

PD-AAC-741-B1

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| AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT PAPER FACESHEET | 1. TRANSACTION CODE <input checked="" type="checkbox"/> A ADD <input type="checkbox"/> C CHANGE <input type="checkbox"/> D DELETE | 197 <u>PP</u> 2. DOCUMENT CODE 3 |
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| 3. COUNTRY/ENTITY TUNISIA | 4. DOCUMENT REVISION NUMBER <input type="checkbox"/> |
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| 5. PROJECT NUMBER (7 digits) [664-0295] | 6. BUREAU/OFFICE A. SYMBOL [NE] B. CODE [4] | 7. PROJECT TITLE (Maximum 40 characters) [Family Planning Services] |
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| 8. ESTIMATED FY OF PROJECT COMPLETION BY [81] | 9. ESTIMATED DATE OF OBLIGATION A. INITIAL FY [78] B. QUARTER [1] C. FINAL FY [81] (Enter 1, 2, J, or 4) |
|--|---|

| A. FUNDING SOURCE | 10. ESTIMATED COSTS (\$000 OR EQUIVALENT \$) - 4300 | | | LIFE OF PROJECT | | |
|------------------------|---|--------|----------|-----------------|--------|----------|
| | B. FY | C. L/C | D. TOTAL | E. FY | F. L/C | G. TOTAL |
| AID APPROPRIATED TOTAL | | | | | | |
| (GRANT) | 1,963 | | 1,963 | 7,797 | | 7,797 |
| (LOAN) | | | | | | |
| OTHER | | | | | | |
| U.S. | | | | | | |
| HOST COUNTRY | | 2,176 | 2,176 | 8,721 | | 8,721 |
| OTHER COUNTRIES | | | | | | |
| TOTALS | | 2,176 | 4,139 | 16,518 | | 16,518 |

| A. APPROPRIATION | B. PRIMARY PURPOSE CODE | PRIMARY TECH. CODE | | E. 1ST FY 78 | | H. 2ND FY 79 | | K. 3RD FY 80 | |
|------------------|-------------------------|--------------------|---------|--------------|---------|--------------|---------|--------------|---------|
| | | C. GRANT | D. LOAN | F. GRANT | G. LOAN | I. GRANT | J. LOAN | L. GRANT | M. LOAN |
| (1) PH | 444 | 440 | | 1,963 | | 2,281 | | 2,013 | |
| (2) | | | | | | | | | |
| (3) | | | | | | | | | |
| (4) | | | | | | | | | |
| TOTALS | | | | 1,963 | | 2,281 | | 2,013 | |

| A. APPROPRIATION | N. 4TH FY 81 | | O. 5TH FY | | LIFE OF PROJECT | | 12. IN-DEPTH EVALUATION SCHEDULED |
|------------------|--------------|---------|-----------|---------|-----------------|---------|-----------------------------------|
| | D. GRANT | P. LOAN | R. GRANT | S. LOAN | T. GRANT | U. LOAN | |
| (1) PH | 1,540 | | | | 7,797 | | MM YY 01 80 |
| (2) | | | | | | | |
| (3) | | | | | | | |
| (4) | | | | | | | |
| TOTALS | 1,540 | | | | 7,797 | | |

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PIO FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PFP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PIO FACESHEET.

2 YES
1 NO

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| 14. ORIGINATING OFFICE CLEARANCE SIGNATURE: <u>Hermon S. Davis</u> TITLE: <u>Director, USAID/Tunis</u> | | 15. DATE DOCUMENT RECEIVED IN AIO/W, OR FOR AIO/W DOCUMENTS, DATE OF DISTRIBUTION DATE SIGNED: MM DD YY 01 01 77 |
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I. Summary and Recommendations

A. Face Sheet Data (See FP Facesheet)

B. Recommendation

| | |
|--------------------------|-------------|
| Grant | \$7,797,000 |
| Total New AID Obligation | \$7,797,000 |

C. Description of Project

Recognizing the essential role of family planning in the improvement of the health status of the Tunisian population, the Government of Tunisia has requested assistance from USAID to further develop the national family planning program with emphasis on the rural areas. The GOT is committed to this program as evidenced by its past involvement and allocation of personnel and financial resources

The primary purpose of this project is to assist the GOT to strengthen and expand family planning services primarily in the rural areas. To achieve this purpose, the GOT has requested assistance in several project areas: (1) support for the development of a household and community-based contraceptive distribution system as a prototype for a national program; (2) training assistance to develop trainers and upgrade medical/paramedical skills; (3) general system support to expand the continued operation of on-going clinical family planning programs, including voluntary surgical contraception; (4) support for the further development of the family planning information and education program; and (5) assistance in developing a stronger research and evaluation capability.

This project will be implemented by the National Family Planning and Population Office (ONFPF) of the GOT. Implementation over the four-year life of the project will require:

1. Short-term technical assistance in the form of specialists in several family planning and health care disciplines.
2. Short-term participant training (80 person months) for selected GOT health personnel.
3. Commodity and other general support to insure the effective delivery of clinical and educational services.

The end of the project status will be a significant increase in the number of family planning acceptors particularly in the rural areas. To achieve this result, the following outputs will exist by the end of the project:

1. A low-cost community based contraceptive distribution system.
2. A trained cadre of medical and paramedical personnel.
3. A well-equipped and effectively functioning network of MCH/FP clinics.
4. A well-planned comprehensive family planning information and education program.
5. A strengthened research and evaluation capability.

Evidence that the project purpose (and related outputs) is achievable can be found in the fact that AID has an extensive and positive history of support for the GOT family planning program. Close working relationships have been developed between USAID/Tunis and the ONPFF. With AID assistance, the ONPFF has developed into a highly effective and well managed agency fully capable of implementing the proposed project.

D. Summary Findings

The project as described in the following sections is both realistic and feasible in terms of planned activities, scheduled time frames and the ability of the GOT to absorb the additional AID inputs required. As a result of the various analyses conducted during the planning stages of this project, USAID/Tunis considers this project to be technically and financially sound. Additionally, the proposed project is compatible with the existing socio-cultural milieu of Tunisia.

The GOT is well aware of its challenges and needs in the area of family planning and has developed an effective infrastructure capable of managing the delivery of family planning services; however, there are some weaknesses in the provision of services to the rural areas. A key element of this structure, the National Office for Family Planning and Population, is well qualified to fully implement this project and has been closely involved with the development of all major program components. As a result, this project is ready for implementation as soon as the Project Agreement is signed. This project meets all applicable statutory criteria.

E. Project Issues

During the review of the FRP for this project, several issues were raised for consideration during the development of the Project Paper. USAID/Tunis has addressed these issues by telegram to AID/W in June, 1977 (See Annex A). However, a summary of these issues will be included in this section to facilitate the Project Paper Review.

1. Training Component

Additional detail was requested regarding the project training component. Further elaboration of the training activities has been included in Part II, Section B. Detailed Description.

2. I, E & C Component

The I, E & C component has been described in more detail in Part II, Section B. Detailed Description. Management issues have been discussed in Part IV, Section A. As currently planned, this project will require short term consultant assistance for the I, E, & C component. Provision for such assistance has been included in this project.

3. 1975 Evaluation

The relationship of this project to the 1975 Evaluation has been discussed in Part II, Section A. Background. Additionally, reference has been made to the 1975 Evaluation Report through the Project Paper. Basically the proposed project is consistent with the recommendations included in the 1975 report.

4. Target Populations

Part II, Section B. Detailed Description includes additional information regarding target populations.

5. Inter-Relationships of Project Components

Further information regarding the inter-relationships of project components is included in Part II, Section. Detailed Description.

6. Incentive Support Costs

This project is no longer providing incentive support costs to MCH/FP centers.

7. Voluntary Surgical Contraception

The VSC project component has been described in Part II, Section B. Detailed Description.

8. Additional Acceptor Data and Contraceptive Requirements

Additional information regarding acceptors and contraceptive requirements is included in Annexes H and K. Also more information on contraceptive needs is included in Part IV, Section B. Implementation Plan.

9. Role of Other Donors

Further discussion about the role of other donors, especially AID-funded donors, is included in Part II, Section B. Detailed Description. Additionally, Part III, Section B. Financial Plan provides information regarding other donor funding levels.

10. Demographic Data

More demographic data has been included throughout the FP. Also, a separate section of selected demographic indicators has been included in Annex H.

11. Implementation Plan

A more detailed implementation plan has been included in Part IV, Section B.

12. Log Frame

The log frame has been revised and is included in Annex C.

13. Demographic Research Efforts

Additional description of ongoing and planned demographic research efforts is included in Part II, Section B. Detailed Description.

14. Role of Training Center for Research and Evaluation

The role of the Ariana Center in research and evaluation activities has been discussed in Part II, Section B. Detailed Description.

15. USAID Management Staff

USAID staff requirements for project management have been discussed in Part II, Section A. Administrative Arrangements.

16. Proposed Rural Health Project

The proposed rural health project seems to be quite compatible with current family planning program activities and future GOT plans to integrate family planning services into basic health care programs. Additionally, the GOT intends to utilize existing health and social service personnel to disseminate family planning information and contraceptive supplies. The types of health personnel who will be trained as a result of the proposed rural health project could also be utilized to deliver some family planning services as part of their normal duties. Close coordination will be required between the ONFPF, the MOH, and the project team for the proposed rural health project to insure the integration of family planning activities.

17. Financial Plans

Detailed financial plans have been included in Part III, Section B. Financial Analysis and Plan.

18. Initial Environmental Examination

The initial environmental examination has been included in Part III, Section A. Technical Analysis.

19. Fixed Amount Reimbursement Scheme

Not applicable for technical assistance project.

20. Other Issues

During the development of the Project Paper, the following additional issues became apparent:

a. Intra-agency Cooperation

As currently planned, the ONFFP through this project intends to train and utilize health and social service workers who are primarily employees of the Ministry of Health and the Ministry of Social Affairs. For this activity to be successful, greater coordination and cooperation will be required between the ONFFP and the other ministries. Some effective mechanism for such cooperation should be developed as soon as possible.

b. Laparoscopy Certification

A problem exists with the certification requirements for physicians who are to be trained to perform laparoscopies. Current FIEGO training course requirements may make it difficult for any French-speaking physician to become certified. Because physicians who are certified by FIEGO are the only ones eligible to receive laparoscopes, there will not be enough laparoscopes in Tunisia to meet the increasing demand for this method of VSC. At the present time, there are not enough scopes available in Tunisia and given the current certification problem, future prospects for additional instruments are uncertain.

II. Project Background And Detailed Description

A. Background

Tunisia's demographic history mirrors that of most other developing nations. Over the past several decades, the country has experienced accelerated population growth due to a steadily declining mortality rate accompanied by a much slower decrease in the birth rate. Since 1921 the number of inhabitants has more than trebled, reaching a total of 5.6 million in 1976. The crude birth rate is currently estimated at 34 per 1,000 population while the death rate is around 10 per 1,000, the lowest on the African continent.

As a result of recent population trends and a present rate of natural increase of 2.4 percent, Tunisia suffers from an unusually high dependency burden. Close to 45 percent of the population is under 15 years of age, placing heavy strains on government efforts to provide adequate education, health facilities, housing, employment and a higher standard of living for the average Tunisian. With the country's current age structure, there is a strong built-in momentum for continued rapid population growth. At the present time, women of childbearing age constitute 47 percent of the total female population. Fifty-three percent of this target group live in rural areas.

The Tunisian Government recognized, at an early stage, the implications of these population trends and succeeded in building over the past decade one of the largest and most comprehensive family planning programs in Africa. Launched as a pilot project in Bizerte in 1964, under the Ministry of Health, it has grown into a nationwide family planning program, providing free contraceptive services in some 482 hospitals, MCH/FP centers, dispensaries and mobile units throughout the country. In 1973, following a series of administrative changes and reorganizations, the National Office for Family Planning and Population (ONFPF) was created as a semi-autonomous government agency under the Ministry of Health.

The ONFPF is responsible for promoting population policies and for providing, free of charge, a full range of contraceptive services as well as training, research and evaluation, family planning information and education. To encourage policy implementation, a National Council for Population was established, chaired by the Prime Minister and including representatives of different branches of government as well as medical, social and pharmaceutical organizations. Broad popular, local, religious and labor group support for the national family planning program has been mobilized over the past several years. Moreover, the government has enacted a number of important legislative and administrative measures aimed at promoting smaller families, including legalizing social abortion and voluntary surgical contraception, as well as drastically reducing the price of orals and condoms. These actions allow Tunisian women full access to all methods of contraception.

Although the program showed only modest progress initially due in large part to manpower shortages and inadequate administrative capabilities and promotional activities, the past several years have witnessed a significant improvement in ONFPF operations and a steady increase in service statistics. The number of married women of reproductive age practicing family planning jumped from 11.5 percent in 1974 to 17.0 percent in 1976, or an increase of 53 percent in three years. During this same period, the number of pill acceptors soared from 10,795 to 25,987 - a 141 percent increase; condom acceptors rose by 53 percent; IUD acceptors increased by 9 percent; and social abortions jumped 64 percent while tubal ligations declined slightly. At the end of 1976, the number of women protected by the four major family methods (tubal ligation, IUD, pills and secondary methods) was estimated at 140,976, of which 117,006 had received services from the public sector and 23,970 from the private sector. In 1977, therefore, approximately 52,750 births will be averted (including those averted by social abortion), surpassing by 17.2 percent the original goal set by the ONFPF.

AID contributions over the past eleven years to the national family planning program have added significantly to the Tunisian Government's effort to stem the high rate of population growth and achieve economic

and social development objectives. Totalling some \$10.8 million, AID grants have included the provision of contraceptives, medicines, audio-visual and surgical equipment, advisory services, participant training and local budget costs. \$3 million of this total represents support of an IERD/IDA family planning construction project and the renovation and expansion of FP/MCH facilities.

During the early phase of the AID assistance program, special emphasis was placed on the development of an infrastructure and training of professional personnel to provide leadership and local expertise to the program. The second major phase of assistance involved an AID grant of \$3,663,063 for FY 1975-1977 to continue the development of an institutional capability within the Tunisian National Family Planning organization and to provide effective family planning information and services to a large proportion of the population of reproductive age (See FROP Population/Family Planning Project for Tunisia, Program No. 664-11-580-224).

Other donors - UN agencies (through UNFPA), the World Bank, Pathfinder Fund, International Planned Parenthood Federation (IPPF), Family Planning International Assistance (FPIA), the Netherlands, Belgium and West Germany, among others - have provided additional training, advisory services, equipment and supplies, as well as population education and family planning programs for the school system, organized labor and agricultural extension workers, etc.

A formal comprehensive evaluation of the project was conducted in July/August of 1975 by a four-man team. The areas which were examined in depth included the effectiveness and efficiency of AID assistance in building up the Tunisian family planning program, the strengths and weaknesses of ONPFP infrastructure, personnel and activities as well as the feasibility of continued AID financial support. The team found a number of shortcomings in program operation and promotion, technical manpower and performance feedback. Other areas, however, were found to be functioning smoothly which, together with a strong government commitment to the program, accounted, in large measure, for the marked increases in acceptor rates since 1974. In spite of the already large expenditure of funds to the ONPFP, the team agreed that continued AID support was required to expand and improve family planning services especially in the rural areas.

The third phase of the program, 1978-1981, is planned in accordance with the recommendations of the 1975 evaluation with "major emphasis on availability of supplies and services to the rural poor." Many of the recommendations, in fact, already have been implemented and will be the focus of continued program efforts, such as: (1) decentralization of authority to implement family planning policies geared to the rural population; (2) improvement and expansion of voluntary surgical contraception; and (3) immediate establishment of a community-based contraceptive distribution system that is capable of reaching the remotest areas of Tunisia.

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Although an earlier phase-out of AID assistance had been suggested, it is our firm belief at this time that an additional input of AID funds over the next four years can make an important difference in the success of the program. Now that a reasonably strong infrastructure has been developed and the Tunisian Government is deeply committed to the extension of effective clinical and non-clinical family planning distribution systems to the rural masses, the program appears, for the first time, to be on the verge of "taking-off." It is crucial to ensure that the momentum which has been established is not lost and that the benefits of AID and other donor involvement are full realized. As a feasible alternative to staggering demands on development funds in the long run, the family planning program is viewed as vital to continued social and economic development and to the durability of a stable government in Tunisia.

B. Detailed Description

The follow-on AID assistance program is designed to coincide with the launching of Tunisia's Fifth Social and Economic Development Five-Year Plan (1977-1981) and to enable the realization of the demographic goals which have been set: a crude birth rate of 30 per 1,000 and a rate of natural increase of approximately 2 percent by beginning 1982. Expanded family planning efforts are viewed by President Habib Bourguiba as crucial to achieve a more equitable balance between population and available resources in Tunisia. In a July, 1977 statement, the President reaffirmed the importance of family planning as a fundamental choice in Tunisia and noted that the success of the new Five-Year Plan is largely dependent upon the family planning program.

To meet a target of 264,413 births averted over the next four years, the ONPFP is planning to embark on an aggressive outreach, promotional and training campaign. This new effort is designed to increase the number, quality and cost-effectiveness of contraceptive services in rural provinces, focusing on their integration with basic health care as these become available.

1. Project Purpose

The purpose of this project is to assist the Government of Tunisia to further strengthen and extend family planning services, particularly in the poorest and most rural areas, through:

- a. developing effective low-cost, community-based distribution systems;
- b. training a cadre of trainers and upgrading the skills of existing personnel;
- c. providing support to medical and educational program components; and,
- d. establishing a strong research and evaluation capability.

2. Areas of Assistance

In discussions between USAID/Tunis and the ONFPF, the following areas of assistance have been identified as high priority and are designed to meet the project purpose:

- a. Pilot contraceptive distribution programs
- b. Training
- c. Family planning service system support
 - (1) Contraceptives
 - (2) Medical equipment and drugs
 - (3) General support
- d. I, E & C
- e. Research and evaluation
- f. Short-term technical assistance

a. Pilot Contraceptive Distribution Programs

(1) Need

Due to the uneven geographic distribution of health facilities in Tunisia, the rural population, which is typically widely dispersed, has received only limited information about and access to family planning services. Women living in rural areas represent 53 percent of the total female population of reproductive age yet only 12 percent of new family planning acceptors. With the existing health infrastructure inadequately serving the contraceptive needs of the vast majority of the rural population, new low-cost complementary delivery systems must be implemented if significant increases in contraceptive prevalence are to be achieved.

In April, 1976 the ONFPF, with the support of USAID/Tunis, launched a pilot household contraceptive distribution project, "Planning Familial à Domicile" (PFAD), in three sectors (population of 12,535; 2,288 households) of the delegation of Bir Ali Ben Khalifa, a rural county 60 kms west of the city of Sfax. The project was designed to test the feasibility of a low-cost delivery system that makes family planning services fully available to all eligible women in a specified area. (See Annex I).

Oral contraceptives are distributed on a household basis by eight locally recruited women who have a minimum level of education and have been specially trained to screen acceptors. Medical back-up services and referral for other family planning methods are also provided. During the first six months, the continuation rate among MWRRA oral acceptors was 56 percent and contraceptive prevalence jumped from approximately 6 percent to 12 percent. The pilot project has subsequently been expanded to include 11 sectors (total study population of 40,234) and to offer all methods of contraception. The introduction of voluntary surgical contraception and IUD insertions in the last several months has significantly increased the number of acceptors in the study area. During 1976, only 5 IUD insertions and 5 tubal ligations were performed in the entire Bir Ali delegation whereas between April and July of 1977, these procedures numbered 46 and 84, respectively.

The most significant outcome of the PFAD program has been a confirmation of the hypothesis that household distribution of contraceptives is both socio-culturally and logistically feasible in rural Tunisia. However, this program has not proven to be cost-effective, with a canvasser-household ratio of 1:1,550 and a cost per acceptor of over \$50 versus an average cost of \$12 in other ONPFP programs. A new operations research project was therefore developed in order to test a system which has the potential for replication on a national scale. The second study was launched early in 1977 in the rural delegations of Jendouba, Fernana and Nebeur. While building upon the PFAD experiment, the new project differs in a number of important respects: (1) the total study population is significantly larger - 140,000, with approximately 25,000 households; (2) the study site is a mountainous region in Northwestern Tunisia; (3) the personnel and other inputs are substantially lower in terms of the population covered (5 canvassers and a canvasser - household ratio of approximately 1:4,000); and (4) contraceptive resupply will be community-based rather than through household distribution.

(2) Outputs

During the course of the next three years, the following major activities will be conducted in an effort to develop an effective low-cost family planning delivery system for rural Tunisia.

(a) PFAD Project

In the fall of 1978, there will be a final canvassing of all households in the 11 sector area (entire delegation of Bir Ali plus two additional sectors). At this time, a permanent resupply system for orals and condoms will be established, using the homes of selected literate women and other retail outlets, in coordination with the Commercial Distribution project. (AID financed contract with Syntax.) Through specified resupply points in each sector and periodic visits by mobile teams, as well as social workers and nurse hygienists, the target population will be assured continued availability of contraceptive services. Before the January, 1979 termination date, a comprehensive quantitative and qualitative evaluation of the three-year experiment will be performed, providing detailed costs, contraceptive behavior and demographic analyses.

(b) Three Delegation Project

By the end of the second year of the project (1978), a community-based contraceptive delivery system will be fully operational in Jendouba, Fernana and Nebeur delegations. Following an initial canvass of all households and one revisit, oral contraceptives and condoms will be provided through a variety of resupply mechanisms - nurse-hygienists and social workers, political party units, administrative officers, and retail outlets (including collaboration, to the extent possible, with the AID financed Commercial Distribution Project), etc. Back-up medical services and transportation for other family planning procedures will also be offered.

Based on the results of an after fertility and contraceptive behavior survey to be conducted early in 1979, a comprehensive evaluation of the pilot project will be performed, including analyses of the cost effectiveness of the contraceptive delivery and resupply systems. The final phase of the project will test an integrated family planning/basic health care delivery system, with each canvasser working in teams which include a nurse hygienist and midwife. Recommendations for future program expansion will be presented.

(3) Inputs

The following AID inputs are proposed to generate the outputs described above.

(a) FFAD Project

Approximately \$55,000 in FY 78 funds will be needed to fund staffing (including a part-time physician and midwife, field director, 8 canvassers and 2 drivers), vehicle maintenance, administrative and other costs for the final year of the three-year project ending January, 1979. No further funds are currently programmed for this activity.

(b) Three Delegation Project

For this centrally-funded operations research project, an estimated additional \$36,000 (not including an inflation factor) will be expended each in FY 78 and FY 79 and \$9,000 for the first quarter of 1980, for a total life of project cost of approximately \$110,000. Expenditures cover salaries (including project monitor, 5 field workers, driver, midwife and part-time physician), transportation and maintenance, and other costs (supplies, evaluation, etc.) Depending upon the results of the evaluation in 1979, additional monies may be obligated to finance initial costs of an expanded community-based distribution program in 1980-81.

b. Training

(1) Need

(a) Physicians

A continuing medical education program for family planning needs to be set up for MOH general and private practitioners to familiarize them with both surgical and non-surgical contraceptive methods so that they can be motivated to offer family planning services to the general public. Since many physicians presently have no training in or experience with family planning techniques a special effort must be made to increase their awareness in order that they can assume a leadership role as physician managers in family planning services delivery. If the concept of teamwork is well promoted, the productivity of these physicians could be enhanced by the delegation of tasks of routine patient examination screening, treatment or referral.

Presently, there is an increase in acceptor demand for tubal ligation by laparoscopy since it is a relatively painless ~~out~~patient

procedure. However, in Tunisia most ligations done with other methods such as the mini-lap are done under general anesthesia and require 4 to 5 days hospitalization. At the present time, hospitals are unable to meet the demand for voluntary surgical contraception due to the constraints of a lack of skilled surgeons, acceptor resistance to spending 5 days in hospital and a lack of up-to-date surgical equipment. There are only 4 PIEGO certified physicians in the country and 4 laparoscopes. Two other gynecologists have been trained in laparoscopy but are without equipment. Very few surgeons in rural areas are familiar with the mini-lap technique which is more feasible than laparoscopy, due to the simplicity and minimal cost of the equipment required. To correct this situation, the Tunisian government is in the process of setting up a Family Planning/voluntary surgical contraception clinic center at Ariana with the assistance of AVS sub-grant proposal No. 096-000-1. This center will train surgeons and gynecologists in VSC procedures.

(b) Paramedical Staff

Many of the difficulties of the family planning program have been the result of physician manpower shortages. Examinations usually must be performed by ob/gyn specialists. Since there are few gynecologists outside Tunis, a serious constraint is imposed on the number of services that can be officially approved, although these could be provided by trained lower level personnel. At the present time, few midwives can place IUD's, and orals can generally only be obtained with physician prescription. It is essential for program expansion that the concept of team work and task delegations be promoted among the country's health professionals so that greater responsibility can be given to midwives, nurses, and nursing aides. Additionally, paramedical staff must acquire supervisory skills in order to coordinate the activities of less skilled outreach workers. In order to increase task allocation to nurses and nurses' aides, their skill levels need to be assessed. Deficiencies identified could be rectified through recycling and job restructuring.

Until now, medical social workers have had limited awareness of the role of family planning in comprehensive social service to families and communities and of the counseling interventions they can make to heighten consumer acceptance and utilization of these services. Regional training programs should focus on integrating family planning into their outreach activities.

Itinerant nurse hygienists have had prolonged contact and are trusted by the inhabitants of rural areas. However, they are predominantly male and have been involved in controlling communicable diseases. This project will provide them with retraining so that they can supply condoms, orals, counseling and education at the village level.

Pharmacists' aids will be the source of resupply for most contraceptive users and must be educated on how to explain use and side-effects of orals, and refer consumers to health facilities.

To undertake this massive program, the GOT will need assistance for the financing of the local costs of rotating physicians, midwives and other paramedicals through national facilities such as the Ariana Center as well as support for the local costs of regionalized training programs for nurse hygienists, social workers, administration, communication and other personnel.

(2) Output

With this proposed project assistance, up to 15 gynecologists per year will be recycled through the Ariana Center to learn the techniques of laparoscopy, mini-laparotomy and vasectomy. Six physicians will receive short-term training or attend conferences abroad so that the country's medical establishment can keep abreast of new methods of fertility control. By the end of this project, all 23 regional family planning systems will have a backup hospital equipped with mini-lap sets, a laparoscope, and trained physicians and will be able to meet the demand for voluntary surgical contraceptions from outlying areas. One hundred private and public general practice physicians will follow courses at the Ariana Center in order to become familiarized with all aspects of contraception so that they can offer services at clinics and private offices. Six supervisory midwives will be sent abroad to study health and family planning service delivery programs using nurse practitioners and nurse-midwives both in the U.S. and other LDC's. The primary aim of these efforts will be to develop a cadre of trainers who will be able to upgrade their technical, teaching and administrative skills and demonstrate them to colleagues. Areas focused on besides alternative family planning methods will be physical examination skills, health education, management, record keeping, maintenance of medical equipment and ordering of supplies. Most of these skills will then be taught at the Ariana Center to teams of paramedical trainees from rural areas as follows: 180 staff midwives already having several years experience at rural maternities, 180 mobile team midwives, 100 obstetrical aides (assistant midwives), and 240 nursing assistants. At the regional level, 360 social workers and 360 itinerant nurses will be recycled in family planning outreach activities.

Approximately 800 pharmacists' assistants from private pharmacies will attend a one-day session on oral contraceptives. The field training will be conducted by the regional family planning directorate. (The curriculum for the above groups is attached in Annex J).

(3) Inputs

AID will fund local costs of in-country training at the cost of \$517,000 and in addition, \$128,000 will go towards financing participant training in the U. S. and third countries.

c. Family Planning Service System Support

(1) Need

(a) Contraceptives

Presently AID is supplying the ONFPF with Norinyl oral contraceptives, Ackwell Tahiti condoms, Ligges loop IUD's, creams, jellies and foams. A limited number of copper-T IUD's are being supplied by AID for research purposes. The UNFPA is also contributing oral contraceptives and is currently supplying Neogynen and Anovular to the ONFPF.

These commodities are distributed by the ONFPF to facilities providing family planning services. The ONFPF also supplies the Central Pharmacy with orals and condoms for sale in private pharmacies where cycles of orals or packets of 3 condoms are sold for \$0.12 U.S. each.

AID financed contractor Syntex, Inc. will assist the GOT over a 3-year period in the setting up of a commercial marketing plan which will increase contraceptive availability. Under this scheme, the GOT will market U.S. funded contraceptives under Tunisian brand names. It is hoped the project will help push commercial distribution beyond pharmacies to other commercial outlets such as stores and tobacco shops. A constraint to this program is the need for consumers to have a physician prescription in order to obtain orals. The contractor will hold special seminars for physicians in order to acquaint them with the benefits of low dosage orals such as Norinyl. This should lower physician resistance and facilitate the GOT's passing a law to waive the prescription requirement for oral contraceptives.

(b) Medical Equipment and Drugs

The universal lack of equipment, supplies and drugs found in rural facilities poses a serious constraint to increasing the quantity of family planning services to be provided as well as improving the quality of services. Many rural dispensaries lack the most basic furnishings necessary for a family planning program. There is little or no equipment to assure aseptic technique. The overall effect is underutilization of facilities by patients. Many MCH centers, although better equipped, need to double their patient intake capacity and could easily do so with additional gynecological tables and examination kits.

Although the VSC program has been provided with 160 mini-lap kits, more will be required as additional physicians are trained in the technique. Laparoscopes will continue to be supplied in limited numbers by PIEGO to physicians certified by their program. However, some thought must be given to spare parts or the acquisition by the ONPFP of less costly models if they become available in the near future.

(c) General Support

Most MOH facilities offering family planning services have had a chronic shortage of funds for operating expenses and maintenance. There is an obvious need to strengthen the logistic support system if program expansion is to be consolidated and maintained. Many of the centers, particularly in the rural areas need upgrading to provide adequate service and attract potential acceptors. To allievate this situation, the GOT intends over the next four years to address the problem through the implementation of a renovation program. In addition, the lack of housing for medical and paramedical personnel in the rural areas necessitates their traveling long distances to work sites. Maintenance of family planning vehicles is required to expand the outreach activities. To recruit physicians and midwives to work under difficult conditions higher salaries must be paid.

(2) Outputs

The project will supply a total of 175,000 gross of condoms to 253,000 male acceptors and approximately 9,000,000 cycles of oral contraceptives to 664,000 female acceptors. Lippes Loops will be supplied with a limited number of copper-T's for research purposes, along with foams, creams and jellies.

160 newly constructed centers and 250 upgraded rural dispensaries will be equipped with gynecological tables, sterilization and medical examination kits. The entire family planning program will be provided with drugs and supplies such as gloves, specula, cotton and antibiotics. Approximately 500 more mini-lap kits will be provided to provincial hospitals.

Administrative strengthening will improve logistic support and supervision. This will have a spread effect on the outreach since their credibility will be contingent upon the improved performance of backup services.

(3) Inputs

AID will partially finance operating expenses and support costs for family planning centers, mobile teams, and the VSC program for a total of \$1,114,000. AID will also contribute \$666,000 towards new equipment and \$800,000 in supplies. In addition, it will finance contraceptive commodities from FY 78-81 for a total of \$2,473,000. The GOT will provide all other operating costs of the program estimated at \$7,127,000.

d. I, E & C

(1) Need

The success of ONPFP's new outreach program and whether acceptor targets will be met is dependent in large part upon a greatly expanded and more effective I, E & C effort at the regional and local levels. To date, ONPFP's activities in this area have been weak and unbalanced, concentrating too heavily on seminars for government workers, women's youth and labor groups etc. and not enough on the public at large, particularly the rural poor.

The shortcomings in ONPFP's I, E & C staff, overall strategy, equipment and supplies have been enumerated several times, most recently in a December, 1976 AID Assessment and Recommendation Report. Among the most important needs are expanded and strengthened radio broadcasts, more emphasis on TV potential, and additional audiovisual equipment and promotional materials, particularly "personal" messages geared to the illiterate rural population. In its program for 1977-1981, the Information Service of ONPFP has improved and broadened its approach, planning a series of activities which are designed to address the needs identified.

(2) Outputs

A new mass communications campaign and information program will be mounted, with emphasis on the rural areas, including diversified radio broadcasts in Arabic and French, a special TV program, a wide range of promotional materials, slide shows, advertisements in movie theaters and a 60-minute film on family planning in Tunisia. Special motivational activities and educational materials will be developed for the illiterate and semi-illiterate rural population, in conjunction with new household, community-based and commercial distribution program. Syntex, Inc., an AID financed contractor, will be conducting a major promotional campaign over the next several years in an effort to increase the visibility and awareness of contraceptive products throughout the country, particularly in rural areas. "Information days" and seminars for regional educational delegates, ONPFP staff and family planning administrators will be continued, but with greater emphasis on upgrading their skills as "communicators of family planning and population information."

(3) Inputs

AID inputs will be technical advice through short-term consultants, training of I, E & C Staff, provision of new production equipment, audiovisual aids and promotional materials (leaflets, posters, etc.) for regional and local distribution, (See Annex L for a detailed illustrative list). An estimated \$202,000 in FY 78 funds will be required, with decreasing amounts for the succeeding three years. The total for 1978-1981 is approximately \$759,000.

Research and Evaluation

(1) Need

As the ONFPF embarks on a major campaign to improve the availability and quality of family planning and health services, particularly in rural areas of Tunisia, the role of research and evaluation takes on added importance. Among the recommendations of the 1975 evaluation is that the ONFPF establish a "continuing program of operationally oriented research to improve the quality and accuracy of statistical reporting required for program development...to evaluate progress, compute at regular intervals various indicators by method, geographic area, and the risk of unwanted pregnancies, an accelerated management monitoring system should be instituted."

In the past year and a half, two operational research projects have been launched - FFAD and the Three Delegation Project - which have begun to generate detailed data on contraceptive behavior, demographic characteristics and delivery system components. These represent small pilot efforts, however, and over the next several years increased emphasis will be placed on timely data collection and processing as well as improved program management and evaluation in order to maximize the impact, efficiency and cost-effectiveness of ONFPF's activities nationwide.

(3) Outputs

The population division of ONFPF has a comprehensive, carefully designed research and evaluation strategy for the period 1977-1981. In addition to the monthly routine collection and processing of service statistics from each region, an important activity will be greater analysis of the available data. Computer searches will be performed and extensive cross tabulations prepared. An expanded semi-annual statistical bulletin will replace the quarterly bulletins. The recently established data bank will continue to be strengthened and will serve as a key instrument in the special evaluation studies planned.

In 1978, two major activities are planned: 1) a national fertility survey (see other donor coordination: AID-funded projects) and 2) an evaluation of ONFPF central and field operations, involving both a quantitative and qualitative assessment of the strengths and weaknesses, input/output ratios at each level, and the overall coordination of program activities. This evaluation will enable ONFPF to reorient program goals and determine the most cost-effective mix of clinical and non-clinical family planning systems. A related study which is being prepared involves an assessment of the impact on the general public of ONFPF promotional and educational activities, including a content analysis.

The final stage of ONFPF's research and evaluation strategy for the next four years is to institute at the clinic level individual acceptor forms which can then be loaded into the data bank, processed and analyzed. This will enable a comprehensive assessment of contraceptive behavior in addition to better patient follow-up. In summary, the establishment of an efficient management monitoring system on ONFPF will help ensure not only that program targets are met but also that program strategy and the quality of service delivery are improved.

(3) Inputs

AID inputs will cover local costs of research programs - data collection, processing and analysis, including strengthening of the ONFPF data bank. In FY 78, an estimated \$46,000 will be spent on these activities, for a total cost over the four years of \$186,000. For special evaluation activities, including an analysis of the cost-effectiveness of ONFPF operations, approximately \$140,000 will be expended during the project period, with an estimated \$50,000 in FY 78.

f. Short-Term Technical Assistance

(1) Need

Although the GOT presently has a highly skilled group of core technicians managing the ONFPF, backstopping with consultants will be required in areas such as operations research, new surgical and medical contraceptive technology, curriculum development and evaluation for paramedical staff, management information systems, data analysis and various I, E & C activities.

(2) Outputs

Up to 30 person months of short-term consultation will be provided under this four-year project. These experts will be drawn from public and private institutions throughout the U. S., Tunisia and other countries. They will be invited by the GOT to perform specific short-term assignments.

(3) Inputs

AID will contribute over the next four years a total of \$300,000 towards financing of short-term consultants in areas such as gynecology, paramedical training as well as I, E & C research and evaluation etc.

3. Major Assumptions

In order for the follow-on AID assistance program to proceed successfully, the most critical assumption is that the ONFPF will continue to be supplied by the GOT with heavy inputs of funds and personnel, including substantial increases in budget support costs over the next four years to make the program more self-sustaining and thus allow AID to phase down

its assistance, particularly in the areas of training and infrastructure support.

Other key assumptions in this program include the following:

- a. The prescription requirement for pills will be lifted;
- b. The GOT and the Tunisian medical profession will reach an accord as to the dissemination of pills and condoms through wider commercial channels;
- c. There will be greater task delegation to and utilization of paramedical personnel to provide family planning services, such as IUD insertion, examination, screening and referral of clients;
- d. New health care/family planning centers and upgrading of existing ones will be concentrated in areas of greatest need;
- e. Trained medical and particularly paramedical personnel will accept assignments in rural areas;
- f. There will be increased cooperation and collaboration between the ONPFP and the MOH (as well as the Ministry of Social Affairs) in providing basic health care and family planning as integrated services to the rural population;
- g. Clinical and non-clinical delivery systems, including the commercial contraceptive distribution program, will be well-coordinated and complementary;
- h. Geographic and cognitive barriers to acceptance of family planning services in rural areas will be minimized through effective community-based distribution programs and greater promotional efforts; and
- i. Sufficient contraceptive supplies, medicines, medical and audiovisual equipment, and vehicles will be available to support the outreach effort.

4. Other Donor Coordination

Since 1966, AID has been the principal foreign donor to Tunisia's family planning efforts. The following AID-funded projects and other major donor agencies will be providing assistance in this area over the next several years.

a. AID-Funded Projects

(1) Syntex, Inc.

The Commercial Contraceptive Marketing Contract in Tunisia (Syntex, Inc.) is providing \$615,000 over a three-year period to carry out sales promotion program for Tunisian pharmacies and selected physicians, intensive promotion campaigns to consumers, and expansion of distribution of orals and condoms into non-pharmaceutical retail outlets. As part of

the first phase of the program, a seminar is scheduled to be held in October, 1977 for the medical and pharmacist community in an effort to create greater interest in Norinyl and other pills and to encourage expanded distribution of condoms.

The project aims at reducing discontinuation rates of oral contraceptives in the public sector by at least 6 percentage points during the three-year period and, through strong promotional activities, increasing by 50 percent the commercial utilization of contraceptives.

(2) FPIA

Under the proposed three-year project (October 1, 1977-September 30, 1980), FPIA will provide financial and material assistance to introduce mobile MCH/family planning services in four Tunisian governorates.

Fully equipped mobile units will visit each delegation on a regular basis. The provision of family planning information, education and counseling services will be effected principally through social assistants who will use mini-motorcycles as a means of transportation. The projected first year cost including salaries and recurring costs for the second and third years is \$225,000. Based on the results of the initial year's activities, FPIA may provide additional assistance so that mobile services can be extended to all governorates.

(3) IPAVS

The AVS sub-grant will provide a maximum of \$354,481 over a three-year period to establish, equip and fund support costs for a major family planning voluntary surgical contraception center in the area of El Ariana, a suburb of Tunis. The El Ariana Center, scheduled to open in October, 1977 will serve as the national training center for medical and non-medical personnel in the field of family planning/voluntary sterilization and will provide voluntary surgical contraception services to the rural population of Tunisia, particularly in the area of Tunis-Sud. A minimum of 1,000 procedures are to be performed during the first year. In conjunction with the Information and Education Office of ONFPP, a program will be conducted for physicians and the general public on the family planning and VSC services being provided at the El Ariana Center.

(4) WFS

Through an AID/W grant to the International Statistical Institute, the World Fertility Survey will fund the majority of local costs (\$138,299) for a Tunisian National Fertility Survey to be conducted in 1978. The survey, based on a sample of 5,500 households, will provide national estimates of fertility and contraceptive knowledge, availability and use. A final report will be available by June, 1979.

b. Foreign Donors

(1) IBRD (World Bank)

Over the next four years, the World Bank will contribute \$8.6 million as part of a major new capital loan program with the ONFPF to construct FMI centers and upgrade rural dispensaries throughout Tunisia. In addition, construction of 4 major maternity hospitals, with a large family planning component, will be completed in 1978.

(2) UNFPA

During the period 1978-1982, the UNFPA will contribute approximately \$4 million to support Tunisia's family planning efforts. This includes: \$1.2 million to support operational costs of regional education and family planning centers (implemented by UNDP); \$820,000 for equipment, new mobile teams, medicine and contraceptives (implemented by UNICEF); \$800,000 to cover medical training and salaries of medical and paramedical personnel (implemented by UNDP); \$316,000 for a population education project in secondary schools (implemented by UNESCO); \$180,000 for a worker population education project (implemented by ILO); \$400,000 for an integrated health and family project in the Kef Region carried out by specially trained family aides (implemented by the Dutch Tropical Region Institute), and \$200,180 for a research and evaluation program on contraceptive methods (implemented by UNC and IFRP).

(3) NORAD

In conjunction with the World Bank loan, the Norwegian Agency for Development has provided a grant of \$4.6 million for construction of hospitals and MCH centers in various parts of Tunisia.

(4) WHO

The World Health Organization is financing an operational research project in the field of basic health care being conducted in Beja. In addition, it will support a new medical research and evaluation program which will be headquartered at the El Ariana Family Planning/Voluntary Surgical Contraception Clinic. WHO is contributing approximately \$967,000 during the period 1977-1981.

(5) IFFF

The IFFF affiliate (Association Tunisienne de Planning Familial, ATFF) has an annual budget of \$50,000 to conduct training of medical and paramedical personnel as well as conferences and workshops for community leaders, etc. In conjunction with the ONFPF program, ATFF will be directing its I & E program towards women and youth in rural communities. It will also provide partial funding of the MCH's Montfleury Clinic in Tunis.

(6) Belgium

The Belgian government provides medical and paramedical personnel to a pilot health/family planning project in the Gafsa region, with \$599,000 budgeted for 1977-1981.

(7) Luxemburg

A total of \$428,000 is being spent on the construction and equipment of 7 pre-fab MCH centers in rural areas.

Korea, Rumania, Bulgaria, Russia and China provide a number of gynecologists and pediatricians for hospitals and mobile teams.

III - PROJECT ANALYSIS

A. Technical Analysis Including Environmental Assessment

Each of the program components envisioned for the project is technically sound and is based upon recommendations made by a 1975 AID evaluation team. In view of the strong performance of the ONFPF in the last few years, continued AID support is feasible and required to consolidate, strengthen and expand the present GOT family planning system so that the country can achieve its population goals. Furthermore the cost elements for each component appear to be reasonable.

The present project will increase the quality and quantity of family planning services available in Tunisia. It has been designed to disseminate methods already utilized and accepted by Tunisian health providers and consumers to all areas of the country and to introduce new technology.

The following sections will provide additional technical analyses for major program elements.

1. Manpower Development

Tunisia is typical of most developing countries with regard to the availability and maldistribution of physicians. About 80 percent of the country's physicians is in urban areas.

TABLE I

Distribution of Physicians, Selected Cities, Tunisia, 1976

| | TOTAL | TUNIS | SCUSSE | SFAK | BIZERTE | GABES | OTHER |
|------------|-------|-------|--------|------|---------|-------|-------|
| Physicians | 1210 | 656 | 97 | 87 | 53 | 32 | 276 |

Much of the leadership in family planning is provided by the country's 89 gynecologists who are similarly maldistributed. The picture is further complicated by Tunisia's excessive dependence on foreign physician manpower. In 1976 there were 537 foreign physicians in Tunisia, many of them with bilateral aid programs. The country's 3 medical schools are relatively new and a quantum jump in the number of graduated physicians cannot be expected until the mid 1980's.

This project will result in the country's surgeons learning more

efficient and safer methods of voluntary surgical contraception. Most tubal ligations will be done as outpatient procedures under local anesthesia. This will do much to avoid the backlog of cases presently building up due to the traditional methods which require lengthy hospitalization and general anesthesia. Many of the country's general and private physicians will also receive intensive training in non-surgical family planning techniques.

To reduce the present almost total reliance on physicians for medical services, the GOT has authorized the recycling of nurses and nurses/midwives in family planning techniques. As a result of this training, midwives will be able to assume many of the gynecologist's tasks such as pelvic examination and placement of IUD's. The MOH presently employs 250 midwives and will have approximately 500 by 1981. This will be sufficient to staff all rural MCH/FP centers. During the interim period, nursing assistants will be recycled to provide many family planning responsibilities. Furthermore, the project will recycle nurse hygienists and non-medical field workers to screen and supply oral pill clients and distribute condoms, as well as provide referral for clients selecting other birth prevention methods.

Since all of the itinerant nurse hygienists are male, it is likely that their activities will focus on village men, although they will distribute orals as necessary. In order to back up the nurse hygienists, outreach social workers will also be trained to focus on village women. These social workers will be involved in initial contacts with the women for counseling and education. Later follow-up will be provided by the nurse hygienists who will be authorized to resupply acceptors during regular monthly visits. The MOH has based its policy for using rural outreach workers to deliver family planning on the successful elements of the FFAD pilot project in Bir Ali Ben Khalifa (as well as the recently launched Three Delegations Project) where canvassers distribute contraceptives house to house. In these pilot programs and in other AID-funded village level health services delivery programs, it has been found that outreach workers who are well known by the community often have greater credibility than outsiders would have in traditional communities with limited outside contact.

2. Mobile Services

There are presently three mobile clinics where a gynecologist and midwife travel to rural zones without health facilities in a VW van equipped for routine gynecological primary care and family planning. The MOH intends to have one mobile clinic for each governorate in order to reach villages without dispensaries. This project, by providing some of the equipment and operating costs, will ensure that even the remotest areas are covered.

Most governorates now have a family planning mobile team consisting of a midwife, social worker and chauffeur, following a predetermined circuit of visits to rural dispensaries (and other localities). During this time,

the midwife does family planning consultations and the chauffeur transports those women opting for voluntary surgical contraception to a regional hospital.

The MOH/OHPFP plans to increase not only numbers of mobile teams but also the scope of their activities. In view of distances a single team has to travel, the MOH plans for each governorate to have several teams, thereby increasing the number of visits, and the productivity of teams as well as providing for more coherent follow-up care. With AID assistance, the mobile midwives will be recycled so that they can assume leadership and monitor the activities of rural health center staff and outreach workers in the delivery of family planning services.

3. Upgrading and Expansion of Facilities

Currently there are 482 Ministry of Health facilities offering family planning services to the general public.

| | |
|-------------------------|-----------|
| Regional Hospitals | 21 |
| District Hospitals | 25 |
| MCH Centers | 84 |
| Community Dispensaries | 77 |
| Rural Dispensaries | 249 |
| Family Planning Centers | 18 |
| Other | <u>14</u> |
| TOTAL | 482 |

Under the next Five Year Plan, the MOH intends to build 80 new rural health centers, and upgrade 250 rural dispensaries which will be equipped with the basic furnishings to be able to provide family planning in rural townships (average pop. 5,000 people). At the county level (15-20,000 people), 25 10-bed family planning/MCH centers will be constructed and 50 existing maternities will have family planning centers added to them. In addition, the existing 84 MCH/FP centers will be given extra equipment so that patient loads can be increased. By 1991, there will be a total of 160 fully equipped and staffed MCH/FP centers providing back-up to the rural health centers. Midwives will be able to provide family planning consultations, perform gynecological examinations and place IUD's with back-up physician services. Equipment in each center should be sufficient enough to permit the gynecological screening of several thousand women and, in addition, the placement of several hundred IUD's during each year of operation.

In order to attract midwives, those MCH/FP/maternity centers without housing shall have houses constructed to provide accommodation for midwives.

Especially singled out for improvement are the rural dispensaries since they will remain the entry point into the family planning services

system for the majority of potential acceptors in rural areas. As these will be visited weekly by mobile midwives, the new equipment such as lights, tables, stools, medical kits and supplies should provide for the sterilization of instruments and make competent physician examination possible. As a result, public esteem will be elevated for the facilities and utilization rates will rise. This will have a positive effect on the success of outreach workers, which is contingent on the overall quality of the health center backing them up.

4. Summary

Continued AID funding will strengthen and expand GOT family planning services. On the one hand, the availability of voluntary surgical contraception will be increased. New techniques can be done on an outpatient basis increasing acceptability and reducing the demand on hospital beds. On the other hand, family planning services will be carried into the remotest villages where clients will not only be offered orals and condoms, but will also be offered counseling on other methods and referral to a nearby facility, if desired. The program will offer clients a variety of methods of birth control -- pills, condoms, IUD's and VSC. AID has supplied and will continue to supply under this project commodities for all these methods.

5. Initial Environmental Examination

Much of Tunisia's land area is severely degraded ecologically, and remains threatened by pressures from both human and animal populations. To the extent that this project is successful in contributing to reduced population growth in Tunisia, environmental effects will be positive, although difficult to measure spatially or quantitatively. Project activities themselves, consisting primarily of training, supply of contraceptive commodities and provision of family planning services will have no measurable adverse environmental impact.

B. Financial Analysis and Plan

Plans for the financing of this project have been developed utilizing past GOT and AID program financial data and figures based upon projected program activities. The plan which has resulted is financially sound and represents what the GOT realistically expects to achieve during the next four years. This section of the paper will present a more detailed analysis of the financial plan including a discussion of key financial trends. Detailed budget tables are also included.

The financial plan for this family planning services project indicates a total USAID requirement of \$7,797,000 over the next four year project period. During the FY 75-77 project period, the USAID total was \$3,663,063 representing an increase of approximately \$4,134,000 for the new project period. This

increase is justified based upon the longer time frame, the expanded project activities and the projected increase in acceptor rate. For example, there has been a 55 percent rise in the number of acceptors over the past two years.

The GOT proposed amount to be expended during this project period is \$8,721,000. During FY 75-77, total GOT expenditures were approximately \$2,479,000; this means an increase for this project period of about \$5,596,000. The GOT input for this project has shown a steady annual rise in past years. For example, from 1974 to 1975 the GOT increased its annual expenditures for family planning services by approximately 9 percent. For the 1976 to 1977 period, the increase was approximately 20 percent. When considering the planned project period, (1978-1981), the GOT will more than double its annual expenditures for family planning program activities by 1981 compared to the annual expenditure in 1974 (1974 actual was \$989,000, 1981 projected figure is \$2,187,000). These figures represent only the operating budget of the ONFPF and do not include Ministry of Health overhead and costs for medical services. The MOH input is an additional GOT resource devoted to the family planning program. Because of these increasing allocations of financial resources to family planning program activities, there can be no doubt that the GOT is firmly committed to the goals of this project.

For the entire project, including AID and GOT inputs, the total projected amount is \$16,518,000, of which AID will support 47 percent of the program cost and the GOT will provide 53 percent. -These figures do not include capital projects, i.e. construction and renovation of MCH centers and related facilities, so that if those costs are considered the AID percentage contribution would be lower. For example, during the 1977-1981 period, the total AID and GOT percentage of support for family planning projects including capital projects would be 28 percent and 62 percent respectively. This indicates that the GOT is absorbing the majority of the overall program costs for the family planning project. The present project is, therefore, well within the GOT capability.

The major proportion of recurring costs for this project is being provided by the GOT. AID, however, is providing support for some recurring project costs i.e., salary support, per diem, transportation costs, etc. For the total project, an estimated \$1,114,000 (8 percent) of the approximately \$13,132,000 * which can be identified as recurring costs is being provided by AID. At project phase-out, it is reasonable to assume that the GOT could absorb this percentage of recurrent costs and could continue project activities with minimal or no decreases in services.

* Figures for recurring costs are estimates. Because of the current GOT budgeting system, some recurring costs are not easily identifiable.

Although this project is considered a bilateral effort for AID programming purposes, there are several other donors providing financial support. (See Section II B for a detailed description of donors activities). Other sources of donor support for family planning services include UNFPA, IPAVS, FPIA, World Fertility Survey, Syntex, WHO, Belgium, Luxembourg, World Bank and NORAD. Combining both capital and non-capital expenditures, the total projected donor support for family planning services including AID, during the period 1977-1981 is estimated at \$35,377,000 (51 percent). For the same period, the GOT projected expenditures are \$33,957,000 (49 percent). Considering all funding sources for the period 1977-1981, the following are the percentages of support: GOT - 49 percent, AID - 19 percent, Other Donors - 32 percent. AID is the largest donor, followed by the World Bank (12 percent) and UNFPA (7 percent). A detailed table illustrating other donor support is included in the following section.

It is apparent from the analysis of the data presented in the financial plan that with the combined efforts of the GOT, AID and other donors, the GOT program as planned is adequately financed. Sources of funding seem secure. The GOT is committed to the program as evidenced by their previous contributions and their planned expenditures.

1. SUMMARY COST ESTIMATE AND FINANCIAL PLAN, 1978-1981

(U.S. \$ 000)

| COST CATEGORY | AID | GOT | TOTAL |
|---|---------------------------|-------|--------|
| 1. U.S. short-term technicians | 300 (30 FM) | - | 300 |
| 2. Training | | | |
| a. U.S. participant training, short term | 128 (80 FM) ^{1/} | - | 128 |
| b. Host country training | 517 | 74 | 591 |
| 3. Other costs | | | |
| a. Contraceptive supplies (orals and condoms) | 2,473* | 160 | 2,633 |
| b. Medical equipment | 666 | 278 | 944 |
| c. Medical supplies and drugs | 800 | 214 | 1,014 |
| d. Medical-surgical support services | 1,114 | 7,127 | 8,241 |
| e. Education & information program | 759 | 111 | 870 |
| f. Research and evaluation | | | |
| (1) Community based distribution programs | 136* | - | 136 |
| (2) Data processing & analysis | 186 | 74 | 260 |
| (3) Other evaluative studies | 140 | 37 | 177 |
| Sub Total | 7,219 | 8,075 | 15,294 |
| Inflation Factor (8%) | 578 | 646 | 1,224 |
| TOTAL | 7,797 | 8,721 | 16,518 |

* USAID Partially Centrally-Funded

SOURCE: Data compiled from unpublished Government of Tunisia budget documents prepared for the 1977-1981 Five Year Development Plan.

^{1/} Transportation to US and return to be funded from GOT Trust Funds.

2. ANNUAL COST ESTIMATE AND FINANCIAL PLAN, 1978-1981
(US \$ 000)

| COST CATEGORY | FY 1978 | | FY 1979 | | FY 1980 | | FY 1981 | | ALL YEARS | | TOTAL |
|---|----------------|-------|----------------|-------|----------------------------|-------|---------------|-------|----------------|-------------------|--------|
| | AID | GOT | AID | GOT | AID | GOT | AID | GOT | AID | GOT ^{1/} | |
| 1. U.S. short-term technicians | 100 (10 FM) | | 100 (10 FM) | | 60 (6 FM) | | 40 (4 FM) | - | 300 (30 FM) | | 300 |
| 2. Training: | | | | | | | | | | | |
| a. US participant training short term | 32 (20 FM) | | 32 (20 FM) | | 32 [*] (20 FM) | | 32 (20 FM) | - | 128 (80 FM) | | 128 |
| b. Host country | 135 | 18 | 136 | 18 | 122 | 18 | 124 | 20 | 517 | 74 | 591 |
| 3. Other costs: | | | | | | | | | | | |
| a. Contraceptive supplies (orals and condoms) | 522* | 40 | 875* | 40 | 736* | 40 | 340* | 40 | 2,473* | 160 | 2,633 |
| b. Medical equipment | 162 | 69 | 180 | 69 | 162 | 70 | 162 | 70 | 666 | 278 | 944 |
| c. Medical supplies and drugs | 199 | 53 | 203 | 53 | 199 | 54 | 199 | 54 | 800 | 214 | 1,014 |
| d. Medical-surgical support services | 278 | 1,781 | 280 | 1,781 | 278 | 1,782 | 278 | 1,783 | 1,114 | 7,127 | 8,241 |
| e. Education & information program | 202 | - | 187 | 27 | 185 | 28 | 185 | 29 | 759 | 111 | 870 |
| f. Research and evaluation | | | | | | | | | | | |
| (1) Community-based distribution | 91** | - | 36* | - | 9* | - | - | - | 136 | - | 136 ** |
| (2) Data processing & analysis | 46 | 18 | 48 | 18 | 46 | 19 | 46 | 19 | 186 | 74 | 260 |
| (3) Other evaluation studies | 50 | 9 | 35 | 9 | 35 | 9 | 20 | 10 | 140 | 37 | 177 |
| Sub-Total | 1,817 | 2,015 | 2,112 | 2,015 | 1,861 | 2,020 | 1,426 | 2,025 | 7,219 | 8,015 | 15,294 |
| Inflation Factor (%) | 146 | 161 | 149 | 161 | 149 | 162 | 114 | 162 | 578 | 846 | 1,224 |
| TOTAL | 1,963 | 2,176 | 2,261 | 2,176 | 2,013 | 2,182 | 1,540 | 2,187 | 7,797 | 8,721 | 16,518 |

* AID centrally funded

** FY 78 figures include the three delegation project which is centrally funded and the Bir Ali Project which will utilize project funds.

^{1/} GOT figures do not include approximately \$ 23.9 million dollars projected in capital expenditures for the Renovation and Construction of FMI centers.

SOURCE: Data compiled from unpublished Government of Tunisia budget documents prepared for the 1977-1981 5 Year Development Plan.

3. SUMMARY OUTPUT TABLE, 1978-1981

(US \$ 000)

| FUNDING SOURCE | Community Based Distribution | | | | Training | | | | Information & Education | | | | System Support | | | | Research & Evaluation | | | | TOTAL ANNUAL | | | | TOTAL ALL YEARS |
|-----------------------|------------------------------|----|----|----|----------|-----|-----|-----|-------------------------|-----|-----|-----|----------------|-------|-------|-------|-----------------------|-----|-----|-----|--------------|-------|-------|-------|-----------------|
| | 78 | 79 | 80 | 81 | 78 | 79 | 80 | 81 | 78 | 79 | 80 | 81 | 78 | 79 | 80 | 81 | 78 | 79 | 80 | 81 | 78 | 79 | 80 | 81 | |
| USAID | 91 | 36 | 9 | - | 167 | 168 | 154 | 156 | 202 | 187 | 185 | 185 | 1,261 | 1,633 | 1,435 | 1,019 | 96 | 83 | 81 | 66 | 1,817 | 2,112 | 1,864 | 1,426 | 7,219 |
| GOV | - | - | - | - | 18 | 18 | 18 | 20 | 27 | 27 | 28 | 29 | 1,943 | 1,943 | 1,946 | 1,947 | 27 | 27 | 28 | 29 | 2,015 | 2,015 | 2,020 | 2,025 | 8,075 |
| Sub-Total | 91 | 36 | 9 | - | 185 | 186 | 172 | 176 | 229 | 214 | 213 | 214 | 3,204 | 3,581 | 3,381 | 2,966 | 123 | 110 | 109 | 95 | 3,832 | 4,127 | 3,884 | 3,451 | 15,294 |
| Inflation Factor (8%) | 7 | 3 | 1 | - | 15 | 15 | 14 | 14 | 18 | 17 | 17 | 17 | 256 | 286 | 271 | 237 | 10 | 9 | 9 | 8 | 306 | 330 | 312 | 276 | 1,224 |
| TOTAL | 98 | 39 | 10 | - | 200 | 201 | 186 | 190 | 247 | 231 | 230 | 231 | 3,460 | 3,867 | 3,652 | 3,203 | 133 | 119 | 118 | 103 | 4,138 | 4,457 | 4,196 | 3,727 | 16,518 |

* Includes USAID commodities

4. TUNISIA FAMILY PLANNING PROGRAM
ESTIMATED SOURCES OF SUPPORT, ALL DONORS, 1977-1981
(US \$ 000)

| COST CATEGORY | FUNDING SOURCE | | | | | | | | | | | | | TOTAL FOREIGN | TOTAL ALL SOURCES |
|---|-------------------|--------|--------------------|-------|-------|------|------------------------------|--------|-----|---------|-----------|---------------|-------|------------------|----------------------|
| | | GOT | USAID | UNFPA | IPAVS | FPIA | WORLD FERTILITY SURVEY | SYNTEX | WID | BELGIUM | LUXEMBURG | WORLD BANK | MORAD | | |
| 1. Capital Projects | | 23,859 | 3,000 ¹ | | | | | | | | 418 | 8,046 | 4,667 | 16,131 | 39,990 |
| 2. Non-Capital Projects (System operational costs, education, training, research, etc.) | | 10,098 | 9,547 | 4,027 | 354 | 469 | 139 | 815 | 967 | 599 | | 562 | | 18,279 | 28,377 |
| TOTAL | | 33,957 | 12,547 | 4,027 | 354 | 469 | 139 | 815 | 967 | 599 | 418 | 8,608 | 4,667 | 34,410 | 68,367 |

SOURCE: Data compiled from unpublished Government of Tunisia budget documents prepared for the 1977-1981 5 Year Development Plan.

¹Rural Community Health Project
(Loan-Construction Health Facilities Sidi Bou Zid-Silliana)

C. Social Analysis

1. Introduction

Since 1966 AED has been providing support for the Tunisian family planning project which has achieved a significant degree of success during the past eleven years. Indeed, the family planning project has received an impressive level of commitment on the part of the GOT and has the potential for being a service model for other predominantly Moslem societies and other African countries. This section of the project paper will review the social soundness of the proposed project and will include a discussion of its socio-cultural feasibility, the project spread effect, the social consequences and benefits to be achieved, and the impact upon the role of women.

2. Socio-Cultural Feasibility

a. Feasibility

Because of this project's long-standing history in Tunisia, the types of services being provided and the delivery system approaches being utilized have already proven to be feasible in this socio-cultural environment. Since there is widespread acceptance of the concept of family planning, the primary task at hand is to make services more accessible to those persons who need them the most, primarily in the rural areas.

A further indication of the feasibility of these services is the experience of the pilot contraceptive distribution program in the Bir Ali Ben Khalifa delegation. The results of this pilot effort have demonstrated that when contraceptives are made readily available, they will be utilized and that there is a demand for family planning services in the rural areas.

b. Target Population

The target population over the next four years will be approximately 1,700,000 women of child-bearing age. This target group, their families, and ultimately the whole economy will benefit from the resulting improvement in the dependency ratio. At the present rate of growth, in the number of new acceptors, most of Tunisia's eligible women will be practicing family planning before the end of the century, an indirect result of this proposed project.

c. Motivation for Family Planning

Past project activities have indicated that when family planning services, including voluntary surgical contraception (VSC), have been made available within Tunisia, acceptance of services has been high. Indeed, there appears to be a rapidly increasing demand for VSC services in particular.

Although those persons who have accepted family planning services appear to be highly motivated, there continues to be a significant number of

women who do not have access to or do not utilize them. There are many factors responsible for this situation; however, two key considerations are the unavailability of services in rural areas and the lack of motivation or even awareness of the need for family planning. All of these factors can be addressed by provision of services accompanied by a well-planned information and education program. One of the elements of the proposed project, besides expanding the availability of services, will be an upgrading of the ONFPF's I, E & C program activities.

d. Religious Factors

There are no major religious barriers towards the acceptance of family planning services in Tunisia which is a predominantly Moslem society. On the contrary, the concept of family planning, including abortions, has received widespread support from Moslem religious leaders. As this proposed program expands into rural areas, through information, education and communications programs and availability of services, any possible religious objections will not be a major constraint.

e. Communication

There is a well developed communication system in Tunisia which can effectively contribute to the dissemination of family planning information. There are four daily newspapers (adult literacy is 55 percent), two state controlled TV stations and three radio stations, all of which broadcast in French and Arabic. Additionally there are about 100 cinemas spread throughout the country. Because of the availability of these resources, there is a high potential for mass media education in Tunisia. While the ONFPF has been utilizing regular radio broadcasts promoting family planning services, there has not been an effective use of all media, however, and one of the results of this proposed project will be to further develop mass media activities of the family planning project.

f. Potential Obstacles

This project will be focusing on the expansion of services into rural areas. In this regard, the project will face challenges which may not have been apparent when designing services for urban areas. Past family planning pilot project activities in Tunisia and in other LDC's have proven the feasibility of the proposed project focusing on predominantly rural areas; however, as this project increases its rural service component, staff should consider the following potential obstacles:

(1) Rural Population Reception of Government Health Services

Currently, rural dwellers perceive that Government health services are often inaccessible, inferior and delivered in an insensitive manner. Consequently, there tends to be a reliance upon either the private health care provider (for the few who can afford it) or the well-established indigenous health care system.

(2) Rural Program Staffing Difficulties

The current system of health care, including the provision of family planning services, has been heavily physician-oriented with minimal use of auxiliary workers. Hopefully, this will change as a result of some of the activities of this project; however, presently, the role of the auxiliary is not highly regarded within the Tunisian health care system. Doctors do not use auxiliaries as efficiently as they could be used and many of the auxiliaries tend to be inadequately trained, poorly motivated and underemployed. As a result, interactions between auxiliaries and rural patients too frequently are negative and further reinforce the perception that care provided in the rural areas is "second class"

(3) Service Locations

Although there is a widely dispersed network of health centers in Tunisia, the majority of them are stationary and confined to cities and towns. As a result, many persons in the more remote rural areas do not have adequate access to needed health services, including family planning services. This accessibility problem provides the rationale for the project's focus on outreach activities such as the household and community based distribution system. In addition, the GOT is utilizing mobile clinics and mobile health teams, as discussed in Section I.

(4) Male Resistance

It is possible that some of the male members of rural Tunisia society may perceive family planning programs as a threat to their prerogatives. To minimize resistance based upon such feelings, the proposed information campaigns will stress the potential savings and improved health of smaller families, and disseminate the public pronouncements of many Tunisian leaders on the benefits of family planning.

3. Spread Effect: Diffusion of Innovation

The responsibility for the diffusion of family planning information and services remains with the ONFFP program personnel. Ultimately, the main resources for the spread of information about the program and for the increase in program acceptors will be the patients themselves. Past family planning program experience in both the United States and in other LDC's has shown that one of the greatest sources of patient recruitment has been through word of mouth. When affordable clinical family planning services are accessible and are provided in a thorough, professionally competent, and, most important of all, sensitive manner, patients will accept and continue to use these services. Not only will they use such services but they will inform friends and relatives who will also become program acceptors. The spread effect from a satisfied patient can be enormous. In a similar fashion, should the quality of services

available be perceived as being inadequate by the patient, there will be a negative effect on the number of acceptors. A key to the effective diffusion of program services is the provision of high quality family planning services, i.e. services that are accessible, affordable, and are provided by a sensitive, well-trained staff.

4. Social Consequences and Benefit Incidence

If the project purpose is achieved, no groups are apt to be adversely affected since no group has a vested interest in couples having more children than they want. Some groups, however, will benefit more than others, at least in the short term. The most immediate beneficiary will be the mother. First, she will face the risks associated with pregnancy less often. Second, fewer children represents a lessening of her work burden which is financially non-remunerative. Third, and as a result of the first two, she should be healthier. Fourth, with fewer children to look after, she may be able to devote her time to pursuits which have an economic return to the family, e.g. cottage industry vegetable gardening, etc.

Children are the next important beneficiaries. Assuming that the family income remains relatively stable, they should be better fed, better educated, better clothed and generally better cared for since the family income does not have to be stretched as far. Husbands and fathers will benefit due to less pressure on them as breadwinners. In the sense that the entire family benefits, even elderly people should benefit since they normally depend on their grown children for support during their old age.

The main social consequence of a successful program is likely to be the increase of the woman's influence in family life, particularly since the behavioral attitudes toward her status in the family will be heavily modified. If these attitudes are modified and if she is able to use her time in a more economically productive fashion, she will have greater independence and a greater authority in family matters. This would represent a minor social revolution. Of course, if power or authority is reviewed in a zero-sum context the husband may then be said to lose authority or power within the family. It does not seem likely that he will perceive things in this fashion, but if he does, it must be weighed against the economic benefits which will also be accruing to the family.

Ideally, one aspect of the family planning message should be to encourage people to plan ahead, to anticipate consequences of actions, and to have confidence in their ability to affect their circumstances. In promoting family planning, people are urged to adopt an innovation, to engage in behavior which is nontraditional, and to establish and maintain contacts with groups outside the community.

Other social consequences are not easy to predict. Certainly, over the long term, the fact that social services do not have to be stretched as far will lead to better education, health, etc. On the other hand, if the population growth rate is not brought under control the consequences are apt

to be an overall degradation of the quality of life in Tunisia.

5. The Role of Women

This project will have a significant impact upon the role of women in Tunisian society. As currently designed, the project has a high ratio of female participation both as recipients of program services and as service providers. For those women who are receiving program services, this acceptance of family planning services will give them a degree of control over their own lives which was heretofore unavailable to them.

Additionally, training plans for this project include midwives, social assistants and health aides who are women. The training programs will result in increased professional skills enabling substantially increased participation in this project.

Tunisia has provided strong leadership among other Moslem countries in its efforts at promoting the increased development of the role of women. There is an active women's movement in Tunisia represented primarily by the National Women's Union (UNF), a group which has been quite successful at sensitizing and educating women for an expanded role in Tunisian society. The UNF has been an enthusiastic supporter of the Tunisian family planning program.

Related to this project are several significant-steps taken by the Tunisian Government which greatly affect the role of women and provide a framework for change in the traditional ways women have been regarded in Tunisian society. The GOT has abolished polygamy and has restricted divorce proceedings to legal court action only. Additionally, the minimum legal age for marriage has been established at 17 for women and 20 for men.

Equally important is the fact that social abortion was legalized in Tunisia (1973). Each of these actions has resulted in women slowly acquiring rights and responsibilities which allow their full participation in Tunisia society. The activities of this proposed project will represent one more step contributing to the changing traditional role of women in Tunisia.

D. Economic Analysis

1. Introduction

A review of key economic indicators reveals that this proposed family planning project is cost-effective and an economically sound investment of AID resources. The purpose of this section will be to consider selected financial variables and present a general analysis of the economic viability of the proposed project. Because the project is not basically a revenue-generating activity, a detailed cost-benefit analysis is not appropriate;

however, some data will be presented to illustrate cost-effectiveness. This analysis will review the GOT expenditures for health and family planning services and will develop illustrative cost estimates based upon the projected number of births averted in Tunisia during 1978-1981. Additionally, cost comparisons between the Tunisian program and other AID-supported family planning projects will be included. Most of the figures presented should be considered as estimates.

2. GOT Health Expenditures

The MOH operating budget has grown from \$34,296,000 in 1971 to \$59,234,000 in 1975, or an increase of 73 percent. Although the budget, as a percentage of the total GOT operating budget has increased, the MOH operating budget has remained relatively stable at 8-9 percent. 1976 estimates indicate that per capita health expenditures in Tunisia are \$24.74.

3. Family Planning Program Costs

Utilizing 1976 figures, the annual per patient cost by method has been calculated as follows:

| | | |
|-----------------------|---------|----------|
| Oral contraceptives | \$26 | per year |
| IUD | \$ 3 | per year |
| Condoms | \$26 | per year |
| Sterilization, female | \$ 3.33 | per year |
| Sterilization, male | \$ 1.75 | per year |
| Abortions* | \$17.50 | per year |

From the above figures, the average per acceptor cost excluding abortions and sterilizations, is approximately \$18. When sterilizations are included, the average per acceptor cost is about \$12. This figure compares quite favorably with worldwide AID cost per acceptor averages of \$10-\$15.

Annual per capita expenditures for AID supported family planning programs fall in the range of \$.10 to \$.25. In Tunisia, however, the annual per capita expenditure for family planning with all sources of financial support included is \$.43. On the other hand, when GOT average annual projected expenditures for family planning are considered, excluding all other sources of financial support, the figure drops to \$.15 which still falls within the acceptable range for AID projects.

4. Selected Indicators

Although the development of a definitive cost-benefit analysis would be quite difficult for this project, there are certain economic indicators which are helpful in illustrating that investment in the family planning program is economically justified. To illustrate this, it is necessary to consider the

* Abortion services do not receive AID funding support.

projected number of births averted for Tunisia during 1978-1981. Although the births-averted concept has been questioned by some experts, it is useful for this present analysis which is intended to be illustrative only.

For the period 1978-1981, the GOT estimates that approximately 264,413 births will be averted as a result of project activity. Using some current estimates of what it costs to provide health services, housing, education and jobs for that number of people, it is possible to develop some idea of the magnitude of the cost savings which would result. Some of these costs should be considered to be very rough estimates and in most cases are under-estimates.

Using the 1977 Ministry of Education budget and the 1977 student enrollment, the per capita cost per year is \$230 or \$1,400 for six years of primary education. The estimated per capita cost for providing housing is \$4,000. Additionally, \$14,000 is needed to create a job in Tunisia. If there were 264,413 fewer people, the cost savings to the GOT for the above selected services would be enormous. Decreased demands placed upon other public services as well, such as health and transportation, etc. would result in further cost savings.

5. Community Based Distribution

One assumption underlying the development of community-based contraceptive distribution systems is that lower program costs can be achieved once such programs have become fully operational. The two household distribution programs currently operational in Tunisia are still considered pilot research efforts, however. While initial results from the Bir Ali Ben Khalifa (PFAD) project indicate that the system, as originally designed, has not proven to be cost effective, both PFAD and the Three Delegation projects have not been operating long enough to enable a detailed cost analysis.

6. Project Training Activities

Traditionally, the provision of health and family planning services in Tunisia has been heavily physician-dependent with only a limited use of para-medical personnel. This approach tends to be quite costly. Some of the training to be conducted under this project will include courses for midwives and other selected health personnel to perform supervised services normally provided by a physician. Through the wide-spread utilization of such lower level personnel, costs savings should result.

7. Conclusion

Any activities which reduce morbidity in a population will have the effect of decreasing lost work time, increasing work effectiveness, and in general increasing productivity. To the extent that the activities in this project increase the effective delivery of basic health and family planning services, there should be a positive reduction in morbidity. Additionally,

it is felt that the combined inputs of this project are the most cost-effective way of addressing immediate problems and that therefore the project may be considered to be economically sound.

IV - IMPLEMENTATION PLANNING

A. Administrative Arrangements

The proposed project is basically an expansion and strengthening of the already existing family planning program in Tunisia. Because the project is considered to be at a mature level of development and implementation, its organizational structure is quite well-defined and fully operational. The current organization has been soundly designed and has the capacity for effectively managing the proposed project. This fact has been confirmed by a recent AID audit in June, 1977 (See Annex M). This section will review the organizational setting developed for the implementation of the current project.

1. Recipient

The primary organization responsible for the implementation of this project is the National Office of Family Planning and Population (ONFPF). Created in 1973, the ONFPF was given the overall authority for planning, coordinating, implementing, and evaluating all family planning and family planning related activities in Tunisia. Included within its overall mandate are programs and services which promote family health, especially maternal and child health. Specific major activities of the ONFPF include:

- a. Conducting population research and special studies;
- b. Establishing, in coordination and collaboration with other public and private agencies, programs which impact upon family health;
- c. Providing the necessary resources to all health providers for the development of family health programs. Such resources include information and other types of technical assistance;
- d. Conducting training for health and social service professionals;
- e. Developing multi-level family planning information and education programs.

As a semi-autonomous agency, the ONFPF organization includes a Director-General responsible for overall administration and four operating divisions: the Education Division, the Medical Division, the Population Division and the Administrative Division. Additionally, a regional service structure has been developed.

a. Education Division

The Education Division is responsible for the development of all information and education programs of the ONFPF. This Division develops

all mass media educational programs as well as general informational programs designed for special groups such as medical informational programs designed for special groups such as medical and para-medical personnel, social workers and teachers. This Division is also responsible for providing guidance to regional health educators and for all ONFFP training activities. For highly technical training activities, this Division works closely with the Medical Division. Finally, the Education Division develops and publishes all educational materials required for ONFFP programs. For this project, all educational and training activities will be coordinated through the Education Division.

b. Medical Division

The Medical Division is responsible for all clinical activities of the ONFFP. Included among these responsibilities are the general expansion of all medical-surgical contraceptive programs, the provision of technical assistance for clinically-related program activities and the coordination of all medical commodities. The Medical Division also has primary responsibility for developing approaches for integrating family planning services into other related basic health programs. For the proposed project, this Division will be in charge of family planning system support activities and for coordinating USAID medical commodity inputs.

c. Population Division

The Population Division is responsible for program planning and evaluation activities of the ONFFP. Additionally, this Division coordinates and develops various family planning program research activities, including all data collection and analysis for the ONFFP. For the proposed project, the Population Division will supervise the household and community based distribution programs, all project data collection and analysis and other special project research and evaluation activities.

d. Administrative and Financial Division

This Division of the ONFFP provides basic administrative and logistical services. Included among its major activities are personnel support, supply procurement and distribution, budgeting, and the coordination of capital projects such as facility construction and renovation. For the proposed project, this Division will provide similar support services for each of the project components.

e. Regional Services

The ONFFP has developed a regional service structure designed to decentralize some of the activities formerly conducted by the headquarters staff. All ONFFP activities in the regions are coordinated through the Regional Administrator for Public Health. At the regional level, ONFFP

staff consists of a health educator who is responsible for all family planning educational activities in the region, a physician coordinator of all clinical family planning services, a midwife supervisor who directs the family planning activities of all midwives, other para-medical staff and other personnel in the region and an administrator who is primarily responsible for all regional level statistical reporting.

f. Office of Coordination

This unit of the ONFPF is responsible for all development activities which consist primarily of the coordination of all foreign donor family planning program support. The Director of this Office is the primary liaison point between USAID/Tunis and the ONFPF.

g. Office of Program Review

This office provides an internal monitoring function for all ONFPF programs. Responsibility for the assurance of quality control and financial accountability are the major functions of this office. A detailed organizational chart for the ONFPF is included in Annex F.

Because of the well-developed organizational structure, the ONFPF has proven itself capable of effectively managing the activities planned for this follow-on project. Indeed, the program success currently being experienced is due, in a large part, to the efforts of the ONFPF. USAID/Tunis has complete confidence in the ability of the ONFPF to strengthen and expand the services described in other sections of this Project Paper.

2. A.I.D.

USAID has a long history of involvement with the Tunisian family planning program and because of this, has developed a management approach which is effective. The GOT through the ONFPF has the primary responsibility for implementing all major elements of this project under the general guidance of the USAID/Tunis project manager. For the household and community-based distribution components of this project, the PFA/POP Research Division will monitor project activities and will schedule two site visits per year for review and consultation.

There will be a major staff commitment required by USAID for the administration of this project. Currently the USAID/Tunis Health/Family Planning Development Officer is assuming the responsibility for managing AID project inputs. For the expanded program being planned, this is still a feasible approach. However, if there is additional USAID expansion into other health areas, such as the approved rural community health project, which may require large amounts of time on the part of the current Health/Family Planning Development Officer, consideration should be given to either another direct hire administrator or a long-term contract technician to assist with the management of this new project. Such assistance is not

currently included as an input for this project. USAID has a direct hire Health Development Officer in its staffing plans and AID/W is currently recruiting to fill this position.

B. Implementation Plan

1. Introduction

The implementing agency for this project is the National Family Planning and Population Office of the GOT (See Part IV A). USAID/Tunis will have the responsibility for monitoring this project through its assigned program manager who will work closely with the ONFPF project officer in the Office of Coordination. Additional details regarding project monitoring plans are included in the Evaluation Plan (Part IV D).

Logistics support for this project will be provided by the ONFPF primarily through the Administrative and Financial Division. From its previous experience the ONFPF is fully capable of providing timely, high-quality support. Currently there are no plans for using a contract organization for this project with the exception of short-term consultants who may be provided by a private contractor, possibly through one of the AID/W existing IQC's.

USAID/Tunis has an excellent working relationship with the ONFPF and there are no major problems which remain in negotiating and reaching agreement on this project. As currently planned, this project does not require any special waivers; however, as the project progresses, some unforeseen needs may become apparent which might require special waivers.

2. Implementation Schedule

The schedule which follows is an estimation of how this project should progress during its four year life span. Some of the milestones scheduled, particularly in the area of training and education, are approximations because firm dates have not yet been fixed by the GOT. These milestones are accurate, however, as to the quantity of events planned during this project period.

a. Project Approval and AID/GOT Commitment

| | <u>Activity</u> | <u>Date</u> | <u>Action Agency</u> |
|-----|-------------------|-------------|----------------------|
| (1) | PP Review | Sept 77 | AID/W |
| (2) | PP Approved | Oct 77 | AID/W |
| (3) | ProAg Prepared | Nov 77 | USAID/Tunis |
| (4) | ProAg Signed | Dec 77 | USAID/Tunis-GOT |
| (5) | Project Initiated | Jan 78 | USAID/Tunia-GOT |

b. Pilot Contraceptive Distribution Programs

PFAD

| | | | |
|------|--|----------------|-------------|
| (1) | Household canvassing (3rd round-Bir Ali and Sdiret sectors) | Jan 78 | ONPFP |
| (2) | Household canvassing (5th round-Oued Echeikh Ouedrane, Candoul) | Feb-Mar 78 | ONPFP |
| (3) | Field Note Report | Mar 78 | ONPFP |
| (4) | Household canvassing (3rd round - Sidi Dahar and El Abraaj) | Apr 78 | ONPFP |
| (5) | Household canvassing (3rd round - Bou Slim and Sidi Ali Ben El Abed) | May 78 | ONPFP |
| (6) | Household canvassing (2nd round - el Redhaa and Kasr el Hammon) | June 78 | ONPFP |
| (7) | Field note report (including details of | June 78 | ONPFP |
| (8) | Evaluation Report | June 78 | AID/W |
| (9) | Household canvassing (4th round - Bir Ali and Sdiret) | Aug 78 | ONPFP |
| (10) | Household canvassing (4th round - Bou Slim and Sidi Ali Ben El Abed) | Sept 78 | ONPFP |
| (11) | Field note report | Sept 78 | ONPFP |
| (12) | Termination Household Canvass (11 sectors) | Sept -- Dec 78 | ONPFP |
| (13) | Final Project Report (including demographic, contraceptive behavior analysis, cost-effectiveness analysis of delivery system; general history of project and qualitative assessment) | Jan 79 | ONPFP/AID/W |
| (14) | Resupply system and back-up medical services functioning in 11 sector area | Jan 79 | ONPFP |

c. Three-Delegation Project

| | <u>Activity</u> | <u>Date</u> | <u>Action Agency</u> |
|------|---|-----------------|----------------------|
| (1) | Training for 2nd round canvass; Resupply system in place | Jan 78 | ONFPF |
| (2) | Household canvassing (2nd round - Fernana) | Jan - Feb 78 | ONFPF |
| (3) | Field Note Report | Mar 78 | ONFPF |
| (4) | Household canvassing (2nd round - Jendouba) | Mar - May 78 | ONFPF |
| (5) | Field Note Report | June 78 | ONFPF |
| (6) | Household canvassing (1st round - Nebeur) | June - Aug 78 | ONFPF |
| (7) | Field Note Report (Vacation - Sep 1978) | Sept 78 | ONFPF |
| (8) | Household canvassing (2nd round - Nebeur) | Oct - Nov 78 | ONFPF |
| (9) | Field Note Report | Dec 78 | ONFPF |
| (10) | Progress Report | Dec 78 | AID/W |
| (11) | Survey of Three Delegation Area | Dec 78 - Feb 79 | ONFPF |
| (12) | Revised System Design; Polyvalent Training of canvassers | Mar 79 | ONFPF |
| (13) | Canvassing of total study area-integration of family planning into basic health services | Apr - Dec 79 | ONFPF |
| (14) | Evaluation report of original system design (demographic, contraceptive behavior analysis, cost-effectiveness analysis of delivery system, including resupply points; general history of project; qualitative assessment) | June 79 | ONFPF |
| (15) | Field Note Report | Dec -79 | ONFPF |
| (16) | Progress Report | Dec 79 | AID/W |
| (17) | Evaluation of revised delivery system | Jan - Feb 80 | ONFPF |
| (18) | Decision on future project activities | Mar 80 | ONFPF-AID/W |

d. Training

Manpower Development.

| | | | |
|------|--|-------------------------|-------------------|
| (1) | Participant Trainees to U.S. | Jan 78 | USAID/Tunis |
| (2) | Training VSC surgeons at Ariana | Jan 78-Ongoing Activity | ONFPF/Ariana |
| (3) | Curriculum evaluation plan prepared | Jan 78-Ongoing Activity | ONFPF/Ariana |
| (4) | Group I Physicians and Pharmacists recycled | Feb 78 | ONFPF |
| (5) | Group I Outreach workers trained | March 78 | MOH/ONFPF |
| (6) | First National Family Planning Conference | April 78 | MOH/ONFPF |
| (7) | U.S. Training evaluation CSLTWF Arrives | May 78 | USAID/Tunis |
| (8) | Training evaluated | May 78 | MOH/ONFPF |
| (9) | Surgeons to U.S. for VSC training | May 78 | USAID |
| (10) | Training curriculum re-design | June 78 | ONFPF |
| (11) | Group II MD's and Paramedics trained | June 78 | ONFPF |
| (12) | Group II Outreach workers trained | July 78 | ONFPF |
| (13) | Participant training 6 regional supervisors Review Paramedical programs | July 78 | USAID/Tunis/ONFPF |

| | | | |
|------|---|----------|-------------------|
| (14) | U.S. surgeon reviews work at Ariana and certifies Tunisian surgeons | July 78 | USAID/W |
| (15) | Regional supervisors Health ed. midwifery and social work recycled | Aug 78 | MOH/MSW/ONFPF |
| (16) | 3 Participant Trainees study outreach programs | Sept 78 | USAID/Tunis |
| (17) | Group 3 MD's and paramedicals recycled | Oct 78 | MOH/ONFPF |
| (18) | Group 3 outreach recycled | Nov 78 | MOH/ONFPF |
| (19) | Surgeons to U.S. for VSC training | Dec 78 | USAID/W |
| (20) | Group 4 MD's and paramedicals trained | Feb 79 | MOH/ONFPF |
| (21) | Group 4 outreach workers trained | Mar 79 | MOH/ONFPF |
| (22) | Second Annual National Family Planning Conference | Apr 79 | MOH/ONFPF |
| (23) | 3 Tunisian MD's to U.S. to study new technological developments | May 79 | USAID/Tunis |
| (24) | Group 5 MD's and paramedicals trained | June 79 | MOH/ONFPF |
| (25) | Group 5 outreach workers trained | July 79 | MOH/ONFPF |
| (26) | Group 6 MD's and paramedicals trained | Oct 79 | MOH/ONFPF |
| (27) | Group 6 outreach workers trained | Nov 79 | MSW/ONFPF |
| (28) | Training program revised | Nov 79 | |
| (29) | Group 7 MD's and paramedicals recycled | Feb 80 | MOH/ONFPF |
| (30) | Group 7 outreach workers recycled | Mar 80 | MOH/ONFPF |
| (31) | Regional supervisors to U.S. participant training in management | Mar 80 | USAID/Tunis/ONFPF |
| (32) | Third Annual National Family Planning Conference | April 80 | MOH/ONFPF |
| (33) | 3 MD's to U.S. to study new technology | May 80 | USAID/Tunis/ONFPF |
| (34) | Group 8 MD's and paramedicals recycled | June 80 | MOH/ONFPF |
| (35) | Group 8 outreach workers recycled | June 80 | MOH/ONFPF |
| (36) | Group 9 MD's and paramedicals recycled | Oct 80 | MOH/ONFPF |
| (37) | Group 9 outreach workers recycled | Oct 80 | MSW/MOH/ONFPF |
| (38) | U.S. Consultant evaluation of utilization of staff and new services | Dec 80 | USAID/Tunis/ONFPF |
| (39) | Group 10 MD's and paramedicals recycled | Feb 81 | MOH/ONFPF |
| (40) | Group 10 outreach recycled | Mar 81 | MSW/MOH/ONFPF |
| (41) | Fourth Annual Family Planning Conference | April 81 | MSW/MOH/ONFPF |
| (42) | Group 11 MD's and paramedicals recycled | June 81 | MSW/MOH/ONFPF |
| (43) | Group 11 outreach workers recycled | June 81 | MSW/MOH/ONFPF |
| (44) | Group 12 MD's and paramedicals recycled | Oct 81 | MSW/MOH/ONFPF |
| (45) | Group 12 outreach recycled | Oct 81 | MSW/MOH/ONFPF |

| e. <u>Commodities</u> | | | <u>Date</u> | <u>Action Agency</u> |
|-----------------------|-----------------------------------|----------------------------------|--------------------|---------------------------------|
| (1) | Local purchase supplies and drugs | | Jan 78- Ongoing | USAID/Tunis/Central Pharmacy |
| (2) | Tranche (1) | Orals | March 78 | USAID/Tunis |
| (3) | " (1) | Condoms | April 78 | USAID/Tunis |
| (4) | " (1) | U.S. Med. Equipment and Supplies | May 78 | USAID/Tunis |
| (5) | " (2) | Orals | June 78 | USAID/Tunis/W |
| (6) | " (1) | Audiovisual Equipment | Sep 78 | USAID/Tunis |
| (7) | " (2) | Condoms | Sep 78 | USAID/Tunis/W |
| (8) | " (3) | Orals | Sep 78 | USAID/Tunis/W |
| (9) | " (2) | U. S. Medical Equipment | Sep 78 | USAID/Tunis |
| (10) | " (3) | U. S. Medical Equipment | Oct 78 | USAID/Tunis |
| (11) | " (4) | Orals | Dec 78 | USAID/W |
| (12) | " (3) | Condoms | Feb 79 | USAID/W |
| (13) | " (5) | Orals | March 79 | USAID/W |
| (14) | " (2) | Audiovisual Equipment | May 79 | USAID/W |
| (15) | " (6) | Orals | June 79 | USAID/W |
| (16) | " (4) | Condoms | July 79 | USAID/W |
| (17) | " (3) | Audiovisual equipment | Aug 79 | USAID/W |
| (18) | " (4) | U. S. Medical Supplies | Aug 79 | USAID/W |
| (19) | " (5) | U. S. Medical Supplies | Oct 79 | USAID/W |
| (20) | " (4) | Audiovisual equipment | Oct 79 | USAID/W |
| (21) | " (7) | Orals | Oct 79 | USAID/W |
| (22) | " (8) | Orals | Dec 79 | USAID/W |
| (23) | " (9) | Orals | Feb 80 | USAID/W |
| (24) | " (5) | Condoms | Apr 80 | USAID/W |
| (25) | " (10) | Orals | May 80 | USAID/W |
| (26) | " (6) | U. S. Medical equipment | June 80 | USAID/W |
| (27) | " (5) | Audiovisual equipment | June 80 | USAID/W |
| (28) | " (7) | U. S. Medical equipment | Aug 80 | USAID/W |
| (29) | " (11) | Orals | Sep 80 | USAID/Tunis/AID/W |
| (30) | " (6) | Condoms | Sep 80 | USAID/Tunis/AID/W |
| (31) | " (6) | Audiovisual equipment | Oct 80 | USAID/Tunis |
| (32) | " (8) | U. S. Medical equipment | Nov 80 | USAID/Tunis |
| (33) | " (12) | Orals | Dec 80 | USAID/Tunis/AID/W |
| (34) | " (11) | Orals | Mar 81 | USAID/Tunis/AID/W |
| (35) | " (13) | Orals | May 81 | USAID/Tunis/AID/W |
| (36) | " (7) | Condoms | May 81 | USAID/Tunis/AID/W |
| (37) | " (6) | Audiovisual equipment | June 81 | USAID/Tunis |
| (38) | " (9) | U. S. Medical equipment | June 81 | USAID/Tunis |
| (39) | " (10) | U. S. Medical equipment | Aug 81 | USAID/Tunis |
| (40) | " (8) | Audiovisual equipment | Sep 81 | USAID/Tunis |
| (41) | " (14) | Orals | Sep 81 | USAID/Tunis/AID/W |
| (42) | " (8) | Condoms | Sep 81 | USAID/Tunis/AID/W |
| (43) | " (10) | U. S. Medical equipment | Nov 81 | USAID/Tunis |
| (44) | " (15) | Orals | Dec 81 | USAID/Tunis/AID/W |

f. Technical Consultant Services

| | <u>Activity</u> | <u>Date</u> | <u>Action Agency</u> |
|------|--|-------------|----------------------|
| (1) | Curriculum development | Jan 78 | USAID/Tunis/AID/W |
| (2) | IEC - Audiovisual specialist | Jan 78 | USAID/Tunis/AID/W |
| (3) | Paramedical training specialist | Feb 78 | USAID/Tunis/AID/W |
| (4) | Curriculum evaluation specialist | May 78 | USAID/Tunis/AID/W |
| (5) | Management consultant for ONFFP evaluation and development of job description | May 78 | USAID/Tunis/AID/W |
| (6) | U.S. surgeon reviews Ariana operations | July 78 | USAID/Tunis/AID/W |
| (7) | Management specialists assist in design new ONFFP operating procedures | Aug 78 | USAID/Tunis/AID/W |
| (8) | IEC Survey design specialists measure program impact on rural populations | Sept 78 | USAID/Tunis/AID/W |
| (9) | Management information system specialists assist ONFFP in design MIS system for operations | Oct 78 | USAID/Tunis/AID/W |
| (10) | Program analyst implements data processing system | Nov 78 | USAID/Tunis/AID/W |
| (11) | Consultants to assist evaluation training progress and participate in mid-project evaluation | Dec 79 | USAID/Tunis/AID/W |
| (12) | IEC Consultant assists in program modification | Apr 80 | USAID/Tunis/AID/W |
| (13) | Consultant assists ONFFP in manpower utilization | Dec 80 | USAID/Tunis/AID/W |
| (14) | Consultants perform final project appraisal | Dec 81 | USAID/Tunis/AID/W |

g. Follow-through Commitments and Evaluation

| | | | |
|------|--|---------|-------------------|
| (1) | I, E & C evaluation | Sept 78 | AID/W USAID/Tunis |
| (2) | ONFFP Special evaluation | Sept 78 | ONFFP-GOT |
| (3) | New ProAg negotiated and signed | Dec 78 | USAID/Tunis-GOT |
| (4) | First Project appraisal report | Dec 78 | USAID/Tunis |
| (5) | New ProAg negotiated and signed | Dec 79 | USAID/Tunis-GOT |
| (6) | Second Project appraisal report | Dec 79 | USAID/Tunis/AID/W |
| (7) | Mid-project special evaluation, including decisions regarding Project continuation/phase out | Jan 80 | USAID/Tunis |
| (8) | Third Project appraisal report | Dec 80 | USAID/Tunis |
| (9) | New ProAg negotiated and signed | Dec 80 | USAID/Tunis-GOT |
| (10) | Fourth Project appraisal report | Dec 81 | USAID/Tunis |

Note: See Annex D for the Planned Performance Tracking Chart

C. Evaluation Plan

The proposed project will be evaluated periodically by both AID and the ONFPF to determine the project's effectiveness and efficiency in meeting stated objectives. The scheduling for the evaluation plan is set out in the implementation plan detailed above. It specifies four regular Project Appraisal Reports during the life of this project. These PAR's are scheduled for December 78-81.

In addition, it is proposed that two special evaluations be conducted over the next four years by outside consultants and AID/W. One special evaluation should be conducted during mid-project for the overall program. If AID wishes this project to be phased out by the end of FY 81, detailed phase-out plans should be developed at this time. The mid-project special evaluation is scheduled for January, 1980.

A second special evaluation is recommended for the I, E & C component of this project. Because of the past weaknesses in this component and following the separate evaluation conducted in 1976, another evaluation should be scheduled to monitor any progress or changes which have resulted since the previous review effort. This evaluation of the I, E & C components is scheduled for September, 1978.

Another element of the evaluation plan concerns the pilot household distribution projects. Since these projects are considered to be operations research projects, separate evaluations are scheduled (under the supervision of the Research Division, AID/W). There will be one major evaluation of each project, scheduled for January, 1979 (FEAD) and June, 1979 (Three Delegation).

The ONFPF will be conducting an internal evaluation of its central and field operations tentatively scheduled for September, 1978. Utilizing information from the data bank, the ONFPF will make a qualitative and quantitative assessment of the overall project. Plans for this internal evaluation are in the process of being developed.

D. Conditions, Covenants, and Negotiating Status

The following special conditions are applicable to this project.

1. Abortion-Related Activities

None of the funds made available to carry out this project shall be used to pay for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions.

2. Surgical Sterilization

Surgical sterilization procedures supported in whole or in part by AID

funds may be performed only after an individual has voluntarily given informed consent at the treatment facility.

The rights of the individual shall be protected in accordance with those standards considered acceptable under the laws and customs of Tunisia. Documents of the patients for each voluntary sterilization procedure will be retained by the operating medical facility of the Tunisian Government for a period of three years.

No AID funds can be used to pay potential acceptors of sterilization to induce their acceptance. Further, the fee or patient cost structure applied to voluntary sterilizations shall be established in such a way that no financial incentive is created for sterilization over another method.

ANNEXES

- A. PRP Approved Cable
- B. PIT/PRP Face Sheets
- C. Log Frame
- D. PPT Chart
- E. Host Country Request
- F. ONPPP Organigram
- G. Map of Tunisia
- H. Selected Demographic/Family Planning Data
- I. The Household Distribution Project in Bir Ali Ben Khalifa, Tunisia
- J. Training Curriculum
- K. Commodity Projection
- L. Drug/Equipment Lists
- M. ONPPP Audit

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20 JUN 77 10 12

TAGS:

SUBJECT: POPULATION - PROJECT REVIEW PAPER

REF: (A) TUNIS 3985; (B) STATE 141397

20 JUN 1977

1. BASED ON REVIEW INFO CONTAINED REFTEL, AND GUIDANCE IN REF (B), USAID AUTHORIZED PROCEED WITH PREPARATION PROJECT PAPER (PP). SUGGEST USAID ENSURE ALL COMMENTS IN PREVIOUS CORRESPONDENCE ON PID AND PAP ARE THOROUGHLY ADDRESSED.

2. REPTET AID/W UNABLE TO PROVIDE LONG TERM FOR ASSISTANCE EXPERIENCED POP OFFICER AS REQUESTED REFTEL. HOWEVER, IF HOST GOVERNMENT AND USAID REQUEST, WE ARE STILL PREPARED TO PROVIDE SHORT TERM ASSISTANCE FOR PP PREPARATION. ADVISE. VANCE

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ANNEX A
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E.O. 11652: N/A

SUBJECT: Population - Project Review Paper

REF: (A) STATE 112569 (B) STATE 225176 (76)

1. Mission has addressed principal issues identified in PID approval message (ref A) in PRP. Per ref A project focus is on developing a community based contraceptive distribution system including household distribution and expanded/improved medical services including voluntary surgical contraception.

Recapitulating main points of PRP with reference to PID message:

a. Overall design of project is based upon pilot projects currently underway in Bir All Ben Mchida, Monastir, Jendouba and Mehur delegations. Distribution system is to be primarily house to house canvassing involving paramedical workers, i.e. nurse hygienists, social workers, health educators, nurse-midwives and others, with re-supply points and mobile

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(Formerly Form 10)

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ANNEX A

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units to provide limited medical services and transport to medical centers.

b. Re-supply systems will be coordinated countrywide with the Syntex commercial distribution project.

c. Prescription requirement for oral still in effect. However, pilot project distributes pills without prescription under auspices of ONERP, and expanded household distribution program will continue provide pills to clients by paramedics without prescription. It is anticipated that during early stages of new project, medical profession will be persuaded to agree to removal of prescription requirement through seminars financed by Syntex Project and ONERP medical program.

d. Voluntary surgical cooperation services now offered in 15 of 18 governorates will be expanded to all governorates and will offer mini-laparotomy and laparoscopy techniques. Program will provide in-country training for chief doctors, medical equipment and supplies.

2. Following items discussed in response ref A wish

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E.O. 11652: also to recapitulate and update information given PPF.

TAGS:

SUBJECT: A. Training Component - ONTFP will launch intensive in-country training program which has been developed in detail through 1981 for medical and paramedical personnel totaling 1350 with emphasis on household canvassing and medical back up services. These programs will be conducted throughout Tunisia by ONTFP training staff with some assistance from AEF. Details including curriculum design available and can be included in PP.

ACTION: B. Management of IEC Project - The IEC component will be managed by ONTFP. USAID inputs will be technical advice through short term consultants and provision of audio-visual materials and equipment based recent AID Field Evaluation of July 1975 and subsequent IEC evaluation November 1976 by Marshal Rothe, AID/W and Thomas McMahon, George Washington University.

C. 1975 Evaluation - The entire program for 1978-79 planned in accordance with recommendations of 1975 evaluation, many of which already implemented such as 1) expanded and strengthened

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| <p>E.O. 11652: TAGS: SUBJECT: ACTION:</p> <p>ed medical division of ONTFP; 2) updated national program goals; 3) decentralisation of authority to implement family planning policies geared to rural population; 4) getting mini-laparotomy and laparoscopy procedures underway; and 5) expanded technical staff at regional level.</p> <p>d. Target population - all married women in reproductive age i.e. 927,000 for 1973 and 948,000 in 1979. ONTFP goal is to attain 22% of these women as acceptors.</p> <p>e. Essential interrelationships each sub-activity - IIC, VCS, GNS and Household Distribution sub-activities will be coordinated through ONTFP divisional offices responsible for these activities. ONTFP Research and Evaluation Committee in Tunis headquarters will be responsible for carrying out evaluations and analysis. Primary goal is to reach rural areas where 33% of women in reproductive age reside. Further description sub-activity interrelationships can be provided FF stage.</p> <p>3. Initial environmental examination - Much of Tunisia's land area is severely degraded ecologically, and remains</p> | UNCLASSIFIED | 4 | |
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threatened by pressures from both human and animal populations. To the extent that this project is successful in contributing to reduced population growth in Tunisia, environmental effects will be positive, although difficult to measure spatially or quantitatively. Project activities themselves, consisting primarily of training, supply of contraceptive commodities and distribution of the latter will have no measurable environmental impact.

4. Based ERP and preceding paragraphs, believe AID/W has sufficient data for ERP approval. Strongly urge that this course be followed, as we are now beginning to confront real time pressures in view of need to prepare new project for first quarter FY 78 obligation in order to ensure momentum not lost in terms QMWP operations.

5. USAID/ERP is aware of extremely heavy workload on single Health/Family Planning Officer in Mission who must also cope with development new health program. EXPERIMENTAL aspects family planning program require disproportionate time and effort but must be managed con-

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UNCLASSIFIED
CLASSIFICATION

OPTIONAL FORM NO. 10
(Formerly 58-201)
MAY 1962 EDITION
GSA GEN. REG. NO. 27

TELEGRAM

INDICATE
CLASSIFICATION
OR CHANGE TO USAID

1985

| | |
|----------------------------------|--|
| FROM | CLASSIFICATION UNCLASSIFIED |
| E.O. 11652: TAGS: SUBJECT: | <p>currently with ongoing program. In short, there is a trade-off between further work on subject ERP and all other program objectives in this sector and we do not believe further work on ERP justified. There is a great deal of additional material relating to demographic analysis, impact measurement, etc, which must be provided to complete the preparation of this project but this is clearly appropriate to the FP rather than ERP stage.</p> <p>6. We appreciate your offer of assistance in project development but we need help of experienced pop officer not only for FP (in particular supporting materials such as budgets, CEM network, etc) but also to meet basic program targets during remainder fiscal year. Accordingly, request minimum 90 day TOI beginning AGAP. Note also this connection Wallace plans HL end August, by which time need to have FP for FY 76 program continuation well in hand.</p> <p>Advice</p> |

DEPARTMENT OF STATE

TELEGRAM

AMEMB A

Ambassy TUNIS.

664-295

INFO:
AMB
DCN ECON
CHRON/14

UNCLASSIFIED

CONTROL:

US RUEHC 2569 1370813
ZNR UUUUU ZZH
R 170110Z MAY 77
FM SECSTATE WASHDC
TO AMEMBASSY TUNIS 0624

4180

BT
UNCLAS STATE 112569

ALLOW COPY
TO FILE TAKEN
EPH 7/23/77
N.A.M.

AIDAC

E.O. 11652: N/A

TAGS:

17 MAY 1977

SUBJECT: POPULATION - PROJECT REVIEW PAPER

17 MAY 1977

REF: (A) TOAID A-31; (B) STATE 225178

3:00 PM

1. SUBJECT PRP HAS BEEN REVIEWED IN AID/W. GENERAL FEELING IS THAT ALTHOUGH THE OUTLINE OF A VIABLE PROJECT IS PRESENTED AND IS ENCOURAGED, PRP IS VAGUE ON A NUMBER OF DETAILS TO THE POINT WHERE WE ARE UNABLE TO MAKE INFORMED JUDGMENT. REVIEWERS RECOMMEND THAT PRP BE REDRAFTED AND SUPPLEMENTAL INFORMATION SUBMITTED TAKING INTO CONSIDERATION COMMENTS IN REF B AND FOLLOWING ADDITIONAL COMMENTS RESULTING FROM THIS REVIEW.

| ACTION INFO | |
|-------------|-------------------------------------|
| SEARCHED | <input checked="" type="checkbox"/> |
| SERIALIZED | <input checked="" type="checkbox"/> |
| INDEXED | <input checked="" type="checkbox"/> |
| FILED | <input checked="" type="checkbox"/> |
| APR 1977 | |
| STATE | |
| AMEMB TUNIS | |
| OFFICE | |
| DATE | |
| BY | |
| REMARKS | |

2. IN ORDER TO MAKE A QUALITATIVE JUDGMENT ON PRP WILL NEED:

- (A) RESPONSE TO ISSUES/RAISED REF (B);
- (B) DESCRIPTION OF THE TRAINING COMPONENT - WHO WILL DO THE TRAINING, FOR WHOM, HOW MANY, WHERE, CURRICULUM DESIGN NEEDED, TARGETS; POST-TRAINING UTILIZATION, ETC.
- (C) WHO WILL MANAGE THE IEC PROJECT -- WILL USAID CONTRACTS BE NECESSARY?
- (D) RELATE NEW EFFORTS TO RECOMMENDATION OF 1975 EVALUATION.
- (E) DEFINE TARGET POPULATIONS OF THIS PROJECT.
- (F) CONCEPTUALIZE ESSENTIAL INTERRELATIONSHIPS OF EACH SUB-ACTIVITY, I.E. IEC, VSS, CRS, HOUSEHOLD DISTRIBUTION SCHEME, MEASUREMENT AND ANALYSIS.

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3. OTHER COMMENTS RAISED IN REVIEW AND WHICH SHOULD BE CONSIDERED IN FINAL PP STAGE ARE PASSED ON FOR YOUR CONSIDERATION:

- A) MEDICAL SERVICES - WHAT ARE INCENTIVE SUPPORT COSTS TO MCH/FP CENTERS?
- B) VSS (VSC) - THERE IS LITTLE DESCRIPTION OF HOW THIS WILL BE CARRIED OUT OR BY WHOM.
- C) MORE DATA NEEDED ON ACCEPTORS -- PAST AND PROJECTED -- BY METHOD; ALSO REVIEW OF CONTRACEPTIVE REQUIREMENTS.
- D) THE ROLES OF OTHER DONORS (ESPECIALLY AID-FUNDED ONES) NEED TO BE SPELLED OUT/AMPLIFIED, PARTICULARLY IN RELATION TO THIS PROJECT.
- E) CONSISTENCY IN DEMOGRAPHIC DATA NEEDED; SHOW ABSOLUTE NUMBERS WITH PERCENTAGES.
- F) A MORE DETAILED IMPLEMENTATION PLAN, INCLUDING CI IS NEEDED.
- G) CERTAIN ITEMS IN LOG FRAME NEED TO BE REALIGNED, I.E. - GOAL IS PURPOSE, PURPOSE IS GOAL.
- H) DESCRIBE IN FURTHER DETAIL ONGOING OR PLANNED DEMOGRAPHIC RESEARCH EFFORTS.
- I) SPECIFY ROLE OF TRAINING CENTER FOR RESEARCH AND EVALUATION AND A.I.D. ASSISTANCE TO IT.
- J) SPECIFY USAID STAFF REQUIRED TO EFFECTIVELY MANAGE EXPANDED AID INPUTS.
- K) SHOW EVIDENCE OF INTENT/CAPABILITY OF GOT TO CONTINUE ACTIVITIES FOLLOWING TERMINATION OF A.I.D. ASSISTANCE TO THIS PROJECT.
- L) DISCUSS RELATIONSHIPS WITH PROPOSED RURAL HEALTH PROJECT, PARTICULARLY USE OF HEALTH CENTERS AND TRAINING OF HEALTH WORKERS.
- M) AMPLIFY FINANCIAL PLANS.

4. ALSO, AN INITIAL ENVIRONMENTAL EXAMINATION WILL BE REQUIRED FOR THE PRP.

5. SUGGEST USAID CONSIDER FEASIBILITY OF FIXED AMOUNT REIMBURSEMENT SCHEME FOR LOCAL CURRENCY COSTS, BASED ON OUTPUTS.

6. REALIZING MISSION POPULATION OFFICER EXTREMELY BUSY, AID/W IS PREPARED TO PROVIDE TDY ASSISTANCE, AS NECESSARY, TO ASSIST IN REDRAFTING PRP. ADVISE NEDD FOR SAME. CHRISTOPHER

| | | | | | | | | | |
|--|--|---|--|--|--|------------------|--|---|--|
| AGENCY FOR INTERNATIONAL DEVELOPMENT | | | | 1. TRANSACTION CODE | | PID | | | |
| PROJECT IDENTIFICATION DOCUMENT FACESHEET | | | | A A = ADD C = CHANGE D = DELETE | | 2. DOCUMENT CODE | | | |
| TO BE COMPLETED BY ORIGINATING OFFICE | | | | | | | | | |
| 3. COUNTRY/ENTITY TUNISIA | | | | 4. DOCUMENT REVISION NUMBER | | | | | |
| 5. PROJECT NUMBER (7 DIGITS) 664-0295 | | 6. BUREAU/OFFICE A. SYMBOL NO. B. CODE | | 7. PROJECT TITLE (MAXIMUM 40 CHARACTERS) Family Planning Services | | | | | |
| 8. PROPOSED NEXT DOCUMENT 2 = PRP 3 = PP | | | | 9. DATE MM YY 03 77 | | | | | |
| 9. ESTIMATED FY OF AUTHORIZATION/OBLIGATION a. INITIAL FY 78 b. FINAL FY 81 | | | | 10. ESTIMATED COSTS (2000 OR EQUIVALENT, \$1 = 430 D) | | | | | |
| | | | | FUNDING SOURCE | | | | | |
| | | | | A. AID APPROPRIATED | | | | | |
| | | | | B. OTHER | | | | | |
| | | | | C. HOST COUNTRY | | | | | |
| | | | | D. OTHER COMOR(2) | | | | | |
| | | | | TOTAL | | | | | |
| 11. PROPOSED BUDGET AID APPROPRIATED FUNDS (2000) | | | | | | | | | |
| A. APPROPRIATION | | B. PRIMARY PURPOSE CODE | | C. PRIMARY TECH. CODE | | E. FIRST FY 78 | | LIFE OF PROJECT | |
| | | | | C. GRANT D. LOAN | | F. GRANT G. LOAN | | H. GRANT I. LOAN | |
| (1) PH | | 444 | | 440 | | 1,963 | | 7,797 | |
| (2) | | | | | | | | | |
| (3) | | | | | | | | | |
| (4) | | | | | | | | | |
| | | | | TOTAL | | 1,963 | | 7,797 | |
| 12. SECONDARY TECHNICAL CODES (maximum six codes of three positions each) | | | | | | | | | |
| 430 | | 460 | | 490 | | | | | |
| 13. SPECIAL CONCERNS CODES (MAXIMUM SIX CODES OF FOUR POSITIONS EACH) | | | | | | | | 14. SECONDARY PURPOSE CODE | |
| | | | | | | | | 401 | |
| 15. PROJECT GOAL (MAXIMUM 240 CHARACTERS) | | | | | | | | | |
| To reduce the national fertility rate to achieve optimum balance between population and available resources. | | | | | | | | | |
| 16. PROJECT PURPOSE (MAXIMUM 400 CHARACTERS) | | | | | | | | | |
| The purpose of this project is to assist the government of Tunisia to further strengthen and extend family planning services particularly in the poorest and most rural areas through: | | | | | | | | | |
| 1. developing effective, low cost community based distribution systems | | | | | | | | | |
| 2. training a cadre of trainers and upgrading the skills of existing personnel | | | | | | | | | |
| 3. providing support to medical and educational program components | | | | | | | | | |
| 4. establishing a strong research and evaluation capability. | | | | | | | | | |
| 17. PLANNING RESOURCE REQUIREMENTS (staff/funds) | | | | | | | | | |
| 18. ORIGINATING OFFICE CLEARANCE | | | | | | | | 19. DATE DOCUMENT RECEIVED BY AIO/W, OR FOR AIO/W DOCUMENTS, DATE OF DISTRIBUTION | |
| Signature Walter S. Davis | | | | Date Signed MM DD YY | | | | MM DD YY | |
| Title Director, USAID/Tunis | | | | | | | | | |

| | | | |
|---|---|--|------------------------------|
| AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT REVIEW PAPER FACESHEET | | 1. TRANSACTION CODE <input type="checkbox"/> A ADD <input type="checkbox"/> C CHANGE <input type="checkbox"/> D DELETE <input checked="" type="checkbox"/> A | PRP 1. DOCUMENT CODE 2 |
| 2. COUNTRY/ENTITY TUNISIA | | 4. DOCUMENT REVISION NUMBER <input type="checkbox"/> | |
| 3. PROJECT NUMBER (7 digits) 664-0295 | 5. BUREAU/OFFICE A. SYMBOL NE B. CODE 4 | 7. PROJECT TITLE (Maximum 40 characters) Family Planning Services | |
| 8. PROPOSED NEXT DOCUMENT A. <input type="checkbox"/> 1 | | 9. ESTIMATED FY OF AUTHORIZATION/OBLIGATION A. INITIAL FY 78 B. FINAL FY 81 | |

10. ESTIMATED COSTS (\$000 OR EQUIVALENT \$1 = .4300)

| A. FUNDING SOURCE | FIRST FY | | | LIFE OF PROJECT | | |
|------------------------|----------|--------|----------|-----------------|--------|----------|
| | B. FY | C. L/C | D. TOTAL | E. FY | F. L/C | G. TOTAL |
| AID APPROPRIATED TOTAL | | | | | | |
| (GRANT) | 1,963 | | 1,963 | 7,797 | | 7,797 |
| (LOAN) | | | | | | |
| OTHER | | | | | | |
| U.S. | | | | | | |
| MOST COUNTRY | | 2,176 | 2,176 | 8,721 | | 8,721 |
| OTHER COUNTRIES | | | | | | |
| TOTALS | | 2,176 | 4,139 | 16,158 | | 16,158 |

11. PROPOSED BUDGET AID APPROPRIATED FUNDS (\$000)

| A. APPROPRIATION | B. PRIMARY PURPOSE CODE | PRIMARY TECH. CODE | | E. FIRST FY | | LIFE OF PROJECT | |
|------------------|-------------------------|--------------------|---------|-------------|---------|-----------------|---------|
| | | C. GRANT | D. LOAN | F. GRANT | G. LOAN | H. GRANT | I. LOAN |
| (1) PH | 444 | 444 | | 1,963 | | 7,797 | |
| (2) | | | | | | | |
| (3) | | | | | | | |
| (4) | | | | | | | |
| TOTAL | | | | 1,963 | | 7,797 | |

12. PROJECT PURPOSE (Maximum 400 characters) "X" IF DIFFERENT FROM PIO

The purpose of this project is to assist the Government of Tunisia to further strengthen and extend family planning services, particularly in the poorest and most rural areas through :

1. developing effective, low cost community based distribution systems
2. training a cadre of trainers and upgrading the skills of existing personnel
3. providing support to medical and educational program components
4. establishing a strong research and evaluation capability

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN PIO FACESHEET DATA, BLOCKS 12, 13, 14, OR 15? IF YES, ATTACH CHANGED PIO FACE SHEET.

2 1 = NO
2 = YES

14. PLANNING RESOURCE REQUIREMENTS (Staff/Funds)

AID/W TDY Assistance May Be Required To Prepare PP

| | | |
|--|--|---|
| 13. ORIGINATING OFFICE CLEARANCE SIGNATURE Herman S. Davis TITLE Director, USAID/Tunis | | 14. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W OCCURMENTS, DATE OF DISTRIBUTION DATE SIGNED MM DD YY 03 16 77 |
|--|--|---|

SCHEDULE AND FOLLOW THROUGH AND EVALUATION

ANNEX D

| | 77 | 78 | 79 | 80 |
|--------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| | J F M A M J J A S O N D | J F M A M J J A S O N D | J F M A M J J A S O N D | J F M A M J J A S O N D |
| FP Review | | | | |
| FP Approval | | | | |
| ProAg Signed | | | | |
| Project Initiation | | | | |
| Evaluation | | | | |
| New ProAgs | | | | |
| Appraisal Reports | | | | |

ANNEX C

Life of Project
 From FY 78 to FY 81
 Total U.S. Funding: 7,791,000
 Date Prepared: August, 1977

Project Title & Number : Family Planning Services (G0429)

| PARATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS | MODES OF VERIFICATION | IMPORTANT ASSUMPTIONS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|--|--|-------|-------|-------|-------|--|-------|-------|-------|-------|-------|-----|-----|----|----|-----|------|----|----|----|----|-----|------|-----|-----|-----|-----|-----|--|------|------|------|------|------|--|-----|-----|-----|-----|-----|--|------|------|------|------|------|--|------|------|------|------|------|--|--|--|
| <p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>To reduce the national fertility rate to achieve optimum balance between population growth and available resources.</p> | <p>Measures of Goal Achievement:</p> <p>Reduction of crude birth rate to 30 per 1,000 by 1981, as an interim target for achieving replacement level fertility in 2001</p> | <p>GOT census, vital statistics and sample surveys.</p> | <p>Continued GOT moral and financial commitment to family planning program as key factor in success of socio-economic development plans.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Project Purpose :</p> <p>To assist the GOT to further strengthen and expand family planning services, particularly in the poorest and most rural areas.</p> | <p>Conditions that will indicate purpose has been achieved: End of project status.</p> <ol style="list-style-type: none"> 07,000 new family planning acceptors. 26% MSHA practicing contraception. 60 % rural women receiving family planning services. 26,413 births averted (1978-1981) | <p>GNFP semi-annual contraceptive distribution and statistical reports; contraceptive prevalence survey.</p> | <p>5-Year Plan that emphasizes need for effective family planning outreach program to rural areas;</p> <p>Increased collaboration between GNFP, MOH and Ministry of Social Affairs;</p> <p>Optimum utilization of existing health facilities and personnel;</p> <p>Acceptance by rural population of benefits of family planning services.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Outputs:</p> <ol style="list-style-type: none"> Effective low-cost community-based contraceptive distribution systems. Trained cadre of medical and paramedical personnel. Well-equipped and effectively functioning network of IEC/FP clinics. Expanded I.E. & C program with emphasis on rural areas. Strengthened research and evaluation capability, including management monitoring system. | <p>Magnitude of Outputs:</p> <ol style="list-style-type: none"> 2 demonstration projects and plan of action for nationwide program. 63 surgeons, 100 general physicians, 120 midwives, 200 nursing aides, 720 outreach workers. 250 centers upgraded, 160 new centers equipped, 640 facilities receiving drugs and supplies. Daily radio broadcasts, new TV program, 60-minute film, wide-range motivational activities and educational materials. Increased staff, data collection and analysis of 1974 GNFP evaluation; MIS established. | <p>Periodic site visits and evaluations; GNFP statistical, training, contraceptive distribution, MIS annual and special reports.</p> | <ol style="list-style-type: none"> Availability of vehicles and contraceptives, including lifting of prescription requirement for pills; well-coordinated and complementary delivery systems and personnel. Opening of Ariana Center; MOH personnel available for training and rural assignments. Accelerated building programs and provision of drugs, equipment and supplies to all health facilities. Availability of qualified personnel and motivational materials. Technical assistance provided. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Inputs:</p> <p>AID - 1. US short term technicians (gynecology, paramedical training, IEC, research & evaluation, etc)</p> <p>2. Training : a. US participant (ST) b. host country</p> <p>3. Other costs (contraceptives supplies, drugs, equipment, support services, IEC, Research & Evaluation)</p> <p>4. Inflation</p> <p>Total</p> <p><u>GNP</u> Total Counterpart costs (including inflation)</p> | <p>Implementation Target (Type & Quantity)</p> <table border="1"> <thead> <tr> <th></th> <th>FY 78</th> <th>FY 79</th> <th>FY 80</th> <th>FY 81</th> <th>Total</th> </tr> <tr> <th></th> <th>\$000</th> <th>\$000</th> <th>\$000</th> <th>\$000</th> <th>\$000</th> </tr> </thead> <tbody> <tr> <td>100</td> <td>100</td> <td>60</td> <td>40</td> <td>300</td> <td>(10)</td> </tr> <tr> <td>32</td> <td>32</td> <td>32</td> <td>32</td> <td>128</td> <td>(70)</td> </tr> <tr> <td>135</td> <td>136</td> <td>122</td> <td>124</td> <td>517</td> <td></td> </tr> <tr> <td>1550</td> <td>1844</td> <td>1650</td> <td>1230</td> <td>6274</td> <td></td> </tr> <tr> <td>146</td> <td>169</td> <td>169</td> <td>114</td> <td>598</td> <td></td> </tr> <tr> <td>1963</td> <td>2201</td> <td>2013</td> <td>1540</td> <td>7717</td> <td></td> </tr> <tr> <td>2176</td> <td>2176</td> <td>2482</td> <td>2187</td> <td>8721</td> <td></td> </tr> </tbody> </table> | | FY 78 | FY 79 | FY 80 | FY 81 | Total | | \$000 | \$000 | \$000 | \$000 | \$000 | 100 | 100 | 60 | 40 | 300 | (10) | 32 | 32 | 32 | 32 | 128 | (70) | 135 | 136 | 122 | 124 | 517 | | 1550 | 1844 | 1650 | 1230 | 6274 | | 146 | 169 | 169 | 114 | 598 | | 1963 | 2201 | 2013 | 1540 | 7717 | | 2176 | 2176 | 2482 | 2187 | 8721 | | <p>AID program documentation, consultant reports; Review of GOT/GNFP budgets, staffing and expenditures.</p> | <p><u>AID</u></p> <ol style="list-style-type: none"> Short-term consultants can be located and assigned expeditiously. Suitable training programs and sites can be provided. Commodities and equipment are available when needed <p><u>GNP</u></p> <ol style="list-style-type: none"> Personnel will be provided for training Additional supplies and equipment will be available. Provision of adequate funds from Government revenues. |
| | FY 78 | FY 79 | FY 80 | FY 81 | Total | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | \$000 | \$000 | \$000 | \$000 | \$000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 100 | 100 | 60 | 40 | 300 | (10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 32 | 32 | 32 | 32 | 128 | (70) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 135 | 136 | 122 | 124 | 517 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1550 | 1844 | 1650 | 1230 | 6274 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 146 | 169 | 169 | 114 | 598 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1963 | 2201 | 2013 | 1540 | 7717 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2176 | 2176 | 2482 | 2187 | 8721 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

PLUG COMPETITIVE DISTRIBUTION PCD

| | 73 | 74 | 75 |
|----------------------|-------------------------|-------------------------|-------------------------|
| | J P H A K J J A S Q N D | J P H A K J J A S O N D | J P H A K J J A S O N D |
| Resupply System | — | | |
| Household Canvassing | — | | |
| Field Note Report | — — — — | | |
| Project Report | | — | |
| Evaluation | — | | |

PPT THREE DELEGATION PROJECT

| | 78 | 79 | 80 |
|--------------------------|-------|-------|-------|
| | J | F | M |
| | A | M | J |
| | J | A | S |
| | O | N | D |
| Resupply System In Place | _____ | | |
| Household Canvassing | _____ | _____ | _____ |
| Field Note Reports | _____ | _____ | _____ |
| Progress Reports | | _____ | _____ |
| Survey | | _____ | |
| Training Revision | | _____ | |
| Evaluation Report | | | _____ |

Resupply System In Place

Household Canvassing

Field Note Reports

Progress Reports

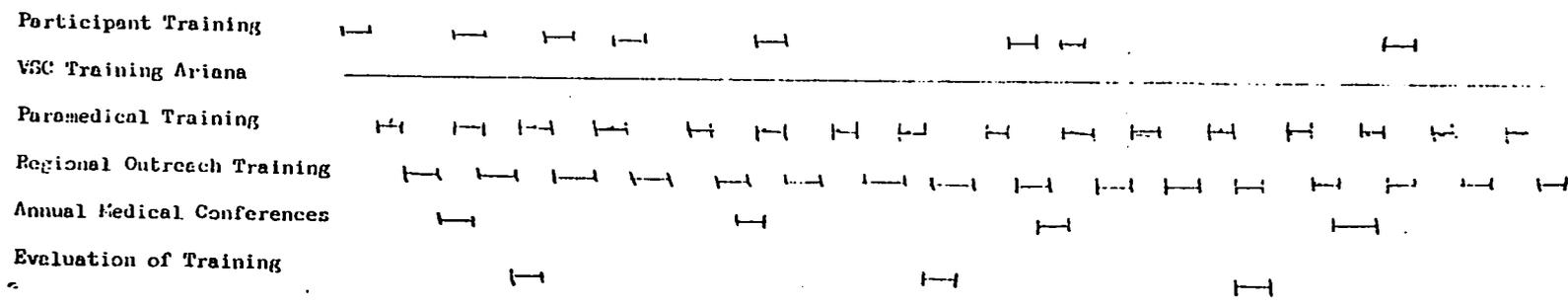
Survey

Training Revision

Evaluation Report

PPP TRAINING

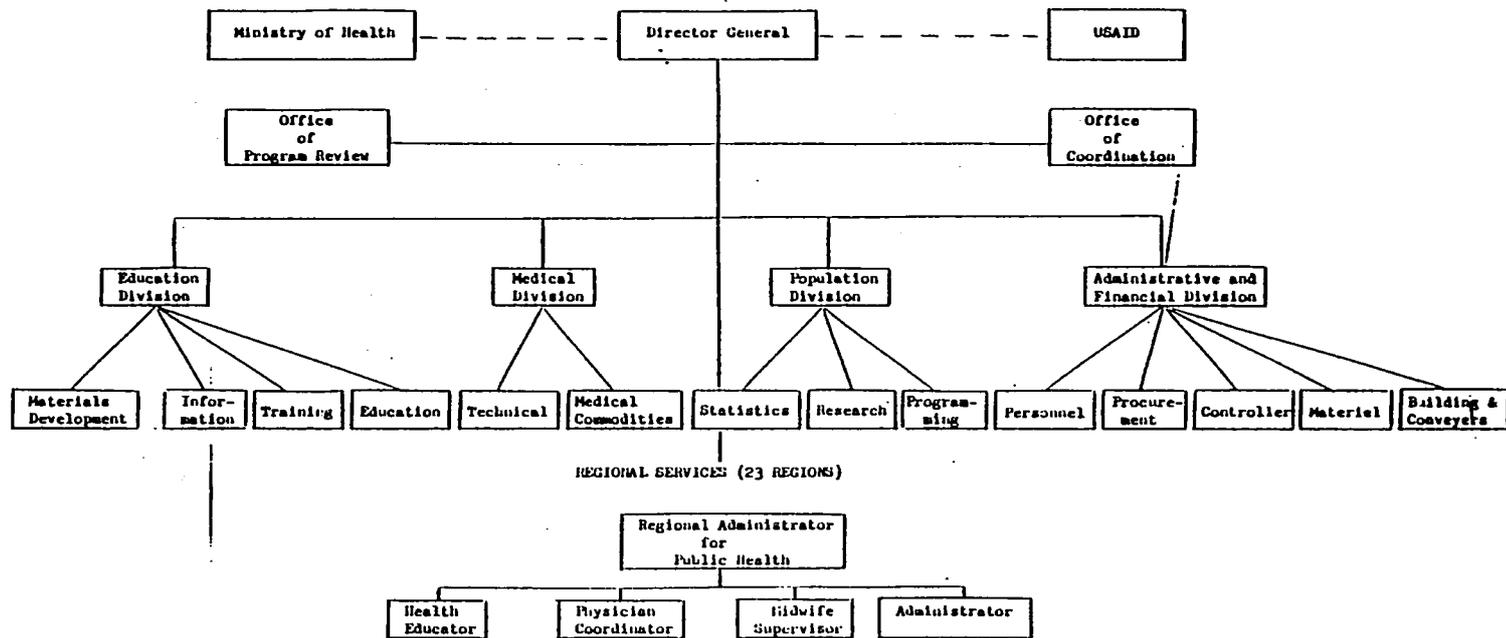
| 78 | 79 | 80 | 81 |
|-------------------------|-------------------------|-------------------------|-------------------------|
| J F M A H J J A S O N D | J F M A H J J A S O N D | J F M A M J J A S O N D | J F M A H J J A S O N D |

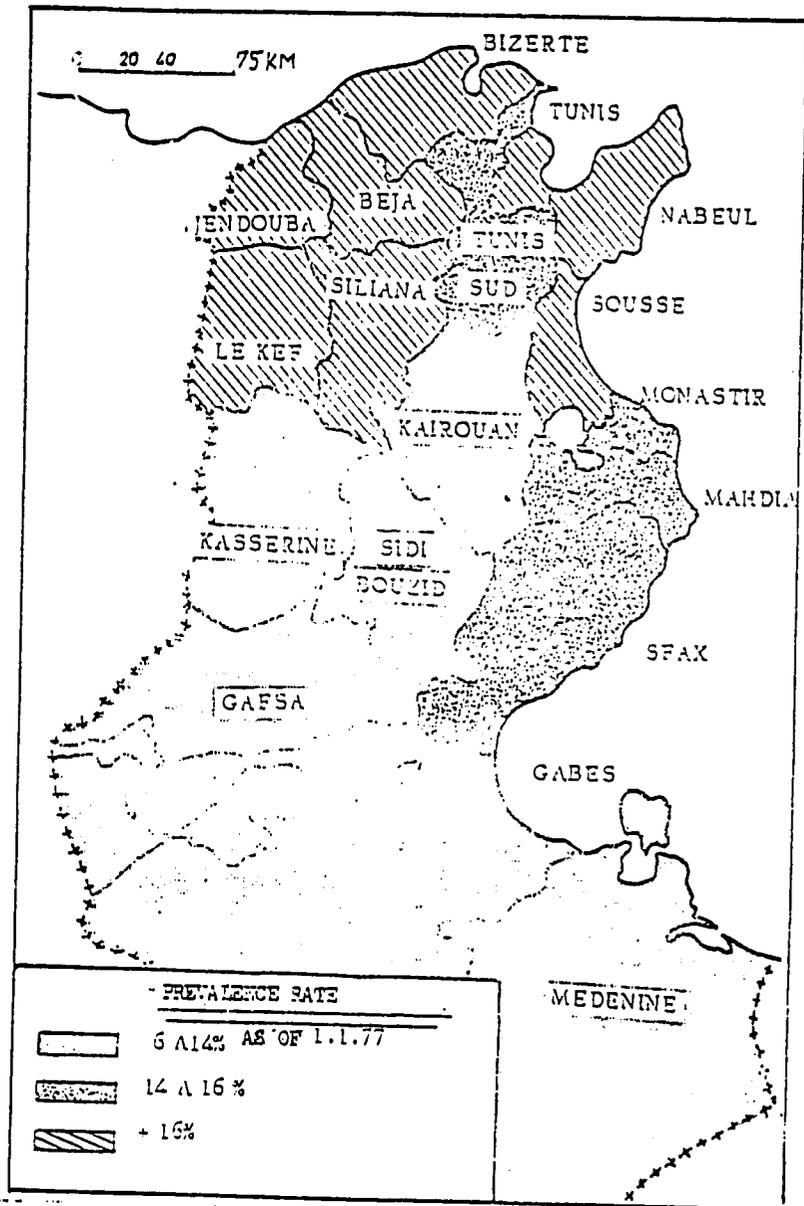


CONSULTANT SERVICES

| | 78 | 79 | 80 |
|----------------------------|-------------------------|-------------------------|-------------------------|
| | J F M A M J J A S O N D | J F M A M J J A S O N D | J F M A M J J A S O N D |
| Curriculum Development |] | | |
| Communications |] | | |
| Training |] | | |
| Curriculum Evaluation |] | | |
| Organizational Development |] | | |
| Surgery |] | | |
| Management |] | | |
| Operations Research |] | | |
| Survey |] | | |
| MIS. |] | | |
| Computers |] | | |
| Evaluation | | | |

ORGANIZATION CHART
 NATIONAL OFFICE OF FAMILY PLANNING AND POPULATION





DEMOGRAPHIC INDICATORS

| INDICATORS | 1966 | 1971 | 1972 | 1973 | 1974 | 1975 |
|--|-----------|-----------|-----------|-----------|-----------|-----------|
| - Total Tunisian population (middle of the year) | 4,717,500 | 5,223,400 | 5,331,200 | 5,444,200 | 5,616,300 | 5,603,000 |
| (1) - Male | 2,323,700 | 2,557,200 | 2,612,600 | 2,652,600 | 2,753,900 | 2,743,000 |
| (1) - Female | 2,393,800 | 2,671,200 | 2,719,200 | 2,791,600 | 2,857,400 | 2,765,300 |
| - Women in reproductive age (15-54) | 1,071,300 | 1,229,300 | 1,263,200 | 1,314,200 | 1,350,000 | 1,353,300 |
| (2) - Village population | 40,0% | - | - | - | - | 49,4% |
| (2) - Urban population | - | 50,4% | - | - | - | - |
| (2) - Rural population | - | 49,6% | - | - | - | - |
| (1) Age Structure | | | | | | |
| - 0 - 14 years | 46,5% | 45,5% | 44,3% | 44,3% | 43,7% | 43,8% |
| - 15 - 64 years | 49,9% | 50,5% | 51,1% | 51,6% | 52,1% | 52,7% |
| - 65 and more | 3,6% | 4,0% | 4,1% | 4,1% | 4,2% | 3,5% |
| (5) Registered births | 206,730 | 133,211 | 130,735 | 134,764 | 134,500 | 202,421 |
| (5) Registered deaths | 48,307 | 48,625 | 40,053 | 43,716 | 40,288 | 40,241 |
| (5) Registered marriages | 27,037 | 37,750 | 45,043 | 43,183 | - | - |
| (5) Registered divorces | 4,616 | 4,584 | 4,930 | 5,099 | - | - |
| (5) Birth rate | 43,8‰ | 36,9‰ | 39,3‰ | 37,7‰ | 36,5‰ | 36,2‰ |
| (5) Mortality rate | 14,0‰ | 12,7‰ | 10,3‰ | 11,0‰ | 9,2‰ | 10,3‰ |
| (5) Fertility rate (15-54) | 193 ‰ | 157 ‰ | 165 ‰ | 166 ‰ | 152 ‰ | 150 ‰ |
| (5) Marital rate | 5,7‰ | 7,2‰ | 3,4‰ | 7,8‰ | - | - |
| (5) Divorces per 1000 inhab. | 0,98‰ | 0,88‰ | 0,93‰ | 0,93‰ | - | - |
| (6) Migratory balance | -12,637 | -32,281 | -24,552 | -12,706 | + 2,352 | - 2,135 |
| - Estimated Births less Deaths | 140,556 | 126,350 | 154,830 | 145,128 | 149,657 | 145,741 |
| Natural Growth rate | 29,8‰ | 24,2‰ | 29,0‰ | 26,7‰ | 26,7‰ | 25,0‰ |
| (7) Net Growth rate | 27,1‰ | 13,0‰ | 24,4‰ | 24,4‰ | 27,1‰ | 25,5‰ |

- (1) I.N.S. Perspectives d'Evolution de la Population - Fascicule III, Septembre 1970; jusqu'en 1974. As of 1975, Projections de la Population de la Tunisie 1976-2001; Mars 1977.
- (2) I.N.S.: Etudes et Enquêtes de l'I.N.S., série démographique No. 5 - Mai 1974. As of 1975, Projections de la Population de la Tunisie, 1976-2001; Mars 1977.
- (3) I.N.S.: Population and Housing Census 1966-1975
- (4) Ministère du Plan : Aménagement du Territoire - L'Armature Urbaine en Tunisie 1973.

DEMOGRAPHIC INDICATORS

- (5) The registered births and deaths have been overestimated by 5% and 27% respectively of the year 1974. However, I.N.S. has considered that all births have been reported and registered as of 1972. Deaths figures have been overestimated by 30%. For 1966 the birth figure has not been corrected as I.N.S. considers a prevalence rate of 100% for this year. This rate is changed to 86.1% if births are overestimated by 5%.
- (6) Ministère de l'Intérieur, I.N.S. "Economie de La Tunisie et chiffres de 1966 et 1971 pour les années 1966 et 1971" bulletin mensuel des statistiques de novembre - décembre 1974, janvier 1975 pour les autres années.
- (7) The migratory balance was taken into account in the calculation of the net growth rate.

FAMILY PLANNING INDICATORS

A. INFRASTRUCTURE OF PUBLIC HEALTH AND ONPPP

| INDICATORS | 1966 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 |
|-------------------------------------|--------|---------|---------|---------|---------|---------|---------|
| Total of visits | - | - | - | 273,156 | 362,025 | 351,722 | 420,391 |
| Total of acceptors | 41,517 | 239,916 | 246,675 | 241,335 | 255,984 | 279,073 | 246,551 |
| New acceptors | 16,176 | 40,360 | 43,665 | 43,840 | 50,901 | 52,052 | 75,723 |
| New acceptors of: | | | | | | | |
| I.M.D. | 12,077 | 12,381 | 13,250 | 16,790 | 19,084 | 17,387 | 20,330 |
| Pills | 350 | 11,778 | 12,026 | 11,194 | 10,795 | 16,283 | 25,287 |
| Tubal ligation | 766 | 2,280 | 2,453 | 4,964 | 10,757 | 9,826 | 3,269 |
| Social abortion | 1,326 | 3,197 | 4,621 | 6,547 | 12,427 | 16,000 | 20,741 |
| Active centers | - | 360 | 330 | 309 | 392 | 420 | 432 |
| Married women (15-49) per center | - | - | - | 2,432 | 1,976 | 1,911 | 1,570 |
| Ob/Gyn specialists | - | 35 | - | - | 69 | NA | NA |
| Midwives | - | 40 | - | - | 92 | NA | NA |
| Medical auxiliaries | - | 60 | - | - | 265 | NA | NA |
| Acceptors/physicians | - | 6,355 | - | - | 3,724 | - | - |
| Acceptors/midwives | - | 5,998 | - | - | 2,793 | - | - |
| Acceptors/Med. Aux. | - | 3,999 | - | - | 970 | - | - |

B. IMPACT OF PROGRAM

| INDICATORS | 1974 | | 1975 | | 1976 | | 1977 | |
|---|--------|----------|--------|----------|-----------|----------|---------|----------|
| | Public | National | Public | National | Public | National | Public | National |
| Women protected as of 1/1 | 54,109 | 74,814 | 77,959 | 89,328 | 94,294 | 107,163 | 117,006 | 140,076 |
| Rate of acceptance per 100 MFWA (15-49) as of 1/1 | 3,47% | 10,0% | 10,06% | 11,5% | 11,75% | 13,5% | 14,54% | 17,5% |
| Births to be averted | 22,500 | - | 26,250 | - | 34,350 | - | 45,000 | - |
| Births averted | 23,117 | 25,793 | 29,720 | 32,720 | 35,573 | 38,800 | 44,508 | 52,750 |
| Birth rate | 36,5 ‰ | | 36,2 ‰ | | 35,2 ‰ ** | | - | |
| Fertility rate (15-44) | 174 ‰ | | 176 ‰ | | 170 ‰ ** | | - | |
| Fertility rate (15-49) | 158 ‰ | | 160 ‰ | | 155 ‰ ** | | - | |
| Fertility rate (15-34) | 152 ‰ | | 150 ‰ | | 145 ‰ ** | | - | |

* Public: Activities of the centers of the Ministry of Public Health and ONPPP structure.

National: All public and private activities supported and guided by ONPPP

** Birth rate and fertility rate for 1976 are temporary.

FAMILY PLANNING METHODS - 1975

| Governorates | Population | 15-49 | | | | | Other Prev. Meth. | Total | Total | Total | Total | Total |
|--------------|------------|------------|--------|----------------|----------------|--------|-------------------|-----------------|-----------------|------------------|------------------|------------------|
| | | ILMRA Oral | IUD | Vol. Steriliz. | Fec. Abortions | Social | | | | | | |
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) = (3) + (2) | (9) = (4) + (2) | (10) = (5) + (2) | (11) = (6) + (2) | (12) = (7) + (2) |
| Tunis | 944,130 | 131,000 | 16,132 | 4,897 | 1,621 | 6,634 | 3,327 | 124 | 39 | 12 | 51 | 26 |
| Tunis Sud | 205,057 | 23,000 | 4,299 | 459 | - | - | 727 | 154 | 16 | - | - | 26 |
| Bizerte | 343,703 | 47,500 | 8,734 | 1,131 | 816 | 1,226 | 1,833 | 184 | 24 | 17 | 26 | 39 |
| Beja | 248,770 | 33,800 | 1,414 | 962 | 881 | 587 | 233 | 42 | 24 | 26 | 17 | 7 |
| Jendouba | 229,702 | 40,000 | 2,936 | 603 | 1,232 | 844 | 423 | 75 | 15 | 21 | 11 | 20 |
| Le Kef | 233,155 | 31,000 | 6,469 | 1,232 | 655 | 548 | 219 | 190 | 36 | 19 | 16 | 6 |
| Siliana | 192,668 | 26,700 | 1,039 | 438 | - | 13 | 85 | 41 | 16 | - | 4 | 3 |
| Kasserine | 238,499 | 36,000 | 1,632 | 287 | 313 | 328 | 241 | 45 | 8 | 9 | 9 | 7 |
| Sidi Bou Zid | 218,511 | 30,600 | 885 | 1,150 | - | - | 134 | 29 | 5 | - | - | 4 |
| Gafsa | 237,844 | 33,000 | 7,024 | 859 | 177 | 452 | 861 | 212 | 26 | 5 | 14 | 26 |
| Kodiane | 292,979 | 43,800 | 5,457 | 358 | 173 | 192 | 1,059 | 111 | 7 | 4 | 4 | 22 |
| Gabes | 255,717 | 40,000 | 9,935 | 462 | 101 | 290 | 1,435 | 248 | 12 | 3 | 7 | 36 |
| Sfax | 474,879 | 67,500 | 8,555 | 1,221 | 910 | 1,250 | 10,583 | 127 | 18 | 13 | 19 | 156 |
| Kairouan | 338,477 | 49,000 | 1,131 | 115 | 845 | 648 | 811 | 24 | 2 | 18 | 14 | 17 |
| Mahdia | 218,217 | 30,400 | 2,122 | 574 | 293 | 433 | 734 | 70 | 19 | 10 | 14 | 24 |
| Monastir | 223,175 | 35,600 | 2,790 | 592 | 373 | 293 | 1,648 | 93 | 21 | 13 | 10 | 59 |
| Sousse | 254,601 | 35,200 | 4,526 | 820 | 1,278 | 1,102 | 1,049 | 129 | 23 | 36 | 21 | 30 |
| Dahoul | 368,114 | 53,900 | 6,254 | 2,147 | 606 | 1,531 | 4,952 | 116 | 40 | 11 | 23 | 92 |
| TOTAL | | | | | | | | | | | | |
| TUNISIA | 5,533,209 | 792,000 | 91,534 | 17,307 | 9,396 | 16,000 | 30,744 | 116 | 22 | 12 | 20 | 39 |
| Total 74 | 5,16,301 | 780,000 | 83,122 | 19,634 | 10,757 | 12,427 | 27,104 | 107 | 24 | 14 | 16 | 35 |
| Total 73 | 5,44,1,209 | 770,000 | 93,397 | 16,790 | 4,964 | 6,547 | 33,163 | 123 | 22 | 6 | 9 | 43 |

FAMILY PLANNING ACTIVITIES IN THE PROVINCES OF TUNISIA

1976

Tableau -1-

| METHODS PROVINCES | Total # of visits | ACCEPTORS | | I.U.D. | I.U.D. | Pills Acceptors | | | Condom Accept. | | Jellies | | Tubal | Social |
|---------------------------------|-------------------------|-----------|---------|------------|----------|-----------------|--------|----------|----------------|--------|---------|-------|-----------|-----------|
| | | New | Old | Insertions | Removals | New | Old | # of cy. | New | Old | New | Old | Ligations | Abortions |
| Tunis-Nord | 88.369 | 16.262 | 49.102 | 5.990 | 1.894 | 4.920 | 16.320 | 59.102 | 1.752 | 929 | 925 | 565 | 1.183 | 7.692 |
| Tunis-Sud | 11.735 | 1.309 | 8.739 | 4.7 | 156 | 557 | 4.229 | 6.228 | 293 | 304 | 116 | 33 | - | - |
| Sizerte | 26.737 | 4.626 | 20.284 | 1.450 | 499 | 1.240 | 9.253 | 11.421 | 590 | 843 | 203 | 100 | 619 | 1.419 |
| Sou | 17.169 | 3.673 | 12.429 | 1.325 | 356 | 595 | 1.375 | 3.988 | 102 | 94 | 24 | 18 | 945 | 972 |
| Medenine | 17.556 | 2.479 | 12.955 | 660 | 422 | 941 | 2.801 | 8.835 | 266 | 151 | 385 | 67 | 665 | 451 |
| La Raf | 28.853 | 3.534 | 18.106 | 1.312 | 777 | 1.455 | 6.823 | 11.694 | 163 | 55 | 8 | - | 613 | 793 |
| Siliana | 10.355 | 1.173 | 7.045 | 387 | 145 | 503 | 2.163 | 2.686 | 31 | 36 | 31 | 2 | - | 37 |
| Massarine | 15.939 | 4.582 | 9.775 | 920 | 79 | 2.426 | 4.252 | 8.742 | 336 | 22 | 112 | 3 | 283 | 456 |
| Sidi Bouzid | 6.548 | 705 | 3.959 | 86 | 49 | 383 | 1.193 | 1.593 | 46 | 59 | 196 | 80 | 29 | 14 |
| Laïse | 29.744 | 3.515 | 17.892 | 1.263 | 307 | 2.205 | 7.357 | 14.195 | 300 | 354 | 107 | 43 | 106 | 736 |
| Medenine | 11.152 | 2.735 | 8.138 | 457 | 159 | 1.198 | 5.550 | 8.619 | 515 | 675 | 73 | 51 | 206 | 282 |
| Sou | 22.373 | 3.537 | 16.402 | 570 | 209 | 1.891 | 9.979 | 15.194 | 765 | 880 | 310 | 73 | 74 | 684 |
| Medenine | 49.485 | 8.750 | 30.469 | 1.192 | 698 | 2.825 | 5.270 | 26.161 | 2.630 | 5.790 | 1.016 | 647 | 853 | 1.550 |
| Sou | 10.359 | 1.972 | 4.760 | 275 | 109 | 438 | 1.218 | 2.729 | 337 | 347 | 42 | 39 | 427 | 447 |
| Sou | 15.274 | 1.932 | 9.422 | 775 | 304 | 833 | 1.825 | 5.741 | 220 | 402 | 68 | 17 | 305 | 625 |
| Medenine | 12.852 | 2.725 | 8.437 | 690 | 327 | 733 | 1.337 | 5.342 | 697 | 731 | 499 | 86 | 354 | 332 |
| Medenine | 22.351 | 6.513 | 10.307 | 1.122 | 249 | 1.362 | 3.876 | 7.609 | 1.359 | 509 | 133 | 75 | 765 | 1.644 |
| Medenine | 32.929 | 5.745 | 22.867 | 1.961 | 1.073 | 1.464 | 7.205 | 12.712 | 1.063 | 2.354 | 837 | 442 | 847 | 1.322 |
| TUNISIE | 429.801 | 75.323 | 271.028 | 20.830 | 7.702 | 25.987 | 91.936 | 124.593 | 11.385 | 14.515 | 5.100 | 2.346 | 8.259 | 20.351 |
| Année 1975 | 551.322 | 98.652 | 231.921 | 17.307 | 7.534 | 26.510 | 75.224 | 123.030 | 8.678 | 15.276 | 3.426 | 2.364 | 9.896 | 16.038 |
| Année 1974 | 592.015 | 50.901 | 206.683 | 19.084 | 6.312 | 16.795 | 72.327 | 97.051 | 7.432 | 14.020 | 5.683 | 1.969 | 10.757 | 12.427 |
| Report Année 1976 Année 1975 | 1,22 | 1,29 | 1,16 | 1,20 | 1,03 | 1,50 | 1,22 | 1,50 | 1,31 | 0,95 | 1,15 | 0,99 | 0,85 | 1,27 |
| Report Année 1975 Année 1974 | 1,42 | 1,47 | 1,33 | 1,00 | 1,00 | 1,27 | 1,11 | 1,11 | 1,53 | 1,03 | 1,38 | 1,19 | 0,75 | 1,63 |

ONFPF PROJECTED FAMILY PLANNING FIGURES

| | <u>1978</u> | <u>1979</u> | <u>1980</u> | <u>1981</u> |
|------------------------|---------------|---------------|---------------|---------------|
| Births to Avert | 55,600 | 63,064 | 69,670 | 76,709 |
| Fill Acceptors | 41,000 | 42,000 | 43,000 | 44,000 |
| IUD Acceptors | 31,000 | 32,000 | 33,000 | 34,000 |
| VSC Acceptors | 12,000 | 10,000 | 99,000 | 8,000 |
| Other Method Acceptors | <u>25,000</u> | <u>28,000</u> | <u>31,000</u> | <u>34,000</u> |
| | 109,000 | 112,000 | 164,000 | 120,000 |

THE HOUSEHOLD DISTRIBUTION PROJECT IN
BIR ALI BEN KHALIFA, TUNISIA

Liliane Toumi

INTRODUCTION

The Planning Familial à Domicile (PFAD) Household Distribution Project is a pilot project situated at Bir Ali ben Khalifa. Its objective is to further the Tunisian national family planning program by identifying the most acceptable and cost-effective distribution system for oral contraceptives and by establishing the best method of extending the system throughout Tunisia.

It must be stressed that it is vital to find a cost-effective and efficient contraceptive distribution system rapidly in order to achieve the specific objectives of the Tunisian National Development Plan before the end of the century. The development plan calls for a gross reproduction rate of 1.2 and a net rate of natural increase of 13.7 per thousand before the year 2000. The PFAD household distribution project is only the first step in an effort that will later be extended to urban and rural areas throughout Tunisia.

ORGANIZATION

The governorate of Sfax consists of 11 delegations. The delegation of Bir Ali ben Khalifa itself contains nine sectors. The PFAD project is a system for household distribution of oral contraceptives and of information concerning family planning, including contraception. The innovative aspects of the project, by comparison with other family planning projects in Tunisia, are as follows:

Distribution to Households. Each household is visited; each woman is registered and followed up. In the former plan of the Tunisian National Office of Family Planning and Population, oral contraceptives were available to urban women through specialized family planning centers and to rural women through the facilities of mobile teams, which were assigned to cities and regularly visited predetermined sites in rural areas.

The urban centers to which the mobile teams are assigned are directed and staffed by either medical or paramedical personnel. There is currently no other household distribution system in Tunisia-- the Bir Ali project is innovative in this respect. By visiting each household, the project team is assured of establishing contact; by furnishing information with confidence and kindness, clients' fear, reticence, and ignorance can be overcome, and motivation for family planning can be created. This approach also allows women who live in rural areas and have no access to transportation to obtain family planning services without leaving their families, their children, or their household duties.

2. Distribution by extramedical personnel. Distribution is carried out by young women who are locally recruited and who have a minimum level of education and special extramedical training for the project.
3. Distribution limited to oral contraceptives. In the field, the oral contraceptive is the only appropriate method since foams and condoms are too bulky for the female project workers to carry. Alternative methods of family planning are explained to women at their request, and the women are then referred to other specialized centers to obtain such supplies if they wish to use them.
4. Distribution exclusively in rural areas. The rural area constituting the project site is isolated and only minimally served by information and services from the mobile family planning teams; the location of the project allows observation of the acceptance rate among those women who are least exposed to family planning information and therefore perhaps least prepared to accept contraception.
5. Distribution to isolated households. Groups of houses in the project site are spaced about 600 to 1,000 feet from one another. Since the dwellings are physically isolated, communication is difficult. Special approaches must be developed to overcome the additional difficulties imposed by the region's minimal transportation facilities.
6. Data collection for statistical analysis. Data are to be collected on the following variables: population size; number of women of reproductive age; problems encountered in transportation, communication, and distribution; method of household

contact; acceptance and continuation rates; reasons for refusal; and contraceptive side effects.

Supervision by a physician. In many similar projects there are no physicians; this necessitates referral of patients or clients to clinics or dispensaries. The National Office of Family Planning and Population has required that a physician be intimately involved in the project. The presence of a physician contributes continuity to the system and promotes confidence among staff in carrying out the objectives of the project.

Origin of the Project

Two other projects were considered prior to the inauguration of the Bir Ali household distribution project. The first was a study of the impact of nonclinical distribution in sample groups of 1,000 households; the other was to be a study of the organization of extraclinical distribution of contraceptives. It is important to conduct such studies specifically in Tunisia because, according to Dr. Marc Vincent, "distribution projects carried out in other countries call upon different social and political structures and cannot be blindly applied in the Tunisian context."

In November 1975, an initial pilot project was established in Sfax by Tunisian family planning representatives and representatives of USAID. The site chosen for the project was 30 km west of the city of Sfax, and consisted of three sectors of the delegation of Bir Ali ben Khalifa, namely Oued El Cheikh, Cuadrane, and El Gandoul.

Geographic and Demographic Setting

The region of Bir Ali ben Khalifa is situated in a zone of semidesert climate that supports grazing activity and the cultivation of olive trees, almond trees, cereals, and vegetables. A blacktop road in poor condition connects Bir Ali and Sfax. In the rest of the area there are several rudimentary roads and numerous pistes of crushed stone.

The inhabitants of the region are Berbers, formerly seminomads who, in recent years, have begun to live mainly in stationary dwellings, returning to a nomadic life style to meet the requirements of grazing or harvesting. They speak Arabic; their dwellings, ranging from a single room to a tent of camel skin or a tent-like structure of dried branches, are extremely simple. The patriarchal system,

formerly dominant, is increasingly being abandoned. However, the authority of the dominant male of the household--that is, the father, the husband, or the older brother--continues to command respect. Women live very much among themselves; there tends to be in each household or in each group of dwellings a grandmother or a dominant aunt to whom other women go for advice.

The population supports itself with agriculture and grazing, and the region's per capita income is very low. Many men emigrate to Europe or Libya to work. The level of education is low, particularly among women--only the youngest of the women served by the Bir Ali project are literate and understand French. In all cases, males are more highly educated than females. The inhabitants of the region are generally undernourished and commonly suffer from a variety of vitamin deficiencies.

Since children are desirable assets for the family, families are large, having on the average 8 to 12 children. The mortality rate is declining. Women are generally married, ~~of reproductive age,~~ and pregnant or lactating; the rest are unmarried girls, widows, or divorcées. They tend to marry at an early age and to have their first child shortly thereafter. The women normally breast-feed their children for two to three years, during which they are typically amenorrheic and usually not fecund. Contraception is largely based, therefore, on the natural condition of postpartum amenorrhea; in that kind of situation, it is difficult to determine the impact of any contraception program.

There were several reasons for choosing what seems to be such an unfavorable site. Because of the highly dispersed nature of the population in the region, any level of success of the pilot project would demonstrate the applicability of the system to other settings. The region was little served by family planning services, particularly those offering oral contraceptives. Even under the program, each sector received only a two-hour weekly visit from the mobile team. Contraceptive use in the region is extremely low; only 2% of the eligible women practice family planning. The region is typical of rural Tunisia. By comparison with other sites where household distribution has been put into practice (for example, Bangladesh, Egypt, Taiwan, and Korea), the Bir Ali site presents numerous and interesting problems of organization and communication. Yet, the socio-economic homogeneity of the population in the study site will facilitate evaluation of the project's effectiveness.

The headquarters of the project consists of a three-room house in Bir Ali. The decision to locate the project facility in the study site was made because the physical presence is reassuring and inspires confidence in the

project and thereby improves relations with project acceptors. Proper upkeep of facilities and the demeanor of the team's workers are important in inspiring confidence in project personnel and in indicating their commitment to the objectives of the project.

All of the project staff are recruited from the study region except for the field director, who comes from Sfax. Staff hiring is done partly through personal acquaintances and partly through the assistance of local authorities. Project staff consists of the following:

- The director, a gynecologist, whose responsibilities are both administrative and medical.
- The field director, who has a major role in administration and surveillance of project activities.
- The deputy field director, who acts as team leader for project workers in addition to assisting the field director.
- Seven project workers, from Bir Ali, who are all young, unmarried women who have completed their second year of secondary schooling, and who are fluent in both French and Arabic. These field workers are responsible for distribution of and education regarding oral contraceptives as well as for collecting data.
- Two chauffeurs, from the region, who transport both field workers on household visits and clients on medical visits.
- One gardener who also serves as guard for the project facility.
- One woman from the region who is charged with maintenance of the project facilities.

There is also an advisory committee comprised of a representative of the local authorities; a representative of USAID, Tunisia; the ONFPF regional director of family planning services; a representative of the Tunisian Women's Union; a sociologist who is an advisor to the project; a demographer and a statistician who work directly with the ONFPF and USAID; and the project director. The advisory committee performs a general advisory role and coordinates project activities with the local authorities. The entire project team, including the drivers and the housekeeper, must be helpful, welcoming, and understanding in view of its important social role in the community.

The project was initiated in January 1976 and is scheduled for completion in December 1977. The major project activities conducted in 1976 were the selection and training of project personnel, the preparation of the project questionnaire, and the field tasks. Field worker training was conducted during the last half of March 1976. It consisted of one week of theoretical training and one week of field practice.

Theoretical training proved to be difficult in several respects because it required that people with advanced and specialized formal training be able to present their material in a fashion simple enough to be understood by the workers. The theoretical training was in three areas: medical, social, and statistical. Medical training, conducted by two physicians, provided instruction in the comparative anatomy of the male and female reproductive systems, as well as basic information about the physiology of the menstrual cycle, pregnancy, and breast-feeding. In addition, human sexual behavior and indications, contraindications, and the effectiveness of contraceptives, particularly oral contraceptives, were discussed. Theoretical social training was carried out by two sociologists who gave instruction in methods of family contact and provided information in a discreet and persuasive manner. To gain a better understanding of their own role, field workers were asked to assume the role of potential acceptors. Statistical training was provided for all aspects of the questionnaire, with special attention to the exact meaning of each question. Numerous sample questionnaires were completed by the field workers to help them anticipate a range of possible responses to the questions.

There were three main types of difficulties encountered in training field workers. First, the field workers had very limited knowledge of medical and contraceptive practices and limited experience with questionnaire coding. Second, young, unmarried field workers felt self-conscious discussing sexual questions with married women. Third, the field workers' own hesitations concerning contraception had to be dealt with.

The questionnaire was designed to obtain general information about the identity of potential acceptors, medical information, information on family members, and information on the knowledge and use of various methods of contraception. A special manual was prepared for the field workers to help them respond to ambiguous or controversial questions.

A field test was conducted during the first week of March 1976, at some distance from the actual project site, in the presence of all of the training personnel of the project. A number of errors, which emerged during the field test, were immediately corrected.

The actual project was begun in April 1976. The first week was devoted to developing the schedule of household visits within the sector; the sector sheikh (director) was involved in this aspect of the program. Usually, visits were made by two or three field workers. Each morning was spent assigning households according to the schedule of visits. At each of the initial visits, the household was contacted and the questionnaire was administered to all women 16 years and over. Each of these women was assigned an identification number, which she retained throughout the project. A supply of contraceptive pills was offered to each woman of reproductive age who was not pregnant or sterile and whose husband was present, if there were no medical contraindications. Eligible women were given six cycles of Norinyl 50-80 or Neogynon 28 and were carefully instructed in the proper use of and possible side effects of the oral contraceptives. In addition, all women of reproductive age were given coupons: acceptors were given a green coupon, which was good for a free medical consultation; women who were sick were given a yellow coupon, which entitled them to a free examination at the local dispensary; and women who chose another method of contraception or for whom the pill was contraindicated were given a red coupon, which entitled them to examination by the mobile medical team.

In addition, oral contraceptives were given to three categories of "potential" acceptors:

1. Women who were at least six months pregnant. Such women would then be protected in the case of premature delivery, stillbirth, or nonlactation. Thus, contraceptives were made available to these women before the five months--the normal period between two successive visits by the field workers--had elapsed.
2. All nursing mothers. Contraception would then be immediately available to these women should they stop nursing or resume their periods. Moreover, if a woman had not resumed her periods after six months of nursing, she was advised to have a medical examination that would artificially stimulate menstruation. Surprisingly, 46% of nursing mothers in this area became pregnant again without resuming their periods.
3. All women whose husbands were absent for less than four months.

July through October 1976 were devoted to follow-up visits to acceptors. Each acceptor was seen by the field worker at least twice. The second visit was a courtesy

visit but proved useful in some cases in providing information or advice to acceptors.

At the beginning of September 1976 the field workers were provided a second, brief training session to explain the use of a follow-up questionnaire, which had been designed to determine the reason for continuation or discontinuation of use among acceptors as well as to determine reasons for refusal by nonacceptors. From September through November 1976, the second questionnaire was administered and the second supply of pills was distributed. Field workers recorded continuation rates and the number of new acceptors in this second phase.

January of 1977 marked the beginning of the second year of the project. Activities were extended to two new sectors--Sdirat and Bir Ali. In February and March 1977, a third distribution of six cycles of pills was carried out.

Reports are to be prepared at the end of each period; definitive evaluations, performed by USAID in collaboration with ONPFP, were scheduled for December 1976 and December 1977 (see Figure 1).

Results of the First Distribution in
the Three Sectors: Qued El Cheikh,
Quedrane, and El Gandoul

Each sector contained approximately one-third of the households in the study. The number and characteristics of acceptors in the first distribution in each of the three sectors are shown in Tables 1 through 3.

TABLE 1
MARITAL STATUS AND AGE OF WOMEN IN
THE THREE SECTORS

| Marital Status | No. | % |
|-----------------------------------|-------|-----|
| Married women of reproductive age | 1,553 | 59 |
| Women aged 45 and above | 607 | 23 |
| Young girls | 343 | 13 |
| Widows and divorcées | 141 | 5 |
| Total | 2,644 | 100 |

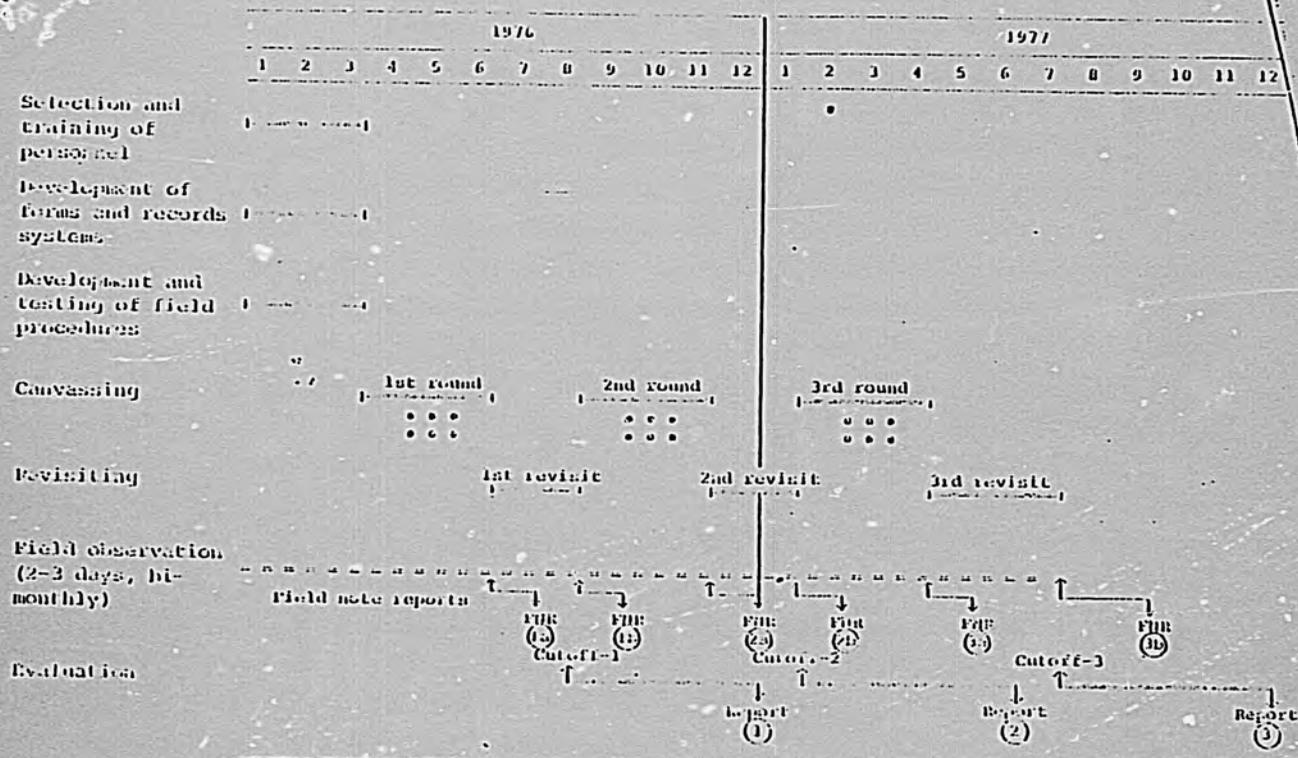


Fig. 1. Timing of activity components

TABLE 2

MARRIED WOMEN OF REPRODUCTIVE AGE
ACCORDING TO THEIR ATTITUDES ON
ACCEPTABILITY OF THE PILL

| Designation | No. | % |
|--------------|--------------------|-----|
| Acceptors | 510 | 33 |
| Nonacceptors | 1,043 ^a | 67 |
| Total | 1,553 | 100 |

^aIncluding 581 women who were ill, sterile, using another method, or whose husband was absent (462 refusals equal to 29.7%).

TABLE 3

POTENTIAL ACCEPTORS

| Characteristics | No. | % |
|--|-----|-----|
| Acceptors likely to take the pill immediately | 412 | 81 |
| Acceptors at least seven months pregnant | 54 | 10 |
| Acceptors breast-feeding a baby less than two months old | 44 | 9 |
| Total | 510 | 100 |

Results of the Second Distribution
of the Three Sectors

Of the 412 acceptors who were "likely to begin taking the Pill immediately" following the first distribution, 166 (40%) actually began using oral contraceptives. Among these, a significant incidence of side effects and discontinued use was observed. A list of medical consultations is shown in Table 4. The majority of the complaints were digestive problems and menstrual irregularities.

TABLE 4

OBSERVATIONS MADE DURING MEDICAL
VISITS OF ACCEPTORS
JUNE 1976-FEBRUARY 1977

| <u>Observation</u> | <u>No.</u> |
|--|------------|
| Preliminary examination before taking the Pill | 85 |
| Spotting/prolonged periods | 14 |
| Amenorrhea | 13 |
| Digestive disorders | 12 |
| Headache | 8 |
| Nervous disorders | 6 |
| Hypertension | 4 |
| Jaundice | 4 |
| Fungal infections | 3 |
| Breast-feeding without menstruation | 2 |
| Tachycardia | 1 |
| Varicose veins | 1 |
| Total | 153 |

The rate of regular use remained low. In order to calculate the continuation rate, it was necessary to consider only those women who began taking the Pill after the first distribution (Table 5). This gives a continuation rate of about 60% and a discontinuation rate of about 40%.

Of the 1,043 women who had not accepted oral contraceptives at the first visit (for all reasons combined), 228

TABLE 5

STATUS OF INITIAL USERS AT SECOND VISIT, BY SECTOR

| Sector | Total Acceptors Who Initiated Use Fol- lowing First Visit | Acceptors Continuing Use at Second Visit | | Acceptors Discontinuing Due to: | | | |
|----------------|---|--|-----|------------------------------------|-------------|-----|-------|
| | | No. | No. | % | Side Effect | | Other |
| | No. | | | | % | No. | % |
| Oued El Cheikh | 79 | 54 | 68 | 12 | 15 | 13 | 16 |
| Ouedrane | 41 | 18 | 44 | 4 | 10 | 19 | 46 |
| El Gandoul | 46 | 28 | 61 | 1 | 2 | 17 | 37 |
| Total | 166 | 100 | 60 | 17 | 10 | 49 | 30 |

(228) became acceptors at the second visit; an additional 15 (13) were using other methods at the revisit. A sizable number of potential acceptors remain.

Extension of the Project

Although successful, the present study is still too costly. Therefore, it is necessary to find a distribution system that consolidates the achievements of the old, but ineffective, system with the results of this study. The method currently employed is not cost-effective. It has been estimated that, at the current ratio of field workers to clients in Bir Ali (1:1,550), this system would require 315 field workers to cover the entire governorate, and 5,670 field workers to cover 18 governorates. If each field worker were to receive 45 dinars per month for 13 months, the cost per year for each field worker would be equivalent to US \$433.

In order to reduce costs in the extension project, it appears necessary to limit the effective amount of time spent by the project personnel, either by employing them on a temporary basis or by increasing the number of households they must visit. It is necessary to economize on the use of scarce vehicles, fuel, and time by selecting specific sites that contain not only highly dispersed but also some clustered housing units. In addition, it will be necessary to reduce the time devoted to those second visits that are not strictly necessary.

Resupplying oral contraceptives could be improved by the use of distribution points--e.g., posted dwellings, each managed by a literate person who is capable of keeping project accounts and providing necessary information.

The ONPFP infrastructure already in place includes a center in each governorate as well as the centralized operation in Tunis. An effort was made to decentralize mobile teams that visit sector dispensaries on a regular basis. The experiences of the Bir Ali household distribution project suggest that the following changes be made in the household distribution procedure:

Discontinue the administration of the questionnaire and the control visits to acceptors, use closely spaced second visits, and use a physician as director.

Maintain the use of paramedical personnel from the region, the use of a part-time physician, and the use of specialists to provide intensive training in household distribution for all personnel.

Locate properly staffed distribution centers in the rural region.

- Improve contacts with husbands.

Household distribution in rural areas of Tunisia is culturally and socially acceptable. The conclusion of the study is that this method of distribution should be extended throughout Tunisia. To achieve the objectives of the project on a national scale, however, several changes should be incorporated:

- Retain the existing infrastructure of the ONPFP in the new system.
- Establish in Tunis a central, specialized training center that consists of one or two physicians, one or two sociologists, two or three project managers, and one demographer; this staff would be used full time initially and part time thereafter to organize a mobile information team that would travel in the various governorates to train paramedical personnel as needed.
- Locate training facilities, including a conference room and a project room, in Tunis.
- Provide assurance by the ONPFP that pills, foams, condoms, and IUDs, as well as medications, will be distributed and restocked.

There should be, in each governorate, a team that works closely with the family planning clinic to assure adequate provision of all necessary family planning services, including IUD insertion and tubal ligation. There should also be, in each delegation, a control agency that has a full-time staff member and an unpaid, voluntary advisory committee consisting of the governor, physicians, sociologists, and others. Moreover, project headquarters in each delegation should be housed either in a dispensary or in a maternal and child health center. Although a single center could serve as many as three small delegations, it should be pointed out both that there are substantial population differences from one delegation to another and that the least populous delegations tend to be those with the most highly dispersed populations. Taking these two factors into account, 136 centers would probably be needed.

Project headquarters should serve as a center of information, medical consultation, and supply distribution. The physician would be able to use its facilities to insert IUDs. Moreover, it would be the headquarters for the field workers and the center for resupplying contraceptives and

medications. The staff necessary to run the center would include: a female director, who would also serve as the team leader of the field workers; a secretary; field workers; and a part-time physician. It would be ideal for each physician to have his/her own automobile for consultations. Field workers would be employed full time initially and part time thereafter. Only three field workers would continue to work at the center: one director, and two others, who were either mobile or potentially mobile. Approximately 1,000 field workers would be necessary to staff the entire system.

General Organization of Distribution

The first stage would be initial supply. Each acceptor would receive from six to nine oral contraceptive cycles, a number of registration cards, and a medical voucher. Most importantly, she would be provided information about correct use and potential side effects of oral contraceptives. Her name, address, and identification number would be recorded in the register. If a woman who had more than two children refused, an invitation voucher would be given to her husband. Conferences and round table discussions for husbands would then be organized within the delegation. These meetings would stress to husbands the importance of resupplying, regardless of the method of contraception. Women who indicated a desire to receive the Pill between field worker visits would have to go to the center or to one of the resupply centers in the sector.

Resupply would be accomplished from specified resupply points, which would be located in the center of the delegation in each case. Effective use could be made of one or two resupply points located in the home of a literate woman or former field worker, or even located in shops. Each woman who had a valid registration card would be able to obtain subsequent supplies in stores through her husband. In the case of loss of the registration card, the woman could obtain a new card at the center where she is registered. It is expected that at least one year would be required to establish the extended program in all of Tunisia.

CONCLUSION

The PFAD pilot project at Bir Ali ben Khalifa, whose goal is to extend the Tunisian national family planning program, is only a first step in an effort to set up household contraceptive distribution in both urban and rural areas throughout Tunisia. Nevertheless, the results

obtained should be crucial to the success of future family planning efforts in Tunisia, and instructive for similar efforts in other areas.

ANNEX C

TRAINING CURRICULUM SUMMARY

TRAINING PROGRAM:

I. Nursing Assistants

- a) Organization and management of family planning
- b) Anatomy and Physiology Female and male sexual organs
- c) Pregnancy - Antenatal features
 - Delivery
 - Post-natal features
- d) Pathological aspects of pregnancy
- e) Care of Under Fives
- f) Contraception
- g) Sterilization and Maintenance of Equipment
- h) Nutrition
- i) Health Education

II. Midwives

- a) Organization and management of family planning
- b) Anatomy and physiology of sex organs
- c) Physical examination
- d) Lab examinations
- e) Pathology and infections female reproductive system
- f) Physiology of pregnancy
- g) Contraception - Medical and surgical
- h) Pediatrics and Under Five care
- i) Nutrition and Health education
- j) Statistics

III. Social Workers and Nurse Hygienists

- a) Organization and administration family planning program
- b) Family planning and family health
- c) Anatomy and physiology of sex organs and contraceptive technology
- d) Interview, communication and motivational technique.
- e) Role of Outreach workers in family planning.

IV. General Physicians

- a) Sterilization and Abortion and Tunisian Law
- b) Anatomy and Physiology Female sex organs
- c) Conception and first trimester of pregnancy
- d) New developments in gynaecology
- e) Diagnosis of pregnancy
- f) Contraception and interruption of pregnancy

TABLE 4

Target Goal #2: 10% and 20% SC BBRU Using condoms and pills, respectively by 1980
 Projected Usage of Contraceptives by the Public and Private Sector

| | 1975 | 1976 | 1977 | 1978 | 1979 | 1980 | 1981 |
|--|-------------|-------------|------|------|------|------|------|
| | Actuals | Projections | | | | | |
| Married Women of Reproductive Age (per 100 MB) | 856 | 886 | 906 | 927 | 948 | 970 | 992 |
| Women Protected Including Abortion | 110 | 158 | 244 | 325 | 409 | 494 | 526 |
| Percent Coverage of Women 15-49 | 12.7% | 17.8% | 27% | 35% | 43% | 51% | 53% |
| Women Protected by Method | | | | | | | |
| Condom | 5 (5%) | 6 | 29 | 52 | 75 | 97 | 99 |
| Pill | 12 (11%) | 39 | 78 | 117 | 155 | 194 | 193 |
| I.U.D. | 40 (36%) | 52 | 61 | 67 | 77 | 87 | 93 |
| Sterilization | 37 (34%) | 44 | 57 | 67 | 77 | 87 | 98 |
| Abortion | 16 (15%) | 18 | 19 | 22 | 25 | 29 | 33 |
| Total | 110 | 158 | 244 | 325 | 409 | 494 | 526 |
| Projected Needs of Contraceptive Supplies | | | | | | | |
| Pill Cycles | 241 | 512 | 1014 | 1521 | 2015 | 2522 | 2574 |
| Private Sector (Actual or projected **) | 113 | 282 | 507 | 761 | 100 | 1261 | 1287 |
| Public Sector (Actual or projected **) | 128 | 230 | 507 | 761 | 1007 | 1261 | 1287 |
| Condom Pieces | 628 | 800 | 2900 | 5200 | 7500 | 9700 | 9900 |
| Private Sector (Actual or projected **) | 136 | 300 | 2000 | 2800 | 5000 | 6467 | 6600 |
| Public Sector (Actual or Projected **) | 492 | 500 | 900 | 1400 | 2500 | 3233 | 3300 |

*projected = women protected x 13

** projected = women protected x 100

Target Goal: 210% and 20% of MIRA Using Condoms and Orals, Respectively by 1980

CONTRACEPTIVE FLOWS FROM ALL SOURCES

| | 1975 | 1976 | 1977 | 1978 | 1979 | 1980 | 1981 |
|-------------------------------------|-------|--------|--------|--------|--------|--------|--------|
| I. Orals | | | | | | | |
| Beginning of Year Stock | 86 | 559 | 1164 | 1290 | 2169 | 2704 | 1132 |
| Deliveries - Total | 714 | 1294 | 1110 | 2400 | 2550 | 950 | 2200 |
| USFPA and Other Donors (per 79 ABS) | (254) | (230) | (500) | (650) | (800) | (950) | (1100) |
| AID (Per 79 ABS) | (460) | (864) | (640) | (1750) | (1750) | (0) | (1100) |
| Distributed - Total | 241 | 689 | 1014 | 1521 | 2015 | 2522 | 2754 |
| Public | (128) | (230) | (507) | (761) | (400) | (1261) | (1287) |
| Private | (113) | (282) | (507) | (761) | (1007) | (1261) | (1287) |
| Unknown | (-) | (117) | (-) | (-) | (-) | (-) | (-) |
| End of Year Stock | 559 | 1164 | 1290 | 2169 | 2704 | 1132 | 578 |
| II. Condoms | | | | | | | |
| Beginning of Year Stock | 2570 | 2590 | 10583 | 7683 | 11123 | 10000 | 8397 |
| Deliveries - Total | 648 | 8793 | 0 | 8649 | 6377 | 8097 | 9500 |
| AID (Per 79 ABS) | (648) | (8649) | (0) | (8649) | (6377) | (8097) | (9500) |
| OTHER (Per 79 ABS) | (-) | (144) | (0) | (0) | (0) | (0) | (0) |
| Distributed - Total | 628 | 800 | 2900 | 5200 | 7400 | 9700 | 9900 |
| Public | (492) | (500) | (900) | (1400) | (2500) | (3233) | (3300) |
| Private | (136) | (300) | (2000) | (2800) | (5000) | (6467) | (6600) |
| Unknown | (-) | (-) | (-) | (-) | (-) | (-) | (-) |
| End of Year Stock | 2590 | 10583 | 7683 | 11123 | 10000 | 8397 | 2997 |

AUDIO-VISUAL EQUIPMENT

1978-1981 Requirements

- A. Equipment to be furnished for Audio-Visual production
- 1 editing table for 16 m/m sound film
 - 2 Cassette video tape recorders with editing head
 - 3 Color TV monitors
 - 1 Developing machine for 35 m/m color reversible film
 - 1 Copier for 35 m/m film strip
 - Classifying accessories
 - Video editing accessories
 - Sound taping and editing accessories
- B. Equipment to be used in the field
- 2 Audio-visual cars equipped with 16 m/m and super 8 m/m projection equipment
 - Sound equipment
- C. Audio-Visual equipment to be used for educational purposes
- Portable sound system
 - Metal writing boards
 - 16 m/m projection moving tables
- D. Audio-Visual equipment for the training centers of of Sousse, Sfax, Nabeul, Kef and Gafsa
- Standard list:
- Color video tape
 - TV monitor
 - 16 m/m sound projector
 - Projection moving table
 - Bl-faced writing board
 - Sound super 8 m/m projector
 - Anatomy cards
 - Demonstration stick
 - 1000 W converters Input 220 V - Output 115 Volts
 - Slide and film strip projector
 - Tape recorder
 - Writing metal board
 - Portable screen (medium size)
 - Retroprojector
 - 50 m (50 yards) extension cord
- E. Audio Visual supports
- 1) 16 m/m and super 8 m/m/cassette movies treating the following subjects:
 - Anatomy
 - Different contraception techniques
 - Different Family Planning experiments
 - Research in Family Planning
 - 2) Scientific and educational filmstrips
 - 3) Spare parts for US equipment being used

LIST OF MEDICINES AND OTHER RELATED SUPPLIESLOCAL PURCHASE

Acide Folique, comp. 5 mg foldine
 Alcool 95c
 Alcool iodé
 Alvityl ou hydrosol
 Amphocycline, comp. vag.
 Atropine, amp.
 Biperacilline, ampicilline, cc
 B complexe
 Buscopan (Donnatol)
 Cebaspirine (enfantz)
 Colimycine
 Coton
 Dakin
 Dolosal, amp. (pethidine)
 Duogynon, comp.
 Ethynil Estradiol
 Epentol
 Extrait de foie, amp.
 Flaxedil, amp.
 Flagyl oral, comp.
 Flagyl vag. comp.
 Ferment lactique
 Gaze (pièces de)
 Glifanan
 Hemocaprol, amp.
 Heptamil
 Ginkar, amp. gel.
 Ketalan
 Labette
 Leucoplast (cm)
 Leucoplast Perfore' (13 cm)
 Mercury II Aurylé, flac
 Methergin, gouttes, inj.
 Mycostatine oral, comp.
 Negatol, fiac.
 Nesdonal
 Promethazine, amp.
 Protexalate de fer, comp.
 Rovamycine
 Rufol
 Syntocinon (ocytacine) amp.
 Talc
 Test de grossesse
 Trioxy-methylene
 Terramycine oral, comp.
 Terramycine vag. comp.
 Totapen
 Valium, comp.
 Vitamine C
 Vitamine K injectable

ANNEX L

ILLUSTRATIVE EQUIPMENT AND DRUG LISTS

U. S. PURCHASES

Examination Kits
Floor Lamps for examinations
Specula
Gynecological Tables
Examination Stools
Flashlights adaptable to medical examination instruments
Suture material
Needles and Syringes - Assorted sizes
Gloves - disposable and non-disposable
Finger cots
Gauze and Bandages
IUD's
Foams, Jellies and Creams

EXCERPTS FROM AID AREA AUDITOR GENERAL'S REPORT (Africa, Nairobi,
Kenya) dated June 28, 1977

SUMMARY

"Among the several on-going programs A.I.D. supports in Tunisia, Family Planning is the acknowledged showpiece. Concrete demographic goals have been established, against which measurable program can already be seen. Better commodity accounting could increase the cost effectiveness of this program even further."

STATEMENT OF FINDINGS AND RECOMMENDATIONS

Family Planning

On balance, the family planning program in Tunisia is well managed. We did observe significant problems in participant training and the GOT stock record keeping. Although these matters are not trivial, they do not override the general excellence of the program. A.I.D.'s overall objective in family planning is to help the Government of Tunisia develop the institutional capacity needed to achieve two national demographic goals: The first is to reduce the 1972 fertility rate of 162 to 137.8 by 1982. (Actual in 1976 was 155). The second is to reduce the estimated 237,400 births that would have occurred in 1976 without family planning to 207,400. (In 1975, actual births were 202,328).

Commodity records at many of the Government of Tunisia's 18 provincial warehouses and 482 family planning clinics are unreliable. We tested inventory records at selected warehouses and clinics. In some cases, warehouse records showed receipts of incoming commodities but did not show issues to clinics; in others, warehouses kept no receipt or issue records but clinics did. On balance, clinic records were no better or worse than warehouse records.

Government of Tunisia officials cite a high turnover in administrative personnel as the principal cause of poor record keeping. The personnel problem has stabilized, but record keeping remains unsatisfactory. Meanwhile, without good commodity records actual usage and requirements forecasts are largely guesswork.

RECOMMENDATION

The Mission should see that the Government of Tunisia improves family planning commodity records.

Only two of the 14 participants sent to the United States for academic training are now engaged in family planning work. Once trained, the participant commands a higher salary in the private sector. The Government of Tunisia will not cooperate with Mission efforts to recover the cost of the training although participant training agreements were signed in all cases.

The Mission has recognized that the percentage of returnees working in family planning is too small. With the exception of two partici-

pants now in the United States, long-term academic training has been suspended.

Results of a short-term training program have been better. Physicians and administrators who are working in family planning are sent to the United States for 1 to six months. So far, 19 have completed training and returned to their posts.

In view of the mission's action we are making no recommendation here."

NOTE

Since this audit report, the GOT has initiated a new record keeping system as of July 16, 1977 in the provincial warehouses and family planning clinics with new inventory stock cards and forms allowing for better control.