対するジョルダンにおける家族計画についての支援要請及び知識普及

（ロ）家族計画サービスの改善

現在、ジョルダンにおける出産の約95%が病院で行われており、そのうち出産後ケア（Post-Partum）を受けている母体は6%にとどまっている。これに対し、新生児の86%が一歳までに奨励されている予防接種を受けている。この状況をより改善するため、出産後の母子に対する医療サービス体制を整備し、母子ともに一ヶ月後検診の受診が容易になるような、病院と保健所の連絡体制を構築したものの、USAIDは、更に次の活動を向こう4年間で実施することとしている。

（a）産後ケアセンター（Post-Partum Center）数の増加（既存の12から21に）及び同センターの改修、機材供与、職員研修

（b）産後ケアセンターにおける出産後ケア率の増加（1997年の30%から2001年の60%）

（c）NGOに対する家族計画の普及及び医療設備を備えたNGO数の増加（現状15から17）

（d）家族計画を全面的に支援する厚生・医療省管轄病院数の増加（現状85から133）

（e）家族計画に精通した医療関係者（NGO及び保健省）の育成（1997年の482人から2001年には1,188人に増加させる）

(ハ) 民間企業の家族計画への参加

家族計画関連製品を適正価格で市場に供給するため、関連民間企業を巻き込むも重要であり、USAIDは既に5種類の避妊関連製品の市場形成に対し投資を実施している。また、テレビを通して家族計画に関する啓蒙活動を実施するとともに、家族計画製品に関連した1,000人以上の薬剤師及び医師に対する訓練を実施した。これにより、避妊関連製品は、ジョルダン国内全土における薬局において、適正価格にて購入できるようになった。

この分野においては、ほぼ目標を達成できたといえ、現在、調査団が設定した次なる活動目標につき、議会の承認を待っているところである。

(二) 医療保健費用補助システムの改善・合理化

ジョルダンの異常な人口増加は、家族計画だけでなく、持続的な医療・保健制度全体を脅かすものである。家族計画は、幅広い医療保健サービスの提供とも密接な関係があるため、医療保健分野における費用を合理化するようなシステムが必要となろう。

1994年に　世銀が実施したジョルダンの保健分野における調査によれば、ジョルダン政府は、必要な改革を推進することにより、国民の健康維持、経済効率、医療効果及び医療提供制度の改善、財政の持続性が達成可能となっている。USAIDは世銀と協力して、これら必要とされる改革実施につき、保健・医療省を支援していくこととし、2001年までの具体的な活動計画として次の6点を挙げている。

（a）公的機関が閲覧可能な保健データシステムの導入

（b）官民による医療保健財政支援に関する論議

及び試験的試み等の実施結果による問題点の認識及び解析

（c）医療プロバイダーに対する免許交付及びその手続きに関する規制及び法律の総合的な見直し

（d）保健・医療省及びその他医療機関の機能強化

（保健医療経済・計画に関する改善、解析、管理等が実施可能な医療機関）

（e）全公的医療機関にて実施されている基本的な医療サービスの改善

（f）健康保険及びその他医療費補助サービスの確立

（パイロットプロジェクト実施後本格的導入）

（3）2001年までの目標

（イ）近代避妊法の普及率41.5%の達成

（ロ）国家人口計画の見直し

（ハ）需要にあった人口家族関連製品の定期的な供給

（ニ）医療費補助制度に関する総合的な改革推進

⑨ 基礎調査報告書サマリー（保健、社会経済、ジェンダー、人口）

A Health Survey of the Southern Ghor District

By: Tokiko Sato

Family Planning and Women in Development Project
Queen Alia Fund for Social Development
National Population Commission
Ministry of Health
In cooperation with Japan International Cooperation Agency

< This draft is for internal discussion only, and not to be cited. >

Executive Summary

The Family Planning and Women in Development Project started on July 1st, 1997, with the duration of a three-year cooperation period. The Project is implemented jointly by the Queen Alia Fund for Social Development, the National Population Commission and the Ministry of Health in cooperation with the Japan International Cooperation Agency. It is a pioneer project in Jordan because it is based on an integrated approach, which intends to utilize the concept of women in development in addressing national population problems. It aims at improving living standards of the local people through the promotion of family planning by implementing a pilot project in the Southern Ghor District, Karak Governorate.

The Southern Ghor District is located in the southern part of Jordan with an area of 2,058 square kilometers and a population of approximately 31,000. Administratively it consists of six villages and towns: Ghor Al Safi, Ghor Al Mazra'a, Ithrah, Haditheh, Fifa, and Mamoura. The climate of the area is dry and semi-arid. The area is characterized by poverty and large family size. The illiteracy rate is rampant and women are confined to their traditional roles. Rapid modernization along with the introduction of electricity and water networks has created a trend for money-transactions-society, yet the labor force situation indicates an urgent need for good development programs. It is explained that recent economic pressure on the nation, after the Gulf War in particular, has caused high percentage of local farmers in the area to become wage earners.

There is sufficient infrastructure of health facilities in the district: for example, one district hospital, three primary health centers, and two village health centers, all under the Ministry of Health (MOH). The names of the facilities and the approximate population covered by each facility are listed as follows:

Existing Health Facilities	Population Covered
Secondary Level:	
Ghor Al Safi District Hospital	31,000
Primary Level:	
Ghor Al Safi Primary Health Center	17,000
Ghor Al Mazra'a Primary Health Center	14,000
Mamoura Primary Health Center	700*
Fifa Village Health Center	1,700
Haditheh Village Health Center	3,000

*Note: Mamoura Primary Health Center was established to encourage nomadic Bedouins to settle in this area.

The district hospital and one of the primary health centers stand next to each other, which may be causing the duplication of service. The quality of health service needs to be appraised notwithstanding these services contributed to decrease Child Mortality Rate under 5 Years Old (U5MR) and Infant Mortality Rate (IMR).

Under these circumstances, the Project conducted three health surveys at the existing MOH health facilities in the district during the period of November and December, 1997. The surveys comprised (1) a facility survey; (2) a service provider survey; and (3) a client survey. The surveys were designed to obtain information on the current level of service offered at the facilities in the field of family planning (FP), maternal and child health (MCH), reproductive health (RH) and community health. It is noted that the surveys include only the Department of Obstetrics and Gynecology as far as the hospital is concerned. The information obtained is planned to be used by the Project and program managers to evaluate and improve FP, MCH, RH and community health programs in the district.

Using the structured questionnaires, trained fieldworkers interviewed a total of 599 women clients at age 15 and above who visited the facilities during the survey period and a total of 36 service providers including doctors, nurses and midwives. The findings are summarized below according to the topics:

Findings

Range of Services Offered by the Facilities:

Almost all the MOH health facilities above serve for consultation and counseling. In terms of FP counseling, the mode of counseling is verbal only and IEC materials have not been used except only a few occasions when the materials are brought from the Health Governorate of Karak for campaigns, mostly donor-driven campaigns.

Common Diseases at the Facilities:

Diseases vary by facility, but many will be reduced in number by improving living conditions of the local people and providing them with sufficient information on preventable measures since most of the diseases are preventable.

Financial Situation of Health Centers in 1997:

Insurance, either government or military, covers 63 percent of the clients. Those under private schemes do not seek service from the MOH health facilities. This indicates that the higher standard of service is provided by private sectors in this country and people do choose the private health sector if choice is given, which is often seen in many countries whether developed or developing. For those under the government or military insurance coverage and those who either seek minimal payment without insurance or cannot afford paying at all, the MOH's facilities are where they go. The government has discussed the scheme of national insurance, but the poor who cannot afford paying are, in fact, coming to the government's facilities for free. Therefore, the national insurance system, if established, will work not only to assist the poor in having medical service but also to ease the MOH's financial burdens.

Training to Service Providers Working for Health Facilities:

At the health facilities except the hospital, it is doctors and midwives who have had full opportunities to take training courses, whereas none of the aid nurses has. The aid nurses have been simply acquiring knowledge and skills while working. The real problem lies with the staff at the village health centers. They have never received any training courses, but have taken heavy responsibility without much support from more qualified personnel. In case of the hospital, most of the staff, whether they are doctors or midwives, have not received any training courses after the completion of schooling. On the whole, it is essential to provide sufficient professional training to aid and practical nurses, aid nurses in particular, who comprise the majority of the staff working at the primary and village health centers. This finding accords with what MOH lists as one of the priority issues to tackle.

Knowledge and Skills of Maternal and Child Care among Service Providers:

A midwife at Safi and Mazra'a MCH centers, respectively, has sufficient knowledge and experience of MCH, but others, whether they work for MCH centers or not, need to acquire either more skills or simply more knowledge.

Knowledge of Reproductive Health among Service Providers:

More than half the staff said that they have heard of Reproductive Health, but their understanding of RH is not accurate.

Attitude toward Family Planning among Service Providers:

FP is well accepted by the staff. The majority either attempt to inform clients of importance of FP or feel it necessary to have training on FP.

Referral and Follow-up:

Most of the staff do refer the women to other facilities, when necessary. Although there is no clear-cut referral system as has been discussed at the national level, the referral is made as a matter of practice in the facilities concerned. Although almost three-quarters of the staff make the women's follow-up including "sometimes," most of the cases are due to personal relations.

Requests from Service Providers:

Although there are many requests from the service providers, one of the top priorities among them is to conduct awareness programs at the health facilities, along with installation of more equipment to MCH centers and the hospital and establishment of a labolatory and the expansion of the center capacity at the health centers.

General Characteristics of Women Clients:

Eighty percent of the women clients are at age between 15-44. It is noted that 48 percent of all the women clients concentrate on the age range between 20-29. Among the women, 76 percent are currently married, and 45 percent have no formal education. Sixty-three percent of the women have children less than 5 on the average due to high percentage of the young women using the facility. In general, the women who utilize the health facilities show the common socioeconomic characteristics of the general population at the communities in the Southern Ghor District.

Reasons for Visiting Health Facilities:

Most common answers of the reasons for the women to come to the health facilities is to treat their sickness (37 percent), followed by treating their own children or their relatives (33 percent). Fourteen percent visited for antenatal care and only about 2 percent made postnatal care visit.

Amount of Payment:

Seventy-three percent of the women usually pay less than 1JD per visit. This amount, for most of the cases, is purely for fee for consultation

and excludes fee for medicine due to lack of medicine available at the health facilities.

Waiting Length for Services:

Seventy-four percent of the women who visited the facilities have to wait for service for more than one hour (74 percent).

Access to Contraceptives:

Eighty-seven percent of the women never tried to obtain contraceptives at the health facilities where they usually go. Although Safi and Mazra'a primary health centers have MCH centers attached, not many women tried to obtain them (only 16 percent and 10 percent, respectively). Among those who sought to obtain contraceptives, 35 percent encountered difficulty in obtaining them. This is particularly the case with Fifa village health center (67 percent) and the hospital (57 percent).

Preference for Female Doctors:

Sixty percent of women prefer seeing female doctors to male doctors no matter what their problems are. The women who mentioned to prefer female doctors by depending on health problems indicate internal checkups such as vaginal checkup or simply taking-off clothes in front of the doctor are the problems for which they feel they prefer female doctors(52 percent). Pregnancy and delivery are also another health issues women feel they wish female doctors (12 percent and 21 percent, respectively).

Referral to Another Health Facility:

When the women are referred to another health facility, 78 percent of the women usually go to the referred facilities.

Improvement in Services to be Made:

At the health center level, the women wish medicine to be available at the facilities (21 percent), followed by more staff, doctors in particular (15 percent), and hopefully specialists (11 percent). At the hospital level, 23 percent of the women mentioned sanitary conditions of the hospital should be improved, which is a distinctively high percentage. As to the improvement in the areas regarding: the number and the quality of the staff, hygienic conditions of the facility, communication with the staff, a female doctor and privacy, the majority replied the issues raised need to be all changed for better.

Identified Problems and Recommendations

Identified Problems:

The following problems are identified regarding FP, MCH, RH and community health programs based on the findings from the surveys conducted in the Southern Ghor District.

1. Family Planning (FP)

(1) Lack of information on contraceptive methods among the staffs including midwives;
(2) Lack of systematic FP education and insufficient contraceptive counseling at the health facilities including MCH centers;
(3) Lack of IEC (Information, Education and Communication) materials;
(4) Lack of awareness among local residents to use contraceptives; and
(5) Difficult access to contraceptives at the health facilities except MCH centers.

2. Maternal and Child Health (MCH)

(1) Low availability of postnatal care;
(2) Lack of systematic training curricula for midwives working at the hospital;
(3) Lack of knowledge on MCH among the staffs at village health centers;
(4) Insufficient antenatal care/postnatal care service at MCH centers; and
(5) Duplication of antenatal care between MCH centers and the hospital.

3. Reproductive Health (RH)

(1) Lack of knowledge on the concept of RH;
(2) Lack of understanding of FP through the scope of RH; and
(3) Lack of understanding of MCH through the scope of RH.

4. Community Health

(1) Doctors' infrequent/irregular visit to village health centers;
(2) No monitoring and evaluation system for quality assurance;
(3) Insufficient training to aid and practical nurses, aid nurses in particular;
(4) Lack of follow-up of patients;

(5) Lack of equipment at the health facilities;
(6) Shortage of doctors at primary health centers;
(7) Shortage of medicine available at the health facilities;
(8) Lack of basic health knowledge among women;
(9) Women's preference for female doctors;
(10) Lack of interpersonal communication skills among the staffs;
(11) Lack of understanding on "privacy" as patients' rights among women; and
(12) Lack of respect for patients' "privacy" among the staffs.

Recommendations:

The recommendations are made below in order to solve the above-identified problems.

Recommendations for Improving FP, MCH, RH, and Community Health Programs:

1. Staffs

(1) Thorough information on FP and MCH should be given to the staffs, particularly midwives at MCH centers and the staffs working at village health centers;
(2) Proper training curricula should be formulated for midwives at the hospital;
(3) Aid nurses should have systematic training programs;
(4) The concept of RH should be taught to all the staffs and be practiced in daily activities;
(5) Roles of nurses at primary health centers and MCH centers should be reviewed; and
(6) Staffs' interpersonal communication skills on how to talk to clients, including provision of information with their diagnoses and medication should be improved.

2. Infrastructure

(1) Proper equipment should be provided.

3. Management

(1) FP education should be given systematically to the women during antenatal care and postnatal care visits;
(2) Informed choice should be given to the clients before using contraceptives;
(3) Coordination among the health facilities should be strengthened to

avoid duplication of services;

(4) Doctors' routine visit to village health centers should be established;
(5) Medicine should be made available any time at the health facilities;
(6) Patients' privacy should be respected at the health facilities;
(7) A follow-up of patients should be attempted as a system;
(8) Efficient management at the health facilities, the hospital and primary health centers in particular, should be established; and
(9) Monitoring and evaluation for quality assurance should be established.

Recommendations for forming FP/health awareness programs for local residents:

(1) Importance of FP should be instructed;
(2) Local residents should be well-informed of the whereabouts to obtain contraceptives;
(3) Importance of postnatal care visit should be emphasized;
(4) General health education should be given;
(5) Preference for female doctors should be discussed as an issue; and
(6) "Privacy" should be introduced as a right.

Conclusion

The Project is developing the strategies for implementation on the basis of the recommendations made above. These strategies will be assessed in completing the Project according to the contribution made to the improvement of FP, MCH, RH and community health programs in the district. It is advised that the strategies recognized as successful should be discussed by program managers to apply to other parts of Jordan, the southern region in particular.

Family Planning and Women in Development

Project

Study of the Social, Cultural and Economic Situation

Of

Southern Ghor District- Al – Karak

With Participatory Rural Appraisal (PRA)

December 11-12, 1997
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Social Development Department of Queen Alia Fund for Social Development (QAF)
QAF Community Development Centers in Southern Ghor District with support from
Japan International Cooperation Agency (JICA)

The report was originally prepared in Arabic as a documentation of the workshop by Hassan Bahjat, CARE International-Jordan Office, who acted as a facilitator of the workshop, then translated into English by Munif M. Abu-Rish, Social Development Department of QAF. This version was edited by Tokiko Sato, Chief Technical Advisor of the Project, to meet the Project's needs.

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SUMMARY

A Participatory Rural Appraisal (PRA) workshop was conducted in the District of Southern Ghor for a total of 5 days in December 1997, by the Queen Alia Fund for Social Development (QAF) with support from the Family Planning and Women in Development Project implemented by the Japan International Cooperation Agency (JICA). The objective of the workshop was to study the social, economic and cultural situation of the area through the perception of people who live in the community. It also aimed to train the QAF staff on PRA techniques: on how to implement, gather and analyze information in partnership and cooperation with members from the local communities. This paper is the summary of the workshop, in particular focusing on how local people have perceived the social, economic and cultural problems of their own community.

First, the concept and techniques of PRA were introduced to the participants, who represented the community and / or were involved in the QAF Center activities. Second, the fieldwork by using the PRA approach was conducted to collect basic information on socio, economic and cultural aspects of the community. Third, the participants summarized the problems and their causes, which are briefed as follows:

The focal social problem: The size of the family

A: Causes :

⇒ Early marriage especially among girls.

⇒ The authority of a man within the family.

⇒ Lack of awareness and education among women, which denies the human and social role they are entitled to in the society.

⇒The weak effect of the women's movement within the local community.

⇒A man marrying more than one woman.

B. Results:

- The traditional and marginal role of women.
- Limited social awareness.

- Overburden of women at home.
- Preference to inter-clan marriage.
- High illiteracy and low level of education in the community.
- "Crimes of honor"
- Inequality between men and women.

The focal cultural problem: The low level of educational achievements and cultural standards

A: Causes:

⇒The weak financial situation which makes schooling of children difficult.

⇒No cultural and social centers, thus there are no cultural events and awareness.

⇒Negative concepts (e.g cousin marriage) among community members.

⇒The traditional attitude towards woman and denial of her right.

⇒Lack of ambitions and aspirations.

⇒Denial of education to girls.

B. Results:

- The man as a decision-maker.
- Traditional views towards women and denial of their rights.
- Preference of work to education which leads to high school drop-outs and low cultural standard (i.e ignorance, lack of ambitions and aspirations, etc.)
- "Crimes of honor".
- Dependency attitude among people.
- The low number of working women in public jobs and the relationship of that with existing social and cultural values.
- Low level of educational standards and achievements.
- The high cost of social occasions.

The Focal Economic Problem: high level of poverty

A. Causes:

⇒Denial of women to practice certain economic activities.

⇒Investment monopolized by people from outside the community.

⇒Limited benefits from the natural resources of the area.

⇒Limited job opportunities although qualified people are available.

⇒Unemployment.

⇒Low income per family as compared to its size.

⇒Lack of financial resources and facilities available for the unemployed to start their own productive projects.

⇒Lack of technical knowledge among farmers.

⇒Lack of experience in technical or service sectors.

⇒Marketing problems.

⇒Lack of capital for farmers.

B. Results

- Bad financial situation and poverty.
- Investment dominated by people from outside the community.
- Sale of land due to inability to use it.
- Denial from land ownership.
- Dependency on women and family members to work in the fields as a free labor : The money earned from the products is expended for the household.

Discussion and findings made in the workshop are expected to contribute to the Project to understand how people in the community perceive their own social, economic and cultural problems.

GENDER RESEARCH

at

Southern Ghor District in Kerak Governorate

Draft

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This draft is for an internal discussion only, and not to be cited.

Executive Summary

This gender research was conducted as a part of the baseline survey of the Project, Family Planning and Women in Development. In December 1997, total of seventy people (two focus groups and sixty individuals) was interviewed at the Southern Ghor District in Kerak Governorate, the Project area.
The findings reported here come from this qualitative research. They, therefore, don't necessarily represent Jordanian population in general.

A large sample survey was also conducted to support the qualitative research. The target population was five hundred and nineteen wives and their husbands in the same area.
The tables of this large survey is found in the appendix, but the major findings of the survey is discussed in the text of the small sample survey.

The characteristic of gender relations among married couples in the area share the same concept as the rest part of Jordan in general: Men's dominance. The final decision-maker in control of money and the family size are husbands. This phenomenon is especially notable among older couples with no or little educational background.
On the other hand, younger generations with high school education in particular show a different attitude. They discuss family matters before husbands make a final decision. The process of decision making is important. Even through it is clear that husbands make a final decision, wive's opinions can be reflected much in husband's decision.
The majority of men take it for granted that they should decide, because they are major breadwinners. Those who earn money will have power to make a decision at home.
Another important finding is lack of information on everything. The population in the area doesn't have good access to higher education, health, job opportunities, and vocational training. They simply don't have choices. Although they realize their problems in their community, they have no clear idea how to solve them.
This indicates that comprehensive programs of awareness and provision of information related to their lives are crucial for the Project area.

A Population Study of the Southern Ghor District

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Summary

Jordan is one of the fastest growing population in the world and has particularly strong regional differences. In the southern region which is socioculturally more conservative, for instance, the inhabitants' educational level has been lower than that of the northern region which accommodates a greater proportion of the population and is relatively developed. The total fertility rate of the women in the southern region was 1.8 more than northern women (Department of Statistics and Ministry of Health, 1990).

Based on the field work in the Southern Ghor District, this study aimed (1) to thoroughly understand the sociocultural conditions, (2) to assess the family planning practices in association with their knowledge, attitude and use of contraception, and (3) to clarify the relative contributions of the multiple factors which determine the fertility rate.

The results indicate five important findings for family planning programs. First, knowledge, practice and intention to use contraception had strong interrelations. Second, the females who had used contraception tended to have more children than those females who had not. Short-term use of contraception hardly contributed to lengthen birth intervals and thus the overall fertility rate, because the majority of the females who used contraception discontinued it within one year. Third, nearly three fourths

of the females who terminated contraception did so because of adverse side-effects, namely headaches and bleeding. Fourth, conservative social customs in the study area have strongly affected the fertility and the different preferences in family size between males and females was apparent. Finally, the death episodes of children significantly were related with the fertility rate.

The findings highlight the need to (1) enhance effective family planning services and contraceptive use after reception of medical-care, in order to prolong the use of contraception, and (2) to provide adequate information on the ideal family size, using such methods as a motivation campaign, for the males in particular, in order to reduce the gap between male and female fertility preferences.