

GOT/USAID MID-TERM EVALUATION
OF THE
TUNISIAN FAMILY PLANNING PROGRAM
Report of the Phase II Mission

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Preface

The 1979-1980 GOT/AID Evaluation of the Tunisian Family Planning Program was significant from a number of perspectives. It emphasized a new approach to evaluation as a collaborative assessment and programming exercise. It developed innovative program planning and monitoring techniques as well as a strategy for a broader, more effective and more independent program in the 1980s. During the course of the two phased mission, important lessons were learned not only for the Tunisian family planning program - how to strengthen outreach and performance - but also for the evaluation process itself - how to carry out a meaningful and productive exercise leading to major program improvements and new directions.

The achievements of this mission would never have been realized without the enthusiasm, dedication and special skills of the individuals who participated. On behalf of the American team members, we would like to express our deep appreciation to our Tunisian counterparts on the team -- Dr. Rafaat Dali and Messrs. Charfeddine, Dimassi, Benzarti, and Kouniali -- for all the time and energy they expended in meetings, work sessions, site visits and report writing, as well as for the valuable insights, comments and suggestions they offered. Throughout the mission there was a strong collaborative spirit and mutual commitment to identifying ways of improving and expanding the family planning program. We found it an extremely productive and rewarding team effort.

Although the names of all those who assisted the Evaluation mission are too numerous to list, we would like to extend our appreciation not only to staff at ONPFP headquarters but also to the field representatives visited by the team as well as to officials of other agencies and members of the medical faculties who willingly gave of their time, interest and hospitality. We wish to thank in particular the following individuals for their important contributions:

- . Mezri Chekir, for the inspiration which he provided to the Evaluation team and for his outstanding leadership and unceasing efforts over the past seven years to overcome obstacles, build broad-based support, and develop a comprehensive family planning program responsive to the special needs of Tunisian couples
- . Mourad Ghachem, for the brilliant job he performed as overall coordinator of the Phase II team activities. He displayed great skill and patience in arranging a tight, complicated schedule of meetings and field visits for four different teams. His guidance and assistance throughout the two weeks were much appreciated.

- . Mongi Bchir, for his insightful comments and perspective of many years of experience with the program and for the effective manner in which he directed a series of lively and stimulating group discussions on the development of family planning objectives and a new, comprehensive rural strategy for 1982-1986. His efforts to restructure the Family Planning Directorate and to install a new "motor" to monitor and administer field activities are to be commended.
- . Rafaat Dali, for his special role in providing a link between Phase I and II of the Evaluation -- as well as for his energy and organization in preparing an impressive documentation covering medical services in family planning, for his candor and skill in discussing service problems and their potential solutions, and for his adroitness and sensitivity in creating constructive liaison with key persons in the Ministry of Health.

The team is also grateful for the strong support provided by Ambassador Bosworth, USAID Director Gelabert and by the Mission population staff, particularly Alan Getson and Anwar Bachbaouab who participated actively in Phase I and II of the Evaluation, offering valuable suggestions and assistance. Finally, we owe special thanks to NE/TECH and Office of Population staff for their encouragement and backstopping throughout the two-part mission.

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I. INTRODUCTION

AID, in close collaboration with the GOT, has recently completed a comprehensive, indepth evaluation of the Tunisian family planning program, assessing past performance and determining future program directions and assistance needs. Launched as a small pilot project in 1964, the Tunisian family planning program is today the broadest and most advanced program of its kind in Africa and the Near East, offering family planning information, education and services, free of charge, in over 700 facilities throughout the country. Planning, programming, coordination and evaluation of all family planning activities is handled by the National Family Planning and Population Office (ONPFP), created in 1973 as a semi-autonomous organization within the Ministry of Public Health (MOPH).

Throughout this period and particularly since the establishment of the ONPFP, AID has provided substantial support to the Tunisian family planning program. Bilateral and intermediary funding have totalled close to \$30 million since 1965. While initial emphasis was placed on the development of an infrastructure and institutional capability, AID assistance efforts in recent years have been directed at training of medical and paramedical personnel, strengthening of ONPFP program support activities, introduction and testing of new techniques and programmatic approaches, and expansion of family planning services in rural areas. Conducted midway through the 1978-1981 GOT/AID bilateral agreement, the present evaluation marks a turning point in the Tunisian family planning program-following 15 years of program development and extension of services to all 18 governorates. The ONPFP is now embarking upon a transition period of refocused, expanded and intensified efforts to reach eligible couples in underserved rural areas, and to stimulate other government agencies, particularly the Ministry of Health, to become more involved in family planning activities.

Evaluation Objectives and Accomplishments

In an effort to make the evaluation as comprehensive and as constructive as possible, it was designed as a joint GOT/USAID activity, to be carried out in two stages with emphasis on future programming as well as on assessment of program performance. The evaluation was conducted during the periods September 20-October 4, 1979 and March 14-29, 1980, thus allowing, in the intervening six months, a number of important corrective measures to be introduced and assessed. The first phase had as its primary objective to collect, review and synthesize existing data on ONPFP activities, assess program strengths and weaknesses and identify key issues for more indepth consideration during Phase II. The detailed report prepared on the Phase I Evaluation findings and recommendations (see Executive Summary, Appendix A), together with a series of descriptive materials prepared by the ONPFP on program activities for 1980-1981 and plans for 1982-1986, provided the background and framework for the Phase II discussions. During the March 1980 mission each major program area was carefully reviewed along with recent efforts to improve program administration and performance. The second phase of the evaluation focused, in particular, on: establishing program priorities

and implementation plans for 1980-1981; outlining strategies for 1982-1986, for incorporation into the GOT Sixth Five-Year Economic and Social Development Plan; and discussing the future role of AID assistance.

The most significant accomplishment of this two-part mission was its truly collaborative GOT/USAID nature with senior ONPFP staff taking an active role in the entire process. The excellent cooperative dialogue which characterized the first phase was continued and even strengthened during the second phase. From an initial evaluation team of three Americans and one Tunisian, the Phase II mission was expanded to a total of five Americans and five Tunisians, including public health physicians, I,E&C experts, program administrators, demographers and an epidemiologist (see Appendix B). During both phases, there was an unusually close and congenial working relationship between AID and ONPFP counterparts. Discussions were open and frank, with a free exchange of information and views on program performance and priorities. ONPFP and USAID staff alike characterized the mission as the most stimulating, successful and constructive family planning review and programming exercise conducted to date. (See Appendix C for a summary of the P.D.G.'s opening and closing addresses to the Evaluation team.)

Although each mission was only two weeks long, instead of the originally scheduled three weeks, the team both held a series of highly productive working sessions at the ONPFP and broadened the dialogue on population/family planning issues to involve officials from other ministries and institutions. In many instances, the mission served as a catalyst to initiate or strengthen meaningful discussions between ONPFP staff and counterparts in other organizations. The agenda for the two-part evaluation included meetings with high-ranking officials from the Ministries of Public Health, Social Affairs, National Education, the National Union of Tunisian Women, the National Statistical Institute and the National Children's Institute. Individual team members also met with the Deans of the three Medical Faculties, Chiefs of OB/GYN, Chiefs and Faculties of Social and Community Medicine Departments, Regional Health Directors, staff of health/family planning special projects along with representatives of other agencies (UNFPA, IBRD, PVO's), and the U.S. Ambassador, Mission Director and staffs. During the course of Phase I and II of the evaluation, all 18 governorates were visited by at least two team members. Official site visits were scheduled to 15 governorates (10 during Phase II) and included meetings with the hospital administrator, family planning délégué (regional ONPFP representative) and staff. (See Appendix B.)

The observations and recommendations of the Phase II GOT/AID Evaluation are presented in a series of sector reports -- Physician Team Report; Service Statistics, Research and Evaluation; ONPFP Management and Administration; and Information, Education and Communication -- prepared jointly during the two-week mission. Sections of the Physician Team Report on Family Planning Services and Training, although based on earlier joint GOT/AID discussions, were finished only after return to Washington due to lack of time in Tunisia. Another important document

completed as part of Phase II is entitled "Family Planning Monitoring in Tunisia (1973-1979): Findings and Implications for the next Five-Year Plan (1982-1986)" by Bernard/Charfeddine (see Abstract, Appendix D). It is an historical profile of the evolution of the ONPFP program, providing a comprehensive analysis of trends in incidence of new family planning acceptors and prevalence of effective protection (by method and by governorate) as well as age-specific fertility. Also outlined are proposed new program objectives for 1980-1986. Collectively, these reports furnish detailed information on ONPFP's 1980-1981 work plan in each major area of activity and program strategies for 1982-1986. In view of the enormous amount of material contained in these documents and overlapping discussion of key topics, an effort has been made to synthesize the team's principal observations and recommendations for ONPFP's 1980-1986 program in a summary report which can serve as a useful working document and a vehicle for broader distribution within the GOT and AID.

II. THE TUNISIAN FAMILY PLANNING PROGRAM: SOURCES OF STRENGTH AND CONCERN

The following is a summary of major program strengths and weaknesses identified during the two-part evaluation mission along with recent initiatives taken as a result of the team's findings and recommendations.

A. Program Strengths

The population problem and the need for generalized family planning services were expressed early by President Bourguiba and solidly integrated into socio-economic development planning. The integral strength of national policy in Tunisia on population and on family planning are attested by:

- . an extraordinary series of laws promoting the equality and development of women, encouraging small family size and permitting free access to all major contraceptive methods, including sterilization and social abortions
- . official demographic concerns expressed since the Second National Plan
- . unremitting continuity of a national family planning program since 1966, the first in Africa and the Middle East
- . open public and media discussion of population/family planning issues without fundamental opposition
- . general acceptance in all sectors of the government, by religious leaders and by the public as a whole
- . humanistic approach to family planning aimed at the harmonious development of the population and the stability and well-being of the family.

With broad political, religious and legislative support, the national family planning program has been able to overcome important obstacles and achieve a dramatic transformation in family planning knowledge, attitudes and practice in Tunisia. Under the dynamic leadership of Mezri Chekir (12/73-4/80) and with a highly dedicated and competent staff, the ONPFP has developed policies, a nationwide administrative structure and a broad range of programs - information, education, training, research and evaluation. It has planned and coordinated the extension of comprehensive family planning services throughout the country, maintaining a well-balanced mix of contraceptive methods, and has served as a training ground and important example for other Francophone African and Near East countries. The accomplishments of the Tunisian family planning program and its leadership role in the region were officially recognized in 1978 when the ONPFP was awarded the International Humanitarian Medal by UNESCO.

As the largest single foreign donor, AID has played a key role in the development and expansion of the Tunisian family planning program over the past 15 years. Major outputs of AID bilateral and intermediary assistance include:

- . strengthened nationwide family planning services, educational and administrative structure in all 18 governorates
- . upgraded/equipped family planning and MCH clinics
- . establishment of a model clinic (Ariana) with a national and international training program in laparoscopy
- . establishment of regional clinics providing laparoscopic sterilization services
- . creation of a national training center, serving sub-Saharan francophone African and Near East countries as well
- . contraceptive commodities, medical and audio-visual equipment
- . training of medical and paramedical personnel
- . strengthened data collection system, research and evaluation program, including completion of a national fertility survey and subnational (Jendouba Governorate) contraceptive prevalence survey
- . testing and evaluation of experimental community-based contraceptive delivery systems using outreach personnel (aides familiales) for replication/expansion
- . technical assistance and short-term participant training

ONPFP program achievements in the last several years are reflected in the following indicators:

- . Nationwide availability of services has expanded significantly, with 770 facilities currently providing family planning services compared to 330 in 1973. The number of annual family planning consultations in the public sector has increased from 273,000 to 535,000 (1979).
- . The private sector, widely encouraged by ONPFP programs and policies, has played an increasingly important role in the provision of family planning services, responsible in 1979 for about one-quarter of national protection prevalence (see Figure 1, Appendix E). Over the past five years, orals and condoms provided by the ONPFP to pharmacies and sold at reduced prices, have shown a steady increase (see Figure 2, Appendix E). In 1979 the ONPFP distributed 477,000 cycles of pills to the private sector, totalling approximately 37,000 couple years of protection (CYP) and 1,863,100 condoms (approximately 15,526 CYP).
- . Contraceptive prevalence among married women of reproductive age (MWRA), 15 to 49 years old, has almost tripled since the creation of the ONPFP, from 8.5 percent in 1973 to 23.5 percent in 1979.
- . The crude birth rate declined from 48 per 1,000 in 1965, to 37.7 in 1973, to 33.5 in 1979, an overall decrease of 43 percent. During this period, the annual rate of natural increase dropped from 2.8 percent to 2.5 percent.
- . According to the results of the 1978 National Fertility Survey, among ever-married women aged 15-49, 92 percent knew of, and 43 percent had used, at least one method of family planning. Thirty percent were practicing contraception (22 percent with oral contraceptives, IUD or tubal ligation; 7 percent traditional methods and 1 percent folk methods).
- . Between 1968 and 1976, ideal family size decreased from 4.8 to 3.9 children.

B. Program Weaknesses

Despite new program inputs, recent data reveal:

- . a plateauing or downward trend in new contraceptive protection provided by the public sector program. Since 1977, for all methods combined, there has been an overall decline in the annual rate of new ONPFP family planning acceptors (see Figure 3, Appendix E). Particularly disturbing are decreasing rates of tubal ligation and recent increasing rates of IUD removal.

- . large urban/rural and regional disparities in access to family planning services, contraceptive availability and use. January 1980 estimates of protection prevalence (provided by ONPFP services) range from 26 percent of MWRA in Le Kef to a low of 4 percent in Sidi Bouzid (See Figures 4 and 5, Appendix E). While 50 percent of MWRA live in rural areas, they represent only one-third of ONPFP family planning acceptors. Crude birth rates range from under 30 per 1,000 in Tunis and several other governorates to an estimated high of 45 in Sidi Bouzid and Medenine. Fertility rates are generally one-third higher in rural than in urban areas.
- . great variations in performance rates over time within certain governorates (see Figures 6 and 7, Appendix E).
- . unmet family planning need among high parity, older women (see Figure 8, Appendix E). Analysis of recent age-specific fertility trends shows that great strides have been made in reduction of fertility among women under 30 years of age (due in large part to increasing age at marriage). On the other hand, there remains a large reservoir of women in their 30s and 40s who are still at risk of pregnancy and are not currently receiving contraceptive services.

The overall downward trend in new ONPFP family planning acceptors and regional variations in contraceptive prevalence are due primarily to service deficiencies and breakdowns (personnel, vehicles, equipment, etc.) rather than to lack of client demand or policy change. Underlying factors include:

- . a critical shortage of medical and paramedical services
- . difficulty and expense of expansion into rural areas (See Section III C. for details of family planning service insufficiencies and difficulties)
- . removal in January 1979 of incentive payments to MOPH personnel for providing family planning services
- . frequent changes in MOPH administration, disrupting continuity of public health policy, personnel and programs
- . political events in 1978 and 1979 that diminished participation of government officials and agencies in the promotion of family planning services
- . weaknesses in ONPFP Central Office monitoring and supervision of field activities
- . shift from the public to the private sector, where the steady growth in demand for oral contraceptives and condoms has resulted, in part, from strong ONPFP support

Although there are indeed encouraging trends in the private sector as well as a recent increase in the rate of new ONPFF program acceptors, nevertheless, three-fourths of all eligible couples are not using family planning services. The ONPFF is indeed faced with a major challenge. Immediate and effective measures are needed to secure an upturn in overall contraceptive prevalence. The reasons for low family planning program performance in governorates of Central and Southern Tunisia, in particular, should be clearly identified. A plan of action should be outlined and implemented, including full availability of tubal ligations (see Table III, Appendix E).

C. Recent Program Initiatives

In the six months between the first and second phases of the evaluation, significant progress was made in redressing program weaknesses and in improving overall performance. Following the excellent collaborative dialogue that characterized the first set of meetings in Fall 1979, the ONPFF initiated a series of important corrective actions including a major restructuring of the Population and Family Planning Directorates in an effort to strengthen program planning, monitoring and evaluation and to expand service delivery in rural areas. Noteworthy developments included:

- . personnel reassignments among senior staff at the central and regional levels. The most important result was strengthened leadership and expanded staff of the Family Planning Directorate and the Medical Division
- . addition of two "animatrices" per governorate to promote postpartum contraception
- . increased Central Office supervision and support of field activities with more frequent contacts and meetings with regional délégués
- . further decentralization of management functions, expanding the regional délégués' financial decision-making authority
- . improved program monitoring techniques, e.g. development of an analog method of monitoring actual funds disbursed in each region; creation of a new management reporting system (series of weekly activity reports) to improve feedback from each of the 18 governorates; and use of epidemiological techniques to monitor and interpret family planning service statistics
- . establishment of program review and planning committees focusing on ways to strengthen and expand rural service delivery
- . preparation of a 1980-1981 work plan and outline of ONPFF's program priorities for 1982-1986

The impact of these changes - a major restructuring of program activities, a new spirit and drive - is reflected in the marked upturn during February 1980 in family planning acceptor rates for all methods (see Figure 9, Appendix E).

Highlights of Phase II Evaluation

The following significant actions were taken during the course of the second mission:

- . completion of a comprehensive analysis of ONPFP program performance by method and governorate for 1973-1979 and identification of target action areas, program needs and options
- . development of more ambitious family planning objectives for 1980-1981 and 1982-1986, projecting large increases in rates of tubal ligation and injectables
- . formation of a new joint commission, ONPFP/INS/Ministry of Plan to develop demographic objectives for the Sixth Plan
- . decision to reconvene the National and Regional Population Councils
- . outlining of a new comprehensive ONPFP family planning service delivery strategy for rural Tunisia
- . discussion of strategies for using the field testing of new contraceptive technologies and delivery systems to extend the range of family planning services
- . preliminary discussions between key officials on the potential role of the Rural Health Project for extension of family planning services and their integration into basic health services (medicine integree)
- . discussions with Medical School Deans concerning the strengthening of family planning/population curriculum and training for promotion of rural community and family health
- . revision and finalization of the 1980-1981 Work Plan for the GOT/AID bilateral Family Planning Services Grant
- . quantification of overall budgetary requirements for 1982-1986, with initial estimates of GOT and foreign donor inputs
- . preparation of sector reports detailing 1980-81 priorities as well as proposed program strategies for 1982-86. These reports provide a framework for ONPFP's next five-year plan and will be presented to the National Population Council for review.

Following the Phase II GOT/AID Evaluation, there have been a number of important political developments which impact favorably on the national family planning program:

- . appointment of a new Prime Minister, M. Mohamed Mzali, a strong supporter of family planning with Mezri Chekir (former P.D.G. of the ONPFP) as his Chief of Staff
- . appointment of a new Minister of Public Health, M. Rachid Sfar
- . appointment of Mme. Souad Chater (former Director of Social Development, Ministry of Social Affairs) as new President Director General of the ONPFP

These changes suggest that there will be a strong commitment to strengthen and expand the national family planning program.

III. RECOMMENDATIONS FOR ONPFP'S 1980-1986 PROGRAM

The observations and recommendations presented below on the ONPFP's 1980-1986 Program are drawn from the Phase II evaluation background documents, work sessions and site visits and include the major points covered in the joint sector reports.

A. National Policy and Programming

Following its early recognition of the serious implications of rapid population growth, the GOT has for many years officially promoted family planning as an integral part of national social and economic development policy. National commitment to family planning remains firm, and the interrelations between population change and all sectors of the economy should be strongly reflected in the 1982-1986 Plan, now in preparation. The upcoming third meeting of the National Population Council, presided over by the Prime Minister, will help to mobilize commitment and resources for population/family planning and to insure that population concerns are incorporated into the new programs and policies of Ministries and national organizations. A joint ONPFP/INS/Ministry of Plan Commission will prepare demographic projections and objectives for the Sixth Plan.

One of the most important functions of the ONPFP is to foster dialogue with and involvement of other Ministries and agencies in population and family planning activities. Since its creation in 1973, the ONPFP has sponsored numerous seminars, round table discussions, training courses and special projects designed to educate personnel in other sectors and organizations on the implications of rapid population growth and to engage their interest and participation in family planning activities. The ONPFP has worked effectively with the Ministries of Public Health, Social

Affairs, National Education, Youth and Sports, Agriculture, Cultural Affairs and Information, etc., as well as with national organizations such as the PSD, UNFT, UGTT, UTICA, UNA, OTTEFP, OTEF and ATPF. As a result of these efforts, broad-based support for family planning has grown in recent years. Over the next Plan period, efforts to promote continued and heightened involvement of other Ministries and national organizations in these activities must continue. The ONPFP must serve as a catalyst for change in other organizations; it must stimulate activity and exchange information, transfer resources, coordinate and train in order to accomplish this. As population/family planning become more integrated into the thinking and activities of other agencies, the ONPFP can assume progressively the role of an Institute or Foundation, promoting the service activities of others, while maintaining high quality services primarily for demonstration purposes, and focusing on policy and program design, coordination of family planning activities, research and evaluation.

A major issue for the GOT and the ONPFP during the next Plan is implementation of the national policy of "integrated health care" which calls for family planning services to be delivered, at a reasonable standard of quality, through all MOPH establishments and personnel as a routine but important part of their activities. As such, integrated health care would be the best vehicle for generalizing and assuring the continuation of family planning services for the entire population. However, the effective implementation of this policy has barely begun. Management and coordination of this integrated effort is a complex process and an enormous challenge. Every effort must be made to protect the gains of the national family planning program after 16 years of careful development and internationally acclaimed progress, insuring that family planning services become an essential element within integrated health care. For integration to be successful, it must result in a strengthening and expansion of both family planning and basic health services throughout rural Tunisia. Recommended actions in this area include the following:

- . Prepare background papers on the implications of population trends and of the options available for each Ministry and national organization to influence change in population dynamics - fertility, mortality, migration - and use of family planning services. These should be available for presentation at the next meeting of the National Population Council. Important elements of the documents should be incorporated into the Sixth Plan. One example of changing population indicators which should be reflected in national social and economic planning is the recent downward trend noted in ideal family size, from four children to three.

- . Continue efforts to promote the interest and active involvement of cadres of other Ministries and national organizations in population/family planning activities through, e.g. meetings of the National and Regional Population Councils, ONPFP-sponsored workshops, seminars and round table discussions, training courses, technical assistance, invitational travel, provision of equipment and educational materials. The use of RAPID should be considered as a means of facilitating discussions, at both policy and service director levels, on development implications of population trends. The programming of funds by the ONPFP for these activities must remain flexible so that their use can be adapted to the commonly perceived needs of other Ministries and national organizations.
- . Consider the designation of one person with overall responsibility for analyzing the needs of other Tunisian agencies in terms of their population/family planning activities and strategies to meet those needs.
- . Further define and establish a plan of action for achieving effective implementation of the national policy of integrated family planning/basic health services. The Central Tunisia Rural Health Project should be used as a testing ground for the provision and management of family planning services, of acceptable quality, truly integrated with primary health care. (See Section III.C "Integrated Medicine" below).

B. Program Monitoring, Targets and Objectives

Over the last six months, following the Phase I Evaluation, the ONPFP has developed increasingly effective program surveillance and response mechanisms, including close coordination between the Statistical and Medical Divisions. On a monthly basis, activity reports of the Regional Family Planning Centers (CREPFS) and trends of method-specific performance for each governorate are analysed, allowing appropriate actions to be taken to reinforce and redirect, as necessary, field activities. The methodology of family planning program monitoring was further developed and refined during and immediately following the Phase II mission (see Bernard/Charfeddine report "Family Planning Monitoring in Tunisia, 1973-79: Findings and Implications for the Next Five Year Plan, 1982-86"). Recommendations for continued strengthening and expansion of ONPFP's epidemiological surveillance data collection and analysis capabilities include the following:

- . Continue monthly calculation and analysis of method and governorate-specific family planning acceptor rates (per 1,000 MWRA), providing quarterly (and later monthly) feedback to the regional family planning délégués. Family planning service statistics should eventually be analysed by age groups (15-29; 30-49) and urban-rural residence, as well.

- . Include as part of ONPFP's service statistics system the number of births occurring in maternities in each governorate, beginning in 1975. Outcome of deliveries should be classified by governorate and type of facility to permit monitoring of selected rates of mortality and morbidity and postpartum contraception.
- . Conduct a validity study (using an outside expert) of ONPFP's 1977-1980 service statistics.

Objectives, Indicators and Targets

Following careful analysis of recent trends in family planning performance during the initial phase of the evaluation, intensive discussions were held during Phase II on program objectives and means to increase contraceptive prevalence. Projection of performance by method, hence of demographic impact, is uncertain at this time in the wake of several years of plateau and a distinct drop in all methods last year, despite considerable resource inputs. This is particularly notable for the most effective method, tubal ligation, which should have benefited from increased training of physicians, placement of laparoscopes in all governorates, and provision of transportation of clients, but has, in fact, declined. It is universally agreed that better management of the family planning service infrastructure -- so that services potentially available are actually available in fact -- would definitely improve program performance. Recent improvements in peripheral management and morale observed on field trips elicited group optimism about future trends that was, fortunately, borne out by preliminary results for February which were up 18 percent over results of the year before (see Figure 9, Appendix E). Attention focused on achieving intermediate objectives of improving service capacity for quantity and quality of family planning acts, which is largely controllable by the ONPFP, would provide the best opportunity for a favorable future trend in program performance. Given the laudable ONPFP policy of maintaining full availability of all methods (except vasectomy) for all Tunisian couples, but with some programmatic emphasis on IUDs in rural areas and on tubal ligations in cities, it is not now clear whether women will opt more for IUDs or tubal ligations. The one slender early indicator available, the February 1980/1979 service statistics, indicate an 18 percent rise for tubal ligations and a 28.5 percent increase in IUDs. The overall incidence trend since 1974 has been gradually up for IUDs, partly related to favorable public image of the "copper apparatus," but slowly down for tubal ligations, for reasons that are not clear.

One set of reasonable forecasts for method performance that emerged from Phase II group discussions projects a doubling of the annual input of new public family planning protection by 1986 (see Figures 10, 11 and 22, Appendix E). This forecast assumes greatly expanded

availability and use of tubal ligations, introduction and gradual expansion of injectables, and slightly decreased although continued high levels of IUD use. Pill and secondary method use are assumed to increase. The unique feature of the Tunisian family planning program -- its balanced mix of methods -- would continue over this period, although with a slight shift towards methods with greatest demographic impact (see Figure 13, Appendix E). Key factors governing the attainment of these goals will be the success of the ONPFP in penetrating more deeply into rural areas not yet covered by the program and assuring the participation of an adequate number of OBGYNs and nurse-midwives who make up the backbone of the service delivery program. Among the priority actions which the ONPFP should take are:

- . Finalize, in joint meetings with the INS and Ministry of Plan, the set of family planning and demographic objectives for the next Plan period, 1982-1986.
- . Formulate a series of intermediate objectives centered around program elements which will facilitate the attainment of overall demographic objectives.
- . Develop a matrix of indicators and reasonable managerial targets using a systems flow gram to show the achievement sought at each level (see Appendix F).
- . Examine regional family planning trend studies (see Bernard/Charfeddine report) determining reasons for low or high performance. Immediate remedial measures should be directed at priority areas in Central and Southern Tunisia, particularly Sidi Bouzid, Medenine, Kairouan and Gabes where over 90 percent of married women of reproductive age are not currently receiving ONPFP services.
- . Establish reasonable areal targets of achievement through comparison of performance levels of units within the areas.

C. Family Planning Services

ONPFP management of family planning services has shown marked improvement in recent months, particularly since the Phase I Evaluation (as noted above). Actions and decisions which have had an important impact include:

- . formulation of strategies for increasing family planning prevalence in rural areas and for achieving integration of family planning and health services
- . automated national monitoring of service activity in all centers

- . expansion and organization of the Medical Division to include three physicians, two supervisory midwives and ten support staff working team-style
- . assignment of governoratal ONPFP organization and management of services to délégués
- . assignment of two female educators for post-partum and other client education/motivation in each governorate
- . involvement of regional health and family planning personnel in practical seminars focused on their needs and participation

Service insufficiencies associated with recent national program performance decline have been due to difficulties in:

- . obtaining rural OB/GYN coverage through contracted foreign MDs
- . obtaining Tunisian midwife coverage due to small numbers and the lack of practical and clinical experience of trainees
- . obtaining active participation and collaboration of Governors, Regional Health Directors, heads of MOPH services, medical schools etc.- all preoccupied with other pressing problems, and most considering family planning to be the responsibility of others
- . managing the entire enlarged family planning service systems--including facilities, personnel, supplies, equipment, transportation, communication, training, supervision--so that services are widely available and of acceptable quality
- . creating and maintaining a climate of reassurance of clients despite problems of side-effects and method failure
- . extending services and increasing user prevalence in rural areas of sparse populations, long distances, minimal health infrastructure, and limited economic opportunities and social services

The action to strengthen routine effort and the new initiatives sketched below (most described further in the background documents prepared by the Family Planning Directorate and the Medical Division) should improve family planning services and significantly increase program impact if steadfastly pursued over a five year period. The detailed list of activities which follow imply a long-term effort. Implementation of a number of these measures has already begun. For those which are clearly new initiatives, it will be necessary to choose a limited number of those of highest priority to obtain a feasible and implementable program during the coming year.

1. Strengthen Existing Program Activities

a. Increase availability of family planning services.

- . manage existing infrastructure better through monitoring of service capacity, governoratal review of service statistics (center-by-center and method-by-method), rapid feedback of results, team self-evaluations and decentralization of service initiatives, conjoint workshops for identification and resolution of problems and realistic/motivated setting of regional targets through "management-by-objectives" negotiations

- . develop infrastructural and activity indicators and targets at governoratal and national levels for:

- ONPFP Service Providers

- . e.g. Mobile Teams (days worked in month; home delivery consultations at targeted centers in month, etc.)

- . e.g. Tubal Ligation Teams (OB/GYN operating hours in a month; transportation shuttles in a month; targeted centers serviced in a month; tubal ligations in a month by delegation residence, etc.)

- . e.g. "Animatrices" in maternities (number of women informed in a month; percent of women delivering in maternities informed, etc.)

- Ministry of Health Service Providers

- . e.g. for all governoratal facilities (provincial hospital, auxiliary hospital, MCH centers, urban dispensaries, rural dispensaries, health rooms, assembly points)--percent of each type of facility actively providing FP services as classified on a five point scale

- . at the national level, monitor service infrastructure, service capacity, and service outputs using "management by exception" to identify the best and worst areas, seek reasons for variations in performance and then identify priority actions for focused efforts

- . at the regional level, facilitate provider setting of objectives and targets through integrated workshops using regular discussion of monitored results, and team-planning techniques (such as "Nominal Group Technique" for identification of service problems, and "Force Field Analysis") for identification of a strategy for action

- b. Improve the quality of family planning services.
 - . improve clinical services by standardizing policies and procedures through Medical Committee decisions, procedure manuals, seminars, training and supervision, (e.g. establish pre-and post-laparotomy procedures, specify the number of cycles of oral contraceptives to be distributed to a continuing user, etc.)
 - . set minimum standards of equipment, supplies, staffing, training and supervision of personnel for each category of facility providing family planning services, and monitor to assure that these standards are met
 - . through appropriate training and supervision, assure that service personnel receive clients agreeably, listen to and dialogue with them sympathetically, identify their problems and advise them correctly, reassure them and maintain continuity through proper use of files and forms
 - . identify strengths and weaknesses of services through discussion with local organizations, and through inclusion of a consumer voice (satisfied users, discontinuers and non-acceptors) in assessments of family planning service quality
- c. Strengthen and decentralize ONPFP management of family planning services.
 - . in addition to actions in a & b above, use improved monitoring of service outputs to make the ONPFP delegate and supervisory midwife responsible for the interpretation and improvement of outputs, while supporting provincial personnel in development of the needed skills
 - . increase the number and length of supervisory contacts between Medical Division staff, regional staff, and governoratal family planning service providers
- d. Strengthen support components of the national family planning program.
 - . strengthen communication in family planning services through educational or linking personnel, by use of aides familiales or through reinforced collaboration with personnel of local organizations like the UNFT, ATPF, etc.; make tapes and other educational materials specifically for reassurance of rural women; develop instructional flip-charts for client education in family well-being; use two animatrices to integrate motivation of the population with clinical family planning services

- . reinforce central supervision through scheduled monthly workshops in all six health regions, regrouping délégués and supervisory midwives with ONPFP staff, plus unscheduled site visits to verify conformity to procedures; field supervision should be extended to adequately cover all service points annually, and to assure adequate follow-up care of clients with method complications
- . strengthen biomedical research, which gains new tools for family planning services as well as the participation and endorsement of the elite medical community
 - send documentation on all new methods under review to the Biomedical Research Center (BRC)
 - provide technical assistance, including epidemiologist review of protocols and biostatistical consultation on significance testing, to the BRC
 - carefully estimate the maximum number of biomedical research studies that can be carried to completion by current personnel
 - accord priority to research projects likely to yield practical and immediately usable results (see Section III 2b below)
 - review progress of biomedical research program yearly
 - publish in La Tunisie Médicale abstracts of the best medical student theses on family health, family planning, community medicine, and/or rural health
- e. Stimulate participation of Ministry of Health facilities and personnel.
 - . activate and monitor services in MOPH facilities through involvement of MOPH Heads of Services, Regional Health Directors, Hospital Administrators, key doctors and supervisory paramedicals in regional workshops together with ONPFP délégués, supervisory midwives, and central cadres, actively continuing the excellent seminar methods developed by the Medical Division
 - . develop reporting procedures between ONPFP délégués and MOH hospital administrators that are acceptable to both
 - . maintain ONPFP funds for training in family planning, and for technical assistance to trainers of MOPH personnel

- f. Stimulate participation of private/commercial sectors in family planning.
 - . include private sector family planning service outputs in monitoring national prevalence of contraception
 - . increase (perhaps double) medical school hours of education in family planning
 - . increase basic education in family planning for pharmacists and pharmacy technicians
 - . increase family planning seminars for private physicians, and for paramedicals who assist them
 - . subsidize family planning material for private sector use, and facilitate acquisition of special items, e.g. copper IUDs, injectable progestagens, etc.
 - . consider creation of ONPFP medical coordinators to relate to regional medical communities and to medical school faculties

- g. Strengthen special programs.
 - . revitalize postpartum (and post-termination of pregnancy) programs in maternities (PPM)
 - meet periodically with Chiefs of maternity services and hospital administrators to gain accord for reinforcement of postpartum education for family planning by assignment of adequate paramedical priority and time
 - establish effective visiting schedules for the two animatrices assigned to postpartum education
 - develop manuals, training and supervision appropriate for PPM education (see example of 1968 manual in Supplementary Documentation)
 - encourage immediate choice of contraceptive before discharge, e.g. condoms, foams, postpartum IUD or injectable progestagen
 - gather current statistics on deliveries in all facilities, and percentage of these receiving postpartum education and methods
 - designate a committee to monitor standards and administration of maternities and MCH centers

- associate selected maternities in the Maternity Care Monitoring program and research to improve their services
- . increase the effectiveness and efficiency of the mobile teams program
 - designate an educational agent (e.g. animatrice sociale, aide familiale, UNFT volunteer, etc.). to work in each community in association with visits by mobile teams
 - conduct educational/motivational work in each community just prior to scheduled visits of mobile teams
 - obtain collaboration of dispensary nurses with mobile teams via their participation in workshops and through the participation of their administrative and supervisory superiors in the Ministry of Health
 - improve auto maintenance and repair services to reduce idle time of mobile teams
 - use summaries of daily logs of mobile teams to compare their performances, and to identify high and low performers, and reasons for and approaches to higher productivity
 - reroute mobile teams according to socio-demographic and geographic criteria for greater efficiency, taking care not to abandon follow-up services for users
 - create new mobile team programs in underserved areas, e.g. Menzel Temime, etc.
 - evaluate the cost and the cost-effectiveness of mobile teams, and the incremental cost-effectiveness of adding various educational agents and approaches to them (AID should provide 3-4 weeks consultation by an experienced health economist)
 - evaluate the several field experiments of combining mobile with other services, e.g. pediatrics (Sfax), selected interventions (Jendouba), preventive services at "meeting places", etc. to clarify the pros and cons, and the comparative cost-effectiveness of these approaches to servicing dispersed populations

- . promote "integrated medicine" with a strong family planning component. Integration into basic health services could assure widespread availability and continuation of family planning services, but it could also absorb and extinguish them. Hence ONPFP must promote and monitor to assure actual delivery of family planning.
- ONPFP and MOPH should hold multilevel discussions on modalities of integration of family planning and health services, with minutes (proces verbaux) sent to the Commission on Integration
- in the AID-assisted rural project area (Siliana-Sidi Bouzid-Kasserine-Gafsa Nord) organize fully integrated governorate-wide basic health services including family planning services of acceptable quality. Provide adequate foreign technical assistance and counterpart Tunisian physician leadership.
- reorganize and retrain service personnel for polyvalence and teamwork, patient education, family planning counseling, team level management, and collaboration with social service personnel
- consider and adopt useful components from the special projects that have attempted various kinds of integration, through meetings of the Chiefs of these projects and through multidisciplinary regional workshops. These should be done so as to favor Tunisification of projects and to improve regional management of health/family planning services
- create adequately structured bodies to deal with required decision-making at the policy, legislative, technical and training levels, e.g. Commission on Legislation for Integration, Regional Health Council, Technical Committee, Training Committee. These groups should assure the quality of services, prescriptions, and the training of physicians and paramedicals; the achievement of functional decentralization of administration; a close association of medical and paramedical training schools with regional health/family planning services; the continuing education of services personnel; and collaboration with social services and other sectors
- ONPFP should continue to monitor selected indicators to insure adequate family planning performance in integrated areas and facilities

- h. Develop and implement a comprehensive rural strategy for penetration of underserved rural areas, especially in South and Central Tunisia. Délégues should develop such plans together with representatives from the areas concerned.
- . for rural areas, successfully implement the special programs indicated above, as mobile teams are needed to bring professional services to dispersed populations, and integration of services and coordination of resources are necessary where these are sparse relative to need
 - . the P.D.G. and Heads of the Family Planning Directorate and Medical Division should examine on site rural family planning approaches used in other successful national family planning programs, e.g. Indonesia, Thailand, Mexico etc.
 - . to assure that selected target areas make progress and are not forgotten, monitor advance of chosen intermediate indicators on coverage, e.g. % service points functioning, physician hours available at centers, midwives posted, % midwives retrained for rural supervision and teamwork with MOPH nurses, etc.
 - . hold frequent meetings and workshops to promote coordination, teamwork and motivation of rural family planning/health/social personnel. Reserve central ONPFP and regional budget and man-days for this to combat "forgotten area" attitude of rural personnel. Use ONPFP resources to train rural personnel of other agencies, e.g. agricultural extension, UNFT, social affairs, education, etc.
 - . enforce minimum duration of visits to profit from costly transportation, e.g. at least one-half hour in centers visited by mobile teams, at least one-half day in regions visited by the Medical Division, etc.
 - . emphasize quality of care and education for IUD clients in rural areas
 - . introduce family planning methods liable to be popular in rural areas, e.g. injectable progestagens, postpartum IUDs
 - . develop linking personnel in rural communities to make personal liaison between families and mobile teams or health/family planning personnel, e.g. aide familiale volunteers, and development agent, etc.

- . supply rural personnel with large quantities of simple, pictorial educational materials on family planning designed for Tunisian rural illiterates
 - . involve rural men in discussion of family planning
 - . assess attitudes, knowledge and practices of rural population toward family planning methods and actual family planning services through "mini-surveys" and group discussions
 - . try out successful innovations developed in rural-oriented special projects, e.g. downward delegation of clinical and contraceptives tasks, where possible, controlling quality through supervision
 - . consider busing of women to family planning services
- i. Improve use of family planning methods.
- . increase acceptance of tubal ligation (TL)
 - through increased educational activity and coordination with postpartum and postabortum programs, promote TL acceptance in urban areas
 - insure that a trained OBGYN or surgeon, and an anesthetist, preferably Tunisian, is available for TLs in all governorates for at least a minimum number of operating hours per month
 - train and supervise doctors and midwives for standardized pre- and post-operative TL procedures
 - insure adequate transportation of clients to and back from TL (at least one full-time vehicle per governorate), and coordination between education, transportation and operating teams
 - insure that all centers doing TL have minimum equipment, supplies and trained personnel to deal with commonest problems and emergencies likely to occur
 - establish procedures and train peripheral personnel to insure adequate follow-up and referral for clients who have complications or problems after return home following TL

- insure that all governorates have functioning laparoscopes and recruit a second trained maintenance man
- eliminate special monetary incentives for personnel providing TL wherever possible, so that all personnel will contribute efforts toward promoting it
- through training and leadership from Dr.Ghachem (Beja) encourage performance of TL under local anesthetic on selected patients
- reinforce priority of TL through more regional seminars, increasing the number of Tunisian doctors in the laparoscopic/sterilization training program, increasing contact and referral between ONPFP regional pilot centers and maternities
- elicit support of private medical community toward TL through Study Days and sharing of program results

increase acceptance and use of intra-uterine devices (IUD)

- through midwives of mobile teams, reinforce availability of IUD insertion in all rural areas
- train medical students in CREPFs in proper IUD insertion prior to their rural service
- through a technical commission, elucidate the main causes of recent increase in IUD withdrawals
- generalize the availability of copper IUDs thru public and private markets

increase use of oral contraceptives (OC)

- field test for acceptability, then generalize availability of low estrogen OCs
- increase OC profit margins in private sector
- insure that OP50 is available in all public and private facilities
- visit pharmacies (by ONPFP pharmacist) in all regions to promote full stocks of OCs

- insure that resupply of all OC users is with minimum regulation number of cycles, to reduce unnecessary client travel time and discontinuation

increase acceptance and use of secondary methods - condoms and foams

- distribute through factory health rooms
 - field-test acceptability of public or male workplace vending machines
 - distribute through preventive health personnel visiting meeting places (points de rassemblement)
 - distribute at family planning discussion groups with men
 - promote distribution through extension cadres in other sectors, e.g. rural development (consider offering a prize annually to the best such distributor of secondary methods.)
 - subsidize souk vendors of condoms
 - distribute jelly, foam or condoms immediately post-partum to interested parturients, in anticipation of resumption of intercourse
- j. Create a physical infrastructure that stimulates and responds maximally to public demand for family planning.

insure adequate equipment for family planning services

- set up a commission to determine minimum equipment standards of facilities, and to estimate mid- and long-term needs of CREPF and MOPH facilities
- bring under-equipped CREPFS up to standard, e.g. Zaghuan, Kairouan, Medenine, Gafsa
- equip all centers performing tubal ligations with equipment necessary for handling TL related emergencies, e.g. electrocardiograph machine, defibrillator, small aspirator, surgical aspirator
- develop a program for routine replacement of worn-out equipment, especially for mobile teams where depreciation rates are high

- before deciding whether to generalize each of the following, study the cost, feasibility, skilled manpower required, yield, and capacity for follow-up of: mobile clinics, PAP smears and clinical laboratory test equipment in CREPFS (beyond that for urine albumin and sugar, and simple blood hemoglobin)
- facilitate acquisition of family planning medical materials by private practitioners

insure adequate stocks of effective drugs and family planning supplies

- set up a commission to evaluate short and mid-term needs
- review current system of pricing and nomenclature of new drugs and their commercialization, e.g. Norigest (WHO)
- use the newly created supply service in the Medical Division to improve the administration of stocks

rationalize use of physical facilities

- standardize forms and filing systems of all service facilities to improve continuity of care and follow-up

k. Develop adequate numbers and competencies of family planning health personnel (see also Section III D, Training).

abolish all but absolutely essential special payments, offering personal training and development programs as incentives to effort

create community and family planning oriented training and field studies for medical students using resources of the rural health project, the community medicine faculties of the three medical schools, and inputs of foreign universities

encourage women Tunisian medical students to specialize in obstetrics/gynecology and pediatrics

develop a public health training degree and training program that is one to two years long as an alternative to the current four year program

maintain interest of Chiefs of services through their collaboration in research on human reproduction and family planning

make 1,2,5,10 year projections of medical and paramedical manpower needs for family planning in Tunisia

2. Introduce new special programs, family planning methods, and uses of existing infrastructure.

- a. Initiate new special programs.

do systematic education/motivation postpartum for women who deliver at home. Train matrons (traditional birth attendants) in healthier practices, and use them for liaison with women who deliver at home. Establish liaison and reporting of home deliveries through local civil authorities. Establish home visiting educational services using local animatrices or aides familiales, and link these with consultation by mobile teams. Organize local resupply and follow-up for rural acceptors of contraception in this home postpartum program.

- b. Conduct field trials of new family planning methods.

under policy guidance of a special Tunisian medical research committee on injectable hormonal contraceptives, field test the public acceptability and continuation rates of available injectable progestagens judged safe and approved by the World Health Organization. Send 2-3 Tunisians, including the researcher responsible for field testing injectable progestagens, to Chiang Mai, Thailand to study their organization of services. The chief investigator should develop a collaborative protocol among the principal gynecologic and family planning services. Policy questions to be decided include whether or not to administer estrogens with the injectable progestagen to regularize menstruation, whether or not to administer progestagens to nursing mothers, whether to field test norethisterone enanthate or depo-medroxyprogesterone acetate or both, etc. Assuming good public acceptability, the medical committee should elaborate a strategy for generalization of injectables, including special educational materials and training of service personnel.

conduct a field trial of available IUDs designed for immediate postpartum insertion. Provide technical assistance in design and protocol (e.g. Dr. Laufe, IFRP).

- . extend the number of centers inserting IUDs immediately after termination of pregnancy, and monitor results. Dr. Ajmi Talaouche should make a seminar presentation of his results and provide practical training of selected gynecologists in the CREPF of Sousse. Field test IUDs especially developed for this use, eg CuT220c, multiload 250, Alza TIPC all used in WHO coordinated collaborative field trials.
 - . conduct field trials of subdermal implants with a progestational agent
- c. Extend use of existing infrastructure.
- . introduce family planning education systematically into well-child clinics in maternal-child health centers. Send midwives and animatrices to the Nabeul program for practicums in this approach
 - . introduce family planning education at "points de rassemblement" in conjunction with the visits of the nurse hygienist, perhaps in combination with child weighing and nutrition education services

D. Training

Establishment of the National Training Center (NTC) in 1979 has enabled the ONPFP to begin needed revision of training methods and materials; to identify trainees' needs for on-the-job skills; to develop approaches that make trainees more understanding and supportive of clients; to train trainers for decentralization of training into five regions; to stimulate and assist Directors and trainers of professional schools to develop and include family planning in basic curricula, as already begun for midwives at all three universities and in three of the 14 paramedical training schools; and, to develop ONPFP personnel at the governorate level in the competence to make and implement a governoratal educational plan. This increased capacity for educational diagnosis and training is an important national resource for development of Integrated Medicine, and getting personnel in other organizations (e.g., social affairs) to contribute their efforts to the national family planning program. It is not clear, however, whether projected training resources will be adequate for accomplishment of the increased volumes of training and the multiple objectives required. These objectives are enumerated below, followed by recommendations for a greatly expanded and more effective national training program in family planning.

1. Develop national training policy, priorities and plan.
 - . appoint a Commission on Manpower Needs for Family Planning to project the numbers of each kind of personnel that will need training in family planning in 1980-81 and 1982-86. Represented on the Commission should be: MOPH Planning Unit and Training of Cadres Division and School; Medical Schools; Family Planning Directorate, Medical and Communications Divisions of the ONPFP; National Training Center; Social Development, Ministry of Social Affairs; and others with needs for training of personnel in family planning or with resources to contribute to it.
 - . draw up specific, time scheduled implementation plans to accomplish designated targets in each of the six objectives listed above
 - . develop comprehensive, regular statistics on all outputs of training efforts, including
 - in-service training of FP providers (doctors, midwives, etc.)
 - basic training of professionals and paraprofessionals
 - curricula developed
 - training materials developed
 - consultations with trainers and training institutions (e.g. pharmacy school)
 - job/task analyses completed
 - evaluations completed
 - . encourage decentralization of training by the NTC back-stopping quantity and quality of training activities in each governorate, helping délégués to formulate educational programs, and improving skills, methods and materials of local trainers
2. Develop regional and governoratal training.
 - . plan, organize, train and equip five Regional Training Centers
 - . convene a three-day workshop at the NTC to teach délégués systematic approaches to community diagnosis and development of an educational program (see Appendix G). Each délégué will develop a governoratal training plan and, as a group, regional training plans and schedules. Progress on these schedules should be monitored at bi-monthly délégué meetings in Tunis.

3. Increase medical school education in family planning beyond the current four hours and improve its quality through:
 - . increased ONPFP physician contacts with faculties
 - . guest lectures from international specialists to ONPFP programs (e.g. JHPIEGO gynecologists)
 - . reinforcement of family planning documents in libraries
 - . inclusion of faculty in family planning biomedical research
 - . technical assistance for selected medical student theses on family planning
 - . development of FP/MCH portion of community medicine program
 - . ONPFP collaboration with the rural health projects in Siliana-Sidi Bouzid, and elsewhere, to reinforce family planning teaching of medical students during supervised field courses in rural community medicine. This would significantly aid achievement of the national policy of Integrated Medicine.
4. Assure adequate family planning training of all paramedicals through in-service clinical experience to complement their currently theoretical basic education.
 - . designate ONPFP personnel to visit paramedicals at work sites to assess continuing education needs for family planning training
 - . develop an orderly training plan and schedule through collaboration of NTC, Training of Cadres Division (MOPH), directors and teachers (moniteurs) of paramedical training schools, délégués, general supervisors (governoratal), and hospital administrators
 - . enlarge and improve family planning training in the basic curricula of the 14 Schools of Public Health
5. Improve the training of personnel from other sectors and organizations (e.g. Ministries of Social Affairs and National Education, UNFT, UGTT, etc.) by identifying their particular training needs, training their trainers, and developing training plans by regional and governoratal representatives together with ONPFP délégués.

- . assemble an inventory of personnel to be contacted in various organizations. Monitor progress against indicators based on such an inventory (For example, of the 4365 nurses aides working for the MOPH, how many have attended some kind of motivation/information session on their potential role in family planning? What percentage of them claim to do some educating of patients in family planning?)
6. Improve and enlarge the ONPFP training infrastructure and capacity as this is the chief vehicle through which the ONPFP can catalyze the increasing participation of various Tunisian organizations and personnel in family planning activities.
- . assure adequacy of funds budgeted for training for NTC programs
 - . supplement honoraria for physicians and midwives
 - . develop national technical assistance in a tiered, downwards application of specialized competencies, i.e.

national level supports regional level supports local training

NTC	Universities	Provincial Hospitals
Ariana Center	Schools of Public Health	Maternities
Bardo Center	→ ONPFP Pilot Centers	→ MCH Centers
School for Training of Cadres	Rural Health Project	Dispensaries
		Meeting points

- . train trainers in good teaching methods, especially midwives and doctors currently teaching in clinics
 - . run MCH/FP seminars with more student participation, narrower themes and deeper discussion of issues, smaller workshops, and more site visits for demonstration and practical field work
 - . send NTC Director and selected délégués (five) for 1-1 1/2 months participant training in training techniques and how to train trainers; or, alternatively, organize such training in Tunisia for all training cadres, using appropriate foreign technical assistance
7. Improve the nature of training to make trainees better listeners, reassurers, problem solvers, team workers and managers.
- . try some combined training of midwives with physicians (especially for laparoscopy and sterilization) to promote teamwork

- . develop worker-centered training by defining jobs, describing tasks of personnel, and the main problems they encounter, as well as facts and skills that they feel they need
- . use videotape for self-assessment in interpersonal relations at NTC and regional training centers
- . develop role play and other training materials from clients' verbatim accounts of problems encountered with methods
- . develop selected training materials in Arabic, e.g. those to train how to dialogue with clients
- . develop new training materials adapted to each of the techniques introduced into the program, e.g. injectable progestagens, post-partum IUDs, mini-pills, etc.
- . obtain prototype teaching materials used in other family planning programs, e.g. U.N.C., East-West Center, A.R.E. Program, etc.

E. Information, Education and Communication (I,E,&C)

The ONPFP has developed over the past seven years an active, broad-based information and education program on population and family planning, consisting of: campaigns, information days, seminars and round table discussions; home visits; education projects in secondary schools and in the organized sector; radio and TV broadcasts; newspaper and magazine articles. (For a discussion of ONPFP-sponsored training, see Section III.D). The success of these efforts is reflected in the results of the 1978 National Fertility Survey showing almost universal knowledge of family planning among ever-married women in Tunisia. The impact of ONPFP information and education activities has been greatest among educated, largely urban-based middle and upper classes where not only knowledge but practice of family planning has risen significantly. The major challenge now facing the ONPFP is developing, for the target rural population, appropriate and responsive educational activities and materials which reflect their concerns and educational level. There must be a concerted effort to dispel confusion and fears about contraceptive techniques and side effects, and to increase knowledge of method availability. This critical need has been underscored in recent evaluations of the IE&C program - 1976 "Assessment and Recommendations" (Rothe/MacMahon); 1978 "IE&C for Family Planning in Tunisia" (Bertrand); and 1979 "Phase One of the GOT/AID Evaluation of the Family Planning Program" (Maguire/Johnson).

The 1980 ONPFP Education Program stresses the importance of a variety of activities and materials directed at different social groups. A new feature which has strengthened considerably the urban program, in particular, is the addition of two animatrices in each governorate to provide information, education and motivation. For rural areas, emphasis is being placed on a greater number of information days, better collaboration with personnel of the Ministry of Social Affairs, ATPF, UNFP, etc. and increased use of mass media and audio-visual resources. The activities of regional délégués are being more closely monitored through a series of forms which are filled out and returned each month to the ONPFP Central Office, indicating the number and type of information and education activities conducted, media coverage provided, materials used and distributed and the motivation activities of the animatrices.

There was not enough time during the Phase II evaluation to address in sufficient depth a number of the key issues, including the I,E&C component of an expanded outreach program. In particular, strategies and implementation plans need to be detailed for developing new materials and activities to meet the family planning information and education needs of rural target groups.

Recommendations for strengthening specific aspects of the ONPFP's Information and Education program include the following:

- . Prepare annual national and governoratal communication strategies, identifying appropriate messages and media for each target audience and including detailed implementation plans.
- . Develop simple educational audio-visual materials (leaflets, small pamphlets, posters, etc.) on family planning, contraceptive methods and maternal-child health care for target rural populations, with low levels of literacy. Field workers and clients should be actively involved in the design of new materials which should explain in simple visual terms the different family planning methods available and how to use each one. These materials should address common problems experienced by family planning users as well as rumors, often-expressed fears and misunderstandings about different contraceptive techniques. They should explain what to do when a common problem arises.
- . Increase the production and distribution of educational materials so that there are sufficient quantities available in regional family planning centers, MOPH facilities and meeting places for use as instructional tools by midwives, paramedical personnel and outreach workers, and for handouts to individuals receiving family planning services.

- . Establish a system of pretesting and evaluating all I,E&C materials. Existing family planning educational materials (pamphlets, posters, radio scripts, etc.) should be carefully reviewed, assessing the appropriateness of the message and the impact on the target audience. Each new information product which is developed must be pretested prior to mass production and distribution. Once a year there should be an evaluation of ONPFP media products and educational activities with modifications introduced as necessary.
- . Promote greater use of male educators and educational dialogue with rural men on family planning. ONPFP educational staff and regional délégués should examine the feasibility of various approaches designed to increase the understanding and acceptance of family planning among men, e.g. (1) using mobile team chauffeurs to gather questions of men about family planning in tape-recorder sessions during visits to towns, such tapes providing the basis for question and answer format for national radio broadcasts; e.g. (2) man-wife teams for home visiting, etc.
- . Explore, on a regional basis, the use of other media (e.g. oral literature, photographs, wall murals) in family planning information and motivation activities in rural areas.
- . Identify essential personnel and technical skills and production capacity required for a strengthened and expanded I,E&C program. Current staff and short-term training needs should be examined. At a minimum, an audio-visual production specialist and a materials development expert must be added to the ONPFP staff. The development of new and more effective educational materials will require increased inputs of ONPFP regional field staff, expert consultants and local contractors.
- . Undertake a survey of the number, condition and use of audio-visual equipment in each governorate and review future ONPFP production, equipment and servicing needs.
- . Initiate a dialogue and exchange information and materials between ONPFP educational staff and counterparts in countries with innovative family planning I,E&C programs. Site visits are recommended for an ONPFP materials production specialist to countries such as Mexico, Thailand and the Philippines as well as to U.S. institutions such as the East-West Communications Institute and University of North Carolina which have developed extensive family planning prototype materials.

Other recommendations for the ONPFP's Information and Education program include:

- . Consider sponsorship of a weekly popular music program for radio with short items on population and family planning and the addition of family planning messages to the "Dr. Hakim" program.
- . Produce a 15-20 min. 16mm film on family planning on an annual or biannual basis, as needed
- . Increase utilization of bulk mailing of materials (to audiences ranging from village leaders to government officials)
- . Obtain additional materials for the ONPFP library - articles on family planning communication, audio-visual aids and examples of media output, etc.

F. Research and Evaluation

The 1980-1986 ONPFP Research and Evaluation program is ambitious and carefully planned, addressing the need for operationally-oriented research and rapid feedback of findings to guide field activities. To insure the systematic presentation of a large body of data, major questions concerning population and development in Tunisia will be presented in the form of comprehensive research files. These files will be published on a timely basis in the Tunisian Review of Population Studies and updated biannually. They will also serve as background materials for special meetings, workshop discussions and conferences. A synthesis of significant ONPFP research will be presented to the National Population Council and incorporated into the Sixth five-year Plan. Research priorities for 1980-1986 include the following:

- . compilation of socio-economic, demographic, health and family planning infrastructure and activity data by delegation for each governorate (18 governorate profiles will be published by the end of 1980 and a national summary in early 1981)
- . analysis and publication of results of the following surveys: 1979 IUD and pill continuation survey; study of social abortions during the 1970s; 1978 national fertility survey; 1979 Jendouba contraceptive prevalence survey. Survey findings will be widely disseminated and discussed with national and governoratal family planning and health authorities. A regional seminar and series of workshops are planned.
- . inventory and comprehensive, comparative analysis (to be completed by the end of 1980) of the results of special projects (PFAD, PFPC, PFMR, Medjez el Bab, le Kef, Nabeul, Gafsa, Mahdia, etc.) and of the innovative family planning/health delivery systems

tested. Key program options (regarding interventions, personnel, resupply, referral, etc.) should be identified with recommendations for approaches to be incorporated into a national strategy of family planning service delivery which insures broader and more effective coverage of the rural population.

- . studies of incremental cost-effectiveness of promising family planning service components, e.g. mobile teams, aides familiales. Procedures for determining costs and outputs from additions to services need to be established, using outside technical assistance.
- . studies dealing with socio-economic factors affecting family planning (e.g. cost and value of children, family size, impact of rapid population growth on development efforts)
- . assessment of the impact of increasing age at marriage on fertility
- . monitoring and evaluation of the impact of ONPFP's educational program and activities in organized sectors
- . contraceptive continuation surveys (every five years)
- . periodic surveys of contraceptive prevalence in the private sector and biannual interviews with private medical practitioners
- . national contraceptive prevalence survey (with an infant mortality component) to be conducted the end of 1981
- . joint study with INS of fertility, mortality and underregistration of vital events
- . family health and epidemiological studies
- . expanded biomedical research program focused on programmatically useful field trials (e.g. injectable progestagen, low-dose estrogen pills, postpartum/postabortion IUDs).
- . initiation of Maternity Care Monitoring studies (with technical assistance from the International Fertility Research Program) in selected maternities in Tunis, Sousse and Sfax. Studies should be expanded later to smaller maternities.

The ONPFP has managed to conduct an impressive array of special studies and surveys in the last several years thanks to the efforts of a small, experienced and dedicated research and evaluation staff and to the ability to sub-contract various projects. However, in order to accomplish the objectives and activities of the 1980-1986

program outlined above and maintain high quality research, additional staff will be required -- several programmers, another statistician, experienced demographer and economist. With the current salary structure at the ONPFP, it has been very difficult both to attract and then keep for an extended period, qualified demographers and researchers. There must be a concerted effort to deal with this problem and to insure that there are sufficient technical personnel in the Population Directorate so that individual staff members can increasingly take advantage of short-term training opportunities, attend conferences, provide technical assistance, and extend collaboration with other GOT agencies. Another important issue is providing stronger, more efficient and more cost-effective data processing capabilities at the ONPFP (see Section III.G below).

G. Program Management and Administration

During the course of the Phase II evaluation, major aspects of ONPFP management and administration were carefully reviewed, focusing in particular on project implementation, personnel, budget and fiscal administration, equipment and vehicles, contraceptives, commercial retail sales and management information systems. Special organizational strengths identified include: excellent financial management; a high degree of budgetary independence and flexibility; an advanced data collection system; and hard-working, competent staff. A number of weaknesses, noted during the first phase of the evaluation, in program monitoring and support of field activities have been corrected by restructuring operations and administrative procedures. An important factor influencing effective program management in the future is continuity of key ONPFP personnel during this transition period. The following recommendations are designed to assist the ONPFP to maximize present resource potential and further strengthen its planning, managerial and administrative capacities to support and fully implement an expanded field program.

The ONPFP should:

- . Develop detailed implementation plans covering each major activity, including postpartum/postabortum program, introduction of injectables, rural outreach program (mobile units and aides familiales), tubal ligation program, I,E&C and training. These implementation plans should: 1) include quantified, time-phased inputs from all sources (human, material, logistic and support activities); and, 2) assign specific responsibility to officers charged with program execution, monitoring and supervision.
- . Undertake a thorough analysis of personnel requirements for an effective field program (esp. program monitors, researchers, statisticians/computer programmers, I,E&C production specialists, OBGYNs and midwives, animatrices/aides familiales).

- . Increase the budget for locally procured medical equipment and drugs.
- . Assess vehicle needs required for an expanded, intensified rural program and determine, in discussions with different donor agencies and the GOT, the most satisfactory means of meeting these needs.
- . Begin making budgetary provision and establish commercial arrangements for procurement of contraceptives (at AID contract prices if possible) in the 1982-1986 Plan period.
- . Review the shelf-life and rotation procedures of orals and condoms.
- . Reschedule additional shipments of Noriday 1+50 and examine ways of increasing local market promotion and use.
- . Monitor trends in commercial sales of orals and condoms, generating new projections annually, and stimulate greater expansion of the private sector program.
- . Continue to strengthen ONPFP's planning, monitoring and support functions and consider fail-safe schemes to insure that phenomena such as illnesses, vehicle breakdowns and logistic snags, etc. do not jeopardize full availability of services on a planned and consistent schedule.
- . Determine cost-effective ways of strengthening data processing capabilities (e.g. acquisition of a mini-computer and additional software packages; hiring of several programmers and a computer specialist) to handle payroll, stock management, processing of service statistics and survey data, etc. AID should provide technical (and financial) assistance to help meet ONPFP's software and hardware needs for efficient processing of management information.

IV. FUTURE RESOURCE COMMITMENTS

National family planning program achievements in increasing contraceptive knowledge, availability and use, in combination with socioeconomic and political factors encouraging smaller families, have resulted in substantial fertility decline in recent years and reduction in Tunisia's rate of population increase. Nevertheless, rapid population growth remains a serious problem. At the current population growth rate of 2.5 percent, Tunisia's population of almost 6.5 million would double in only 27 years. During the next five year Plan period, there must be expanded commitment of resources to the national family planning program and greater efficiency in using them if the GOT is to achieve its demographic and social and economic development goals.

The ONPFP currently faces several major challenges - one is rebuilding family planning program momentum from the recent period of plateau in performance levels. A second challenge is redressing serious regional imbalances in contraceptive availability and use. A third is that of stimulating other national organizations to assume greater roles and activities in support of family planning, particularly the Ministry of Health. Their policy of "Integrated Medicine," if actually implemented, could create a large scale availability of family planning services through its approximately 10,000 personnel in 1,000 facilities. Redirected, greatly intensified and more effective efforts are needed in rural areas. Priority target areas are Central and Southern Tunisia which contain approximately 25 percent of MWRA but which have very low levels of contraceptive prevalence. At the beginning of the 1982-1986 Plan, the program will be in a transitional phase reaching out into new areas, experimenting on a large scale with various delivery systems, introducing a new contraceptive on a broadening scale (injectables) and building the managerial capacity to sustain a high level of program effort and performance. With increased funding and better targeting of program effort, the ONPFP should achieve during this five year period a much higher demographic impact.

A. GOT Support

During the course of the Phase II Evaluation, efforts were made to quantify the elements of a newly strengthened program in terms of human, material and financial resources. Initial ONPFP budget estimates from 1982-1986 are \$49.6 million (excluding MOPH inputs), of which the proposed GOT contribution is \$29 million. These are only preliminary figures and will have to be carefully examined and revised in the coming months in discussions with GOT and donor agency officials. GOT financial support of the family planning program has shown a steady increase in recent years. In light of overall declining donor assistance, it is critical that during the Sixth Plan there be a significant proportional increase in GOT financial commitment to guarantee continuation of the necessary long-term effort and the implementation of an expanded, intensified national effort which integrates family planning with basic health services.

B. AID Support

As the largest single donor agency, AID has played a leading role in the development and expansion of the Tunisian family planning program providing over the period 1974-1980 some 31 percent of ONPFP operating plus activities budget. During the 1982-1986 Plan Period, continued AID assistance is essential if the ONPFP is to achieve significant increase in program performance. Following termination of the current AID bilateral agreement, adequate levels of support must be maintained through AID-funded intermediary organizations

IPAVS, JHPIEGO, FPIA, Population Council, Westinghouse Health Systems, IFRP, Universities of Chicago, Johns Hopkins and North Carolina etc.- with assistance in areas such as clinical services, training, rural outreach efforts, expansion of voluntary surgical sterilization, information and education activities, program monitoring, research and evaluation. Efforts must now be directed at insuring expanded, more effective and better coordinated and administered AID-funded intermediary support of the ONPFP program in the future. The transition to increasing independence of the ONPFP program must be orderly and carefully planned to avoid major disruption of program activities and to assure that the momentum generated by AID assistance is self-sustaining.

For the remaining two years of the current bilateral agreement, 1980-1981, the Phase II Evaluation strongly endorses USAID efforts to accelerate the obligation of the balance of funds programmed and to obtain additional funds, if possible, during this period to support new program initiatives. From initial budget estimates, AID support being sought by ONPFP for 1982-1986 (\$14.5 million) exceeds what can realistically be provided. The evaluation team recommends that AID and ONPFP carefully examine over the next several months overall budgetary requirements for 1982-1986 and proposed assistance levels. Since AID population funding levels during the next Plan period remain uncertain, the ONPFP should continue to develop its plan and budget estimates for 1982-1986, based on achieving maximum impact from resources already committed. Estimates of incremental program impacts which could be realized with modular additions of AID funding should be identified.

C. Other Donor Support

The role of donor agencies in support of the Tunisian population/family planning effort over the past fifteen years has been a vital one - enabling the ONPFP not only to expand its activities and services but also to adapt to changing situations and technologies, drawing from lessons learned elsewhere and proceeding rapidly to integrate new technologies into the national program. Financial, technical and material assistance from the UNFPA, IBRD, AID and other donors must continue during this transition period of redirected and expanded family planning program effort. Given limited resources, it is important that this assistance be well coordinated, complementary and respond effectively to GOT needs, structures, programs, and absorptive capacity. Efforts must be made to limit information and time demands by donor administrations on MOPH and ONPFP personnel.

V. TUNISIA'S INTERNATIONAL ROLE

As a small, stable country with a moderate foreign policy, strong orientation toward social development, and the current site of the Arab League, Tunisia is accessible to many developing countries as a place to see and discuss the merits, problems and methods of family planning. The Tunisian family planning program has an importance that far transcends its own borders. It serves as a leader and an example for other Arab and Francophone African nations in terms of the legal, philosophical and religious framework it provides for family planning and the full range of services and activities offered. Outstanding features of Tunisia's population/family planning policy and program which have attracted the attention and interest of other countries include:

- . early and sustained official government recognition of the population growth problem, of its reciprocal relationship with socio-economic development and of the importance of family planning to both
- . a humanistic approach to family planning as an integral part of basic health care and family well-being
- . an impressive array of national laws that support a couple's right to determine the size and spacing of their family
- . Islamic leaders' backing of the program
- . a well-balanced service program offering free access to all methods of birth control
- . multisectoral activities in support of family planning
- . a well-developed service statistics and monitoring system of family planning acceptors and contraceptive prevalence by method and governorate
- . comprehensive education, research and evaluation programs
- . international training in laparoscopy, sterilization and reproductive health

The Tunisian family planning program has become an increasingly important demonstration and training site visited by delegations from numerous other African and Near East countries. In the last two years, OBGYNs and midwives from 16 Francophone African, one Caribbean and four Near East countries have been trained in surgical contraception. The number of foreign medical and paramedical personnel receiving training in Tunisia will continue to grow in the next several years. Another area where Tunisia has provided some assistance, and which has potential for

expansion, is orientation and motivational training in family planning and Islam for religious leaders from other Muslim countries. A program has recently been developed for 150 ulemas of Bangladesh, over a period of two to three years, to receive training in Tunisia on Planned Parenthood, Family Welfare and Islam.

Tunisia has also played a prominent role in Maghrebian conferences on Demography, Family Planning and Maternal-Child Health. The ONPFP arranged to have family planning featured in the meetings this year of the Association of Arab Physicians in Tunisia and in the Maghreb Medical Congress in Morocco. In the future, it is likely to become an increasingly active participant and spokesman in regional and international forums on population/family planning issues. Moreover, ONPFP staff will be called upon to provide short-term technical assistance in this area to sub-Saharan Francophone African and other Arab countries.

With the acquisition of additional computer hardware and software, the ONPFP could eventually be developed into a regional data collection, processing and analysis center with training capacity to service some of the needs of other Francophone and Arab countries. The ONPFP has made great strides in epidemiological surveillance of family planning performance and is beginning to monitor maternity care as well. Such a rich data source on family planning and maternal-child health should be made available to other countries in the region. The feasibility of developing, at some future date, a family planning communications, production and distribution center for the region should also be explored.

In the decade ahead, Francophone sub-Saharan African and other Near East countries, in an era of increasing technical cooperation between developing countries (TCDC), will continue to examine and benefit from Tunisia's experience as they develop and expand their own family planning activities. Tunisia was a leader in development of a strong national family planning program in the 1970s. During the 1980s, it will hopefully provide an example for the region of successful implementation of comprehensive rural outreach programs, as well as of integration of family planning services fully and effectively into basic health care.

APPENDIX A

EXECUTIVE SUMMARY OF PHASE I EVALUATION

APPENDIX A

Tunisia Family Planning Services

(A.I.D. Project No. 664-0295)

Mid-Term Evaluation (Phase One) Report

October 1979

SUMMARY

The Tunisian Family Planning Program began as a small pilot project in 1964. Over the past fifteen years it has developed into one of the largest and most comprehensive family planning programs in Africa and the Middle East. In 1973, the National Family Planning and Population Office (ONPFP) was created as a semi-autonomous agency within the Ministry of Public Health, with responsibility for planning, coordinating, implementing and evaluating all family planning activities in Tunisia. The ONPFP headquarters in Tunis administers a nationwide information and education program, medical, research and evaluation activities as well as a national training center, a model clinic and training program in laparoscopy. In each of Tunisia's eighteen provinces, there is a Regional Center of Family Planning and Education. Free contraceptive services and education in family planning are provided at approximately 617 hospitals, family planning clinics, maternal and child health centers, dispensaries and mobile units throughout the country. The program has enjoyed broad political, popular and religious support. A committed government leadership has enacted important legislative reforms encouraging small family size and permitting comprehensive family planning services.

Program Impact: Quantitative and qualitative indicators point to the impressive gains achieved by the Tunisian family planning program. In this country of 6.1 million inhabitants, the crude birth rate has fallen from 48 per thousand in 1965 to a current rate of 33.9, the lowest level in the Arab world. Between 1975 and 1978, the marital fertility rate dropped from 262.3 per thousand married women of reproductive age (MWRA) to 240.6, a decline of 8.3 percent. Contraceptive prevalence nationwide, estimated at 10.1 percent in 1975, reached 21.3 percent in January 1979 according to ONPFP calculations. Early data of the National Fertility Survey suggest that current levels of contraceptive prevalence may be even higher; an estimated 47 percent of MWRA have used or are currently using a modern method of contraception. The achievements of the Tunisian Family Planning program and its President Director General (P.D.G.),

Mezri Chekir, were recognized in 1978 when the ONPFP was awarded by U.N.E.S.C.O. the International Humanitarian Medal for outstanding work in the field of population. Moreover, the program has assumed an important leadership role on the continent of Africa and in the Middle East. In the past two years the Ariana Center in Tunis has trained medical and paramedical personnel from 15 countries in laparoscopy and human reproduction. Increasingly, high-ranking Ministry of Health officials from other countries in the region are coming to visit the Tunisian family planning program.

Concerns with the future development of the program focus on three facts. Nationally, program performance, as measured by family planning acceptor rates among MWRA seems to have entered a period of plateau or even decline. There continues to be a large disparity between rural and urban Tunisia in the availability and use of family planning services. Despite steadily declining fertility, the crude death rate has dropped to a low of 8.1 per thousand resulting in a current annual rate of natural population increase of 2.6 percent, or an estimated net rate of 2.1 percent.

History of A.I.D. Involvement: There has been substantial AID assistance to the Tunisian family planning program since 1965, totalling over \$26 million, including \$14.2 million through such intermediary organizations as IPAVS, FPIA and JHPIEGO. During the early phase of AID assistance, emphasis was placed on the development of an infrastructure and training of professional personnel to provide leadership and local expertise. The second phase of the assistance program (FY 75-77) was designed "to continue 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." Although a project phase-out was originally planned for FY77, the results of a 1975 evaluation recommended continued AID assistance. The primary purpose of the current four-year (1978-1981) \$6.6 million bilateral program is "to assist the GOT to strengthen and expand family planning services primarily in rural areas." Program activities include: pilot community based contraceptive distribution projects, training, general systems support including supply of contraceptives and equipment, research and evaluation, IEC support, short-term participant training and technical assistance.

Recent Project Accomplishments: The ONPFP has taken major steps towards realizing the objectives of the current bilateral grant agreement. Accomplishments over the past two years include:

- An expanded and strengthened nationwide educational and administrative structure with offices, staff and programs in each of Tunisia's eighteen provinces
- Pilot projects testing different household and community-based distribution systems with the goal of developing an appropriate model for a nationwide strategy
- A national training center, operational since March 1979
- An expanded research and evaluation activity
- Expansion of the clinical program to include voluntary sterilization using laparoscopy
- Establishment of a model clinic with a national and international training program in laparoscopy
- The maintenance of performance levels during a period of program expansion and penetration into less easily served rural areas
- The demonstration of the importance of a female family planning outreach worker for program effectiveness in rural areas.

The Evaluation Process: An in-depth, two-stage evaluation is being carried out at the mid-point of the current 1978-1981 bilateral agreement. It is designed as a joint, participatory GOT/USAID effort. The first phase (September-October 1979) concentrated on collecting and synthesizing program data and establishing an agenda of issues. It was characterized by an open and frank exchange of views and cooperative dialogue between the team and officials of the Ministry of Public Health, other ministries and agencies, members of the medical faculties and, especially, with the personnel of the ONPFP, led by the P.D.G. The second phase of the evaluation, now tentatively scheduled for late February or early March 1980, will focus on establishing new program priorities and directions for the remaining two years of the bilateral agreement and subsequent assistance efforts. It will also help provide the population and family planning framework for Tunisia's Sixth Five Year Plan, 1982-1986, now in the early planning stages.

Program Issues: The challenge currently facing the family planning program in Tunisia is the consolidation of recent achievements as a means to expand activities and raise performance in rural

Tunisia. The following issues, identified during the first phase of the evaluation, are among those which need to be addressed to achieve that objective.

1. Define the future role of family planning with respect to the national policy of integrated health care in rural Tunisia.
2. Strengthen the existing infrastructure and the delivery of services in rural areas by promoting greater:
 - a. national/regional communication and support
 - b. multisectorial collaboration in meeting rural problems
 - c. decentralization of decision-making so that existing resources, human and material, are effectively deployed.
3. Encourage more effective penetration of rural areas through
 - a. generalizing a program of community-based distribution of contraceptives and postpartum services
 - b. assuring the availability of all family planning services, including tubal ligation and IUD insertion in rural areas.
4. Strengthen the ONPFP administrative capability and thus its capacity to respond to and manage rural programs by developing a management-oriented information system, enlarging planning and management units, expanding mid-level technical personnel and strengthening the Medical and Population Divisions.
5. Expand the recruitment and training of medical and para-medical personnel to serve in rural Tunisia.
6. Develop and implement an IEC program to meet the informational and educational needs of rural women and male heads of households in the area of family planning.
7. Improve the management and effectiveness of AID assistance through:
 - a. more careful programming of assistance categories, including a detailed scope of work and expected outputs

- b. closer administration and monitoring of on-going projects by USAID, ONPFP and the intermediary organizations
- c. an annual review of AID assisted activities
- d. greater focusing on rural programs in regions which are the least served in south and central Tunisia.

The Future of AID Assistance: Each year the Government of Tunisia has played a larger financial role in support of the family planning program and the percent of donor support has declined. Phase Two of the evaluation will address the issue of phase-out of bilateral assistance and the further development of alternative funding mechanisms to assist the GOT in extending service delivery in rural Tunisia and maintaining a strong and viable program, able to meet national demographic objectives while serving as a model and training center for family planning programs in the Middle East and Francophone Africa.

APPENDIX B

PHASE II EVALUATION TEAM COMPOSITION AND LIST OF PERSONS CONTACTED

APPENDIX B

A: Phase II Evaluation Team

	<u>AID</u>	<u>ONFPF</u>
Team No. 1: Family Planning/Medical Activities	Dr. Melvyn Thorne *	Dr. Rifaat Mrad Dali
Team No. 2: Information, Education and Communication	Dr. James Echols	Dr. Sadok Kouniali
Team No. 3: Research and Evaluation	Ms. Elizabeth Maguire * Dr. Roger Bernard	Mr. A. Charfeddine
Team No. 4: Administration/Management	Mr. William Trayfors	Mr. Dimassi Mr. Benzarti
Coordination: Mr. Mourad Ghachem Miss Machat		*AID Team Leaders

B: List of Persons Contacted

AID/W

1. Elizabeth MacManus, NE/TECH
2. William Oldham, NE/TECH/HPN
3. Barbara Turner, NE/TECH/HPN
4. Catherine Fort, NE/TECH/HPN
5. Lenni Kangas, NE/TECH/POP
6. Marschal Rothe, NE/TECH/POP
7. Pamela Johnson, NE/TECH/SA
8. Mary Huntington, NE/NENA
9. Joseph Brooks, NE/NENA/T
11. J. Joseph Speidel DS/POP
12. Pat Baldi DS/POP
13. William Johnson DS/POP

USAID

Mr. William Gelabert, Director
Mr. Edward Auchter, Program Officer
Mr. William Kaschak, Acting Program Officer
Mr. Gerald Zarr, Legal Advisor

Dr. Oliver Harper, Health, Nutrition, Family Development Officer

Mr. Alan Getson, Family Planning Development Officer

Mr. Anwar Bachbaouab, Health, Nutrition, Family Planning Program
Development Specialist

U.S. Embassy

Ambassador Bosworth
Mr. David Mack, D.C.M.
Mr. John Grimes, Labor Officer
Dr. Newton Jassie, Medical Officer

USICA

Mr. William Gresham, PAO

Director, Print Shop
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Ministry of Public Health (M.O.P.H.)

Dr. Hannablia, Minister
Dr. Taoufik Nacef, Director of Preventive Services
Dr. M. Zouari, Deputy Director of Preventive Services
Mr. Mekki Chekir, Director, Planning Unit
Mr. Tahar Ben Youssef, Cabinet Attaché
Mme. Slama, Director, School of Cadres
Mme. Daghfous, Representative for International Relations
Dr. H. Rejeb, Director, Special Projects
Dr. Chakroun

Chiefs of OBGYN Medical Services

Personnel from Special Projects - Nabeul, LeKef, Gafsa, Medjez El Bab

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Mr. Mezri Chekir, President Director General
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* Dr. Rafaat Dali, Chief, Medical Division
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- * Mr. A. Charfeddine, Chief of Statistics and Programming Division
 - Mr. Kilani, Head, Research and Evaluation Office
 - Mr. Ben Messaoud, Project Coordinator
 - Mr. H. Grioui, Chief of Documentation Division
 - Mr. A. M'Zah, Librarian
 - Mr. Bradai, Print Shop
- * Mr. Dimassi, Director, Administrative and Financial Directorate
- * Mr. Benzarti, Special Assistant for Administration
 - Mr. Jelassi, Chief of Administration Division
 - Mr. Masnoudi, Chief of Finance Division
 - Mr. Moorad Ghachem, Chief of International Cooperation
 - Miss. Machat, Assistant, International Cooperation Division

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Dr. Hamda Guedri
Dr. Cherif Bahri
Dr. Khrouf
Dr. Zghal
Dr. Chamakh

National Children's Institute

Professor Bechir Hamza

National Statistical Institute

Mr. Tarifa

National Union of Tunisian Women

Mrs. Mzali

UNFPA

Mr. Cittone

* Phase II Team Members

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Kairouan

Mr. Daachoucha Taoufik, Regional Family Planning Delege
Mr. Youssfi Md., Regional Secretary
Mr. Md. El Aloui, Hospital Administrator
Ms. Ben Halima Arbia, Supervisory Nurse-midwife
Ms. A. Abide, Animatrice

Siliana

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Dr. Cannon, Dept. Community Medicine
Dr. Gomer, Dept Community Medicine

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Dr. Rekik, Head Dept. OB/GYN

Gafsa

Mr. Habdi, Regional Family Planning Délégué
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5 Administrators of Region of Gafsa, Sidi Bouzid, Metlaoui, Tozeur

Medenine and Gabes

Mr. Mohamed Bouchiha, Regional Family Planning Delegué
Mr. Bechir Beltaifa, Director of Hospital of Jerba
Dr. Ali Ben Ali, Medical Director of Zarzis Circumscription

Mr. Salah Bhourri, Governor of Medenine

Mr. Mehdi Chebbah, Delegate of Beni Keddache

Dr. Dhaouadi, Medical Director of Tataouine Chenemi Circumscription

Mme. Faouzia Chaffar, Midwife of Zarzis Hospital

Mr. Sgaier Habib, Regional Family Planning Dêlêgué

Social workers of Gabes and Medenine

Staff of Regional Planning centers and Maternities of Medénine,
Zarzis and Gabes

APPENDIX C

SUMMARY OF MEZRI CHEKIR'S OPENING AND CLOSING ADDRESSES TO
THE EVALUATION TEAM

APPENDIX C

April 1, 1983

thru: Anwar Bachbaouab, Health, Nutrition, Population Program Specialist
Oliver M. R Harper, Health, Nutr. Family Planning Development Officer
Project 664-0295 Family Planning Services, Mid-Project Evaluation

Summary of Mr. Mezri Chekir, President Director General, National Family
Planning and Population Office address to the joint evaluation team.
members 1st session. Friday March 18, 1980

to: the files

Participants: CNPPP: Mr. Mezri Chekir, President Director General
Mrs. Radhia Moussa, Director of Population
Mr. Mongi Echir, Director of Family Planning Services
Mr. Fahti Mzaoui, Administrative Director
Dr. Rida Chadi, Director, Ariana Clinic
Mr. Mourad Chachem, International Cooperation Division
Ms. Samia Machat, International Cooperation Division
Mr. Abdelmalek Charfeddine, Chief Statistics Service
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Mr. Boubaker Benzarti, Management Specialist
Mr. Kilani, Demographer, Population Division
Dr. Rafat Daly, Medical Director
Mr. Hedi Gricoul, Chief, Documentation Services
Mr. Mohamed Ayad, Demographer, Population Division
Mr. Abderrazak Thraya, Director, of Training Center

Evaluation team: Mrs. Elizabeth Maguire, Demographer-Research Specialist
Dr. Melvin Thorne, Physician Family Planning Specialist
Dr. James Scholz, Health Educator - Training Specialist
Mr. William Traylor, Management - Administration
Specialist

USAID/Tunis: Mr. Alan V. Gets n, Family Planning Development Officer
Mr. Anwar Bachbaouab, Health, Population, Nutrition
Program Specialist

After having welcomed the evaluation team and introduced his staff,
Mr. Mezri Chekir stressed the importance he attaches to the bilateral
program evaluation, reiterating his satisfaction at the collaborative
spirit that characterized the discussions between the two parties,
during the 1st phase evaluation. Mr. Chekir mentioned that phase one
report was thoroughly reviewed by CNPPP personnel and its recommendations
taken into account during the elaboration of CNPPP CY 80 programs.

Among the major changes implemented during the interim period between phase one and ~~phase~~ ^{stage} two Mr. Chakir cited personnel re-assignment at the regional and central levels, the restructuring of the two key departments of Population and Family Planning services and the introduction of improved program monitoring techniques.

Admitting the (deceptive) program performance during 1979 Mr. Chakir indicated that 1979 was a transition year in several aspects and pointed out at the recent ministerial change, elaborating on the difficulties encountered by NFPF at the Ministry of Health structural level, where, he said, the absence of a permanent Director of Technical Affairs to provide continuity of action hampers the implementation of policy decisions and programs, the result of several years of laborious efforts. Mr. Chakir stated that NFPF will continue to devote its effort to further promote a closer cooperation with the Ministry of Health departments. In this connection he mentioned his recent encouraging meetings with the newly assigned Director of Hospitals and Health Inspector General.

At this point Mr. Chakir introduced the subject of services integration stating that too much has been said about this complex process. This issue needs to be assessed in terms of infrastructure and human and material resources in order to "protect the gains of Family Planning" and assure an effective expansion of health activities as well as family planning in the rural areas. Mr. Chakir indicated that MOH has created a special study committee for the national policy of integrated health care. This committee will submit a report to the Ministry in the near future.

On the subject of NFPF plan of action for the next five years Mr. Chakir stated that emphasis will be placed on the consolidation of the program and the expansion of services particularly in the rural areas, this, he said, will require strengthening the existing family planning delivery services in both rural and urban Tunisia by ways of improved management, better service delivery and information programs designed to extend family planning education to the large segment of women living in the rural areas. Mr. Chakir also stated that NFPF efforts will be directed to research and the further development of training programs for medical and paramedical personnel in cooperation with the medical faculties.

Saying that the evaluation of the bilateral family planning project has another dimension as it coincides with NFPF program planning for the sixth five year plan. Mr. Chakir concluded with his best wishes

for success to the team, expressing his conviction that the same spirit of joint effort and open dialogue will be established during this 2nd phase of the evaluation.

cc: DIR
PRDG
HPH
Ms. Maguire
C&R 2

HPH:ABachb:umb:sc 4/1/83

APPENDIX C

Abril 1980.

thru:

Anwar Bachbouab, Health, Nutrition, Population Program Specialist
Dr. Oliver M.R. Harper, Health, Nutrition, Family Planning Development Officer
Family Planning Services, 2nd Phase Evaluation Debriefing Session with
Mr. Mezri Chekir, President Directeur General, National Family Planning
and Population Office, March 29, 1980.
the files

Mr. Mezri Chekir's address to the joint evaluation team members at the above mentioned meeting lasted some two and half hours and covered in detail each of the program areas of the Tunisian family planning program. The intent of this memo is to summarize only some of the major topics on new program priorities and directions introduced for the first time by Mr. Chekir:

I. Adolescent Fertility

Mr. Chekir stated that one of the challenges facing the family planning program for the next five years will be the development of appropriate educational programs and services responsive to the need of the younger generations. Existing programs must be further expanded to include universities, vocational training centers and youth clubs.

II. Impact of Population on Economic Development Planning

Mr. Chekir emphasized the need for the CNPFP Research Division to expand its coordination and collaboration with other agencies of the GPT such as INS and CERES, to develop studies and research programs to assist economic development planners in the various departments of the government to incorporate demographic considerations in the development of the planning process and to raise their level of awareness of the impact of population growth on the country's socio-economic development. In order to achieve this goal the CNPFP will increase the research potential of the Population Division by recruiting new talent on a contractual basis.

III. Incorporation of Population/FP Education in the Medical Faculties

Mr. Chekir stated that CNPFP will make a major effort to further strengthen the existing ties with the three medical schools of Tunis, Sousse and Sfax. A program of lectures and conferences on population and family planning will be established in coordination with the "Centre National Pedagogique" of the Ministry of Health and the deans of the three faculties. In addition CNPFP intends to further expand its medical research in close cooperation with the medical schools.

IV. Collaboration with the Private Medical Sector

CNFPF will study the possibility of increasing the participation of the private sector in the national family planning program. Ways and means of achieving this are not clearly defined but could include equipment, cost sharing, etc.

V. Conseil Supérieur de la Population

Mr. Chekir indicated that the Population Advisory Council to the Government of Tunisia will meet in the near future to review among other matters, the four topics discussed above.

cc: DIR
PROG
HPN
Ms. Maguire DS/POP/R AID/W ✓
C&R 2

Draft: ABachbaouab:sc 4/10/80

APPENDIX D

ABSTRACT, "FAMILY PLANNING MONITORING (FPM) IN TUNISIA (1973-1979):
"FINDINGS AND IMPLICATIONS FOR THE NEXT FIVE-YEAR PLAN (1982-1986)"
(BERNARD/CHARFEDDINE)

APPENDIX

FAMILY PLANNING MONITORING (FPM) IN TUNISIA (1973-1979):
FINDINGS AND IMPLICATIONS FOR THE NEXT FIVE-YEAR PLAN (1982-1986)

SURVEILLANCE DU PLANNING FAMILIAL (SPF) EN TUNISIE (1973-1979):
OBSERVATIONS ET IMPLICATIONS POUR LE PLAN QUINQUENNAL (1982-1986)

Roger P. Bernard

et

A. Charzfedine²

An Inquiry into the Trends of (Incidence and Prevalence)
of Protection and Fertility

Une Etude des Tendances des (Incidences et Prédominances)
de Protection et de Fécondité

Report developed in April, 1980, subsequent to the Bilateral
ONFPF/USAID Evaluation of the National Family Program in
October, 1979 (Phase 1) and in March, 1980 (Phase 2).

Etude effectuée en Avril, 1980, à la suite de l'évaluation
du Programme National de Planning Familial par une mission
Tuniso-Américaine en Octobre, 1979 (phase 1) et en Mars, 1980
(phase 2).

¹ Director of Field Epidemiology, International Fertility Research Program,
and International Federation for Family Health, Geneva, Switzerland.

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RÉSUMÉ / ABSTRACT

Cette étude propose un examen approfondi des résultats obtenus par l'ONPFP durant les premières sept années de son existence (1973 - 1979).

L'approche méthodologique est, par excellence, celle de l'épidémiologie analytique: la prédominance de protection effective (PPE) ainsi que l'incidence du nouvel apport (INA) de planning familial sont étudiées dans le temps (une séquence de sept années) et dans l'espace (18 ou 15 entités géographiques: les gouvernorats) pour en dériver le potentiel d'impact selon les méthodes. De même, "l'oeil épidémiologique" prend sous sa loupe la tendance de fécondité par âge pour en cristalliser un réservoir à grand potentiel pour l'action de PF.

(1) L'étude des tendances de l'éventail des méthodes (incidence) au niveau du gouvernorat permet alors de proposer une meilleure répartition des méthodes de PF pour augmenter très sensiblement l'impact démographique du programme national durant le prochain plan quinquennal (1982-1986). Une période de transition de deux ans (1980-1981) est jugée nécessaire et suffisante pour l'adaptation à un régime d'incidences qui mènerait à cette nouvelle répartition. La composition de l'éventail des méthodes va subir un enrichissement autant qualitatif que quantitatif en introduisant - petit à petit - les injectables et en favorisant une *évolution naturelle* de la composition de l'éventail des méthodes vers les méthodes à rendement démographique plus conséquent. L'équilibre du nouvel apport annuel atteint à la fin du plan quinquennal serait alors comme suit: 20% de méthodes secondaires, 30% de pilules, 30% de D.I.U. et d'injectables, et 20% de ligatures des trompes (Fig. 19). Les avortements sociaux évolueraient sans avoir fixé des objectifs - témoignant ainsi de l'efficacité du programme.

(2) L'étude des tendances de fécondité par âge (incidence) a démontré l'existence actuelle d'un très grand réservoir de femmes mariées, dans leur trentaine et quarantaine, à risque élevé de voir continuer leur fécondité bien qu'elles soient, pour la plupart, des grandes multipares dont les risques accrus pour la santé de famille (mère et enfant) sont à redémontrer aussi en Tunisie (Etude genre OMS: santé familiale). La convergence de ces deux risques réels justifie amplement la "médicalisation du PF" en introduisant en priorité les injectables et les ligatures des trompes comme une prestation de routine dans chacun des 18 gouvernorats. Il n'y a pas tâche plus grande que de garantir la mise en place de ces prestations au niveau régional durant 1980 et 1981 (Fig.23).

(3) L'étude des tendances de prédominance de protection effective (PPE) a permis de constater un arrêt du *progrès de la protection* durant l'année 1979 pour la Tunisie entière; l'analyse géographique montre que cela est le résultat d'évolutions opposées au niveau régional. Trois gouvernorats ont vu leur taux de protection augmenter de plus de 1% des FMAR: Gafsa, Sousse et Siliana. Suivent alors quatre gouvernorats avec un accroissement de 0.5-0.9%: Kasserine, Bêjâ, Le Kef et Monastir; tandis que les cinq gouvernorats suivants ont subi un accroissement minime (0.03-0.25%): Jendouba, Kairouan, Zaghouan, Gabès et Bizerte. Par le recul de leur niveau de protection générée à travers les années par le programme national de PF, les 6 gouvernorats suivants ont réussi à neutraliser le peu d'avance enregistré durant 1979: Sfax, Medenine, Tunis, Mahdia, Nabeul et Sidi Bouzid. A eux seuls, ils groupent 46% des FMAR. Cette observation montre bien que le programme national de PF doit accentuer ses efforts autant dans les grandes villes que dans le rural. Un programme postpartum bien fourni devrait aider à surmonter assez rapidement les creux qui se tranchent actuellement à Tunis et à Sfax, parmi d'autres (Fig. 5). La mise en place d'un système de surveillance des soins de maternité (SSM) permettra - parmi d'autres considérations - de quantifier l'apport nouveau de PF dans les institutions par rapport au dénominateur de l'obstétricien: le nombre d'accouchements. Les maternités ont besoin de "leur étude épidémiologique".

(4) L'étude des prédominances de protection effective au niveau régional révèle une très faible protection pour les gouvernorats de la Tunisie centrale et la Tunisie du sud (Figs. 2,3 et 4). L'étude des tendances d'incidence par méthodes montre par ailleurs que l'apport à travers les années a été généralement faible (Série des Fig. 9, en annexe). Il est évident qu'un apport substantiel dans ces gouvernorats devra se planifier dans le contexte d'un programme de santé rurale à mettre sur pied sans attardement. L'aide bilatérale a ici une occasion unique puisque les besoins ont été identifiés avec une précision épidémiologique exceptionnelle. Le défi est de concevoir et aider à réaliser en commun un projet combinant les aspects essentiels de la "santé de famille et de reproduction" -- les deux éléments étant inextricablement liés.

(5) Ce n'est que par le truchement d'un dénominateur commun (les femmes mariées en âge de reproduction: FMAR) que ce véritable tissu d'études épidémiologiques a vu se tisser en un temps record. La surveillance mensuelle du programme national de planning familial devient assez sophistiquée, puisque

l'Office a su se procurer les numérateurs par méthode et région, ainsi que les dénominateurs à travers le temps. Une ère nouvelle s'ouvre donc sur son deuxième septennat de travail ardu pour favoriser une pénétration équitable de l'action du PF à travers la Tunisie toute entière. La mise à jour systématique des profils épidémiologiques permettra de mieux saisir la nuance de l'effort nécessaire pour garantir un progrès réel dans chaque gouvernorat. Au moins deux fois par an une revue totale de l'évolution du programme de PF au niveau régional devient maintenant la réalité opérationnelle la plus promettante. Le programme est devenu transparent à ses propres points forts et faibles. L'analyse épidémiologique continue sera le meilleur garant pour le progrès optimal du programme national puisqu'elle agit comme agent promoteur au niveau régional.

(6) Une des finalités de la surveillance épidémiologique du programme national de planning familial est de déterminer ce qui est possible à réaliser dans le cadre d'un système grandissant, essentiellement mis en place durant le premier septennat de l'Office. Cette rétrospection quantifiée mène à prouver ce que les dirigeants de l'Office avaient commencé à percevoir il y a bien des années: que la médicalisation du planning familial -- la responsabilisation du médecin -- doit nécessairement intervenir pour mener le programme national à ses potentiels réels. Il faut bien le souligner, l'aspect quantitatif n'est pas un but en soi. C'est la médicalisation du programme qui va enfin permettre à la "santé familiale" de se déployer professionnellement à travers tout le réseau de la santé publique. De la surveillance du programme de PF à la surveillance des soins de maternité il n'y a qu'un petit pas de technicité: le dénominateur commun (FMAR) est soumis à un échantillonnage biologique: le souci de prévention et curatif se dirige surtout vers les femmes enceintes qui accouchent et allaitent parmi toute les femmes mariées en âge de reproduction. (FMAR). Le médecin penche son regard sur ce sous-groupe à haut risque. Une des grandes tâches nouvelles de l'Office est donc de soutenir de plus en plus les facultés de médecine et le ministère de santé dans une recherche ardue et par une surveillance des soins de maternité -- allant du début de la grossesse jusqu'à la fin de l'allaitement en passant par l'accouchement -- afin de garantir l'évaluation continue de la santé de famille dont le planning familial n'est qu'un volet - bien que l'un des plus importants. Ainsi, la surveillance du programme de PF apparaît comme le premier pas vers une surveillance plus large; aussi la surveillance des soins de maternité apparaît comme l'extension naturelle d'un processus mis en route par l'Office à travers le pays.

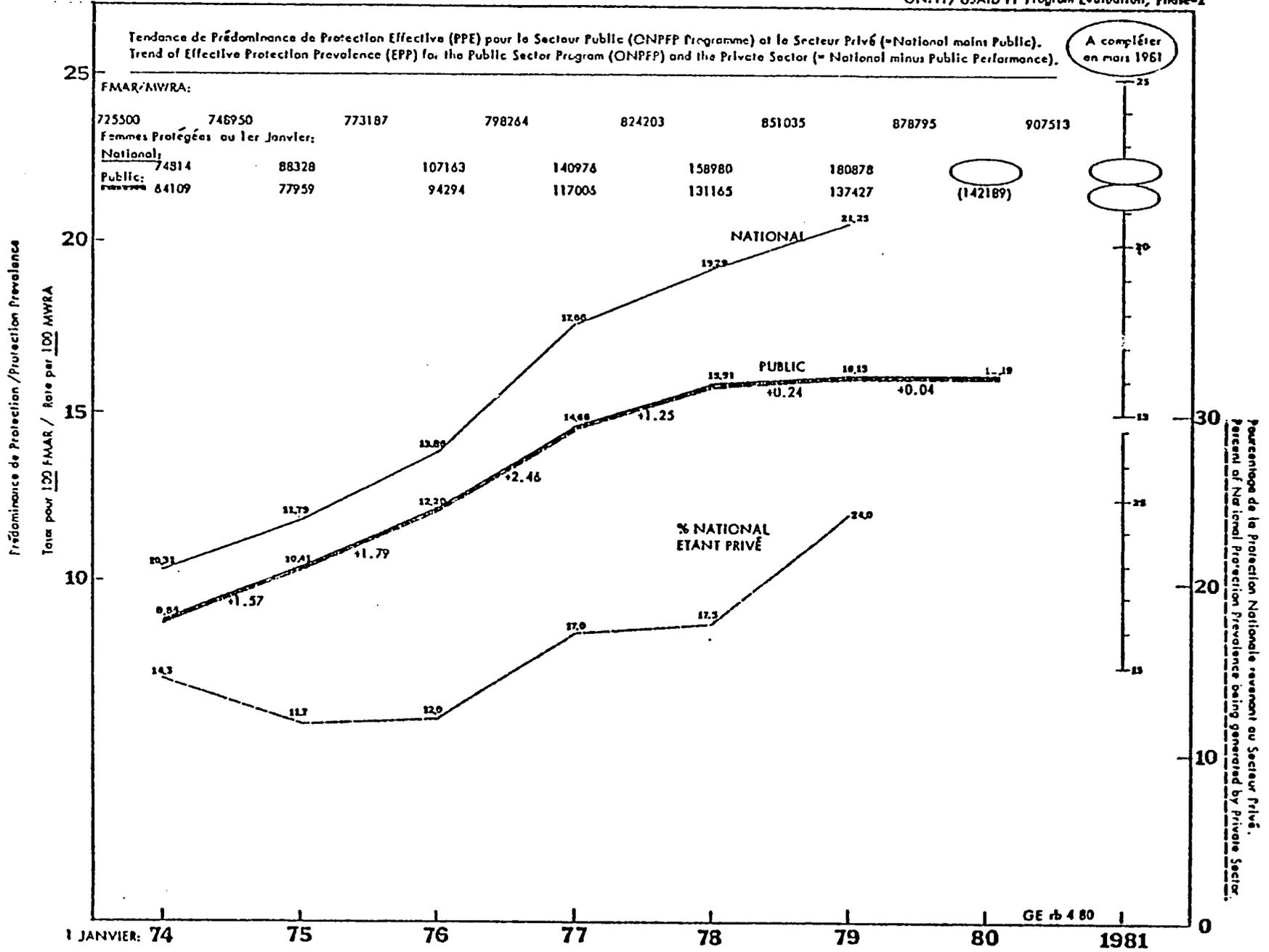
(7) Le caractère mixte, bilingue, de cette mission tuniso-américaine d'évaluation a posé - une fois de plus, hélas - le problème de communication et de compréhension mutuelle, en particulier lorsqu'il s'agit de mettre sur papier les observations et recommandations. En outre, ce travail d'analyse et de synthèse se propose d'aller bien au delà d'un rapport à ranger dans la bibliothèque. Il s'agit d'acquérir une façon de penser et de travailler qui génère des solutions tout au long de l'évolution d'un programme dont la phase actuelle n'est que transition. Nous traitons d'un seul élan toute une série de questions dont chacune est en fait une étude particulière dans un contexte complexe dans le temps et dans l'espace. (1) "Où avons-nous abouti aujourd'hui?" est traité par la protection actuelle; (2) "Que faisons-nous aujourd'hui?" est traité par l'apport nouveau de protection; (3) "L'éventail des méthodes influe-t-il sur la protection démographique ultérieure?" trouve une réponse par une comparaison de la prédominance de protection et l'incidence des méthodes à travers le temps; (4) "A quelle vitesse faut-il développer le "progrès" des incidences d'apport pour chaque méthode?" doit trouver une réponse dans l'évolution du passé pour chaque méthode dans chaque région, c'est-à-dire dans une étude des méthodes dans le temps et dans l'espace; (5) "Quels sont les groupes prioritaires de population à atteindre dans un programme de PF visant à un impact démographique précoce?" trouve sa réponse dans l'étude des tendances des taux de fécondité par âge: un réservoir important de femmes à double risque néfaste fut identifié (Fig. 23); etc.

De répondre à ce tissu de questions d'une manière cohérente et en se basant sur les faits n'est possible qu'immédiatement après une telle mission à échanges de vues et d'informations multiples et en profitant pleinement du privilège d'accès aux données fiables et des plus récentes. D'où la responsabilité accrue de partager tout ce qui semble faire sens lors d'une synthèse épidémiologique. Mais il y a aussi apprentissage continu et il importe de donner les étapes. Une telle esquisse méthodologique demande documentation successive. Il nous a paru que le trait d'union entre membres de la mission mixte et les collègues à diverses spécialisations est l'image scientifique, le graphique. Un grand soin a été appliqué à l'élaboration de ces 38 (23+15) graphiques documentés; c'est la vraie structure de ce travail et ayant comme point de départ une "mini banque des données". Ces graphiques et 10 tableaux en content bien plus que le texte en serait capable dans une version française ou anglaise. Les perceptions sont plus nuancées à partir d'une exposition permanente et continue des faits et des options esquissées. Par ailleurs, la liste des figures ainsi que celle des tableaux ont été donné dans les deux langues.

APPENDIX E

FAMILY PLANNING PROGRAM PERFORMANCE TRENDS AND PROJECTIONS:
FIGURES 1-13; TABLES I-III

Figure 1. TUNISIE

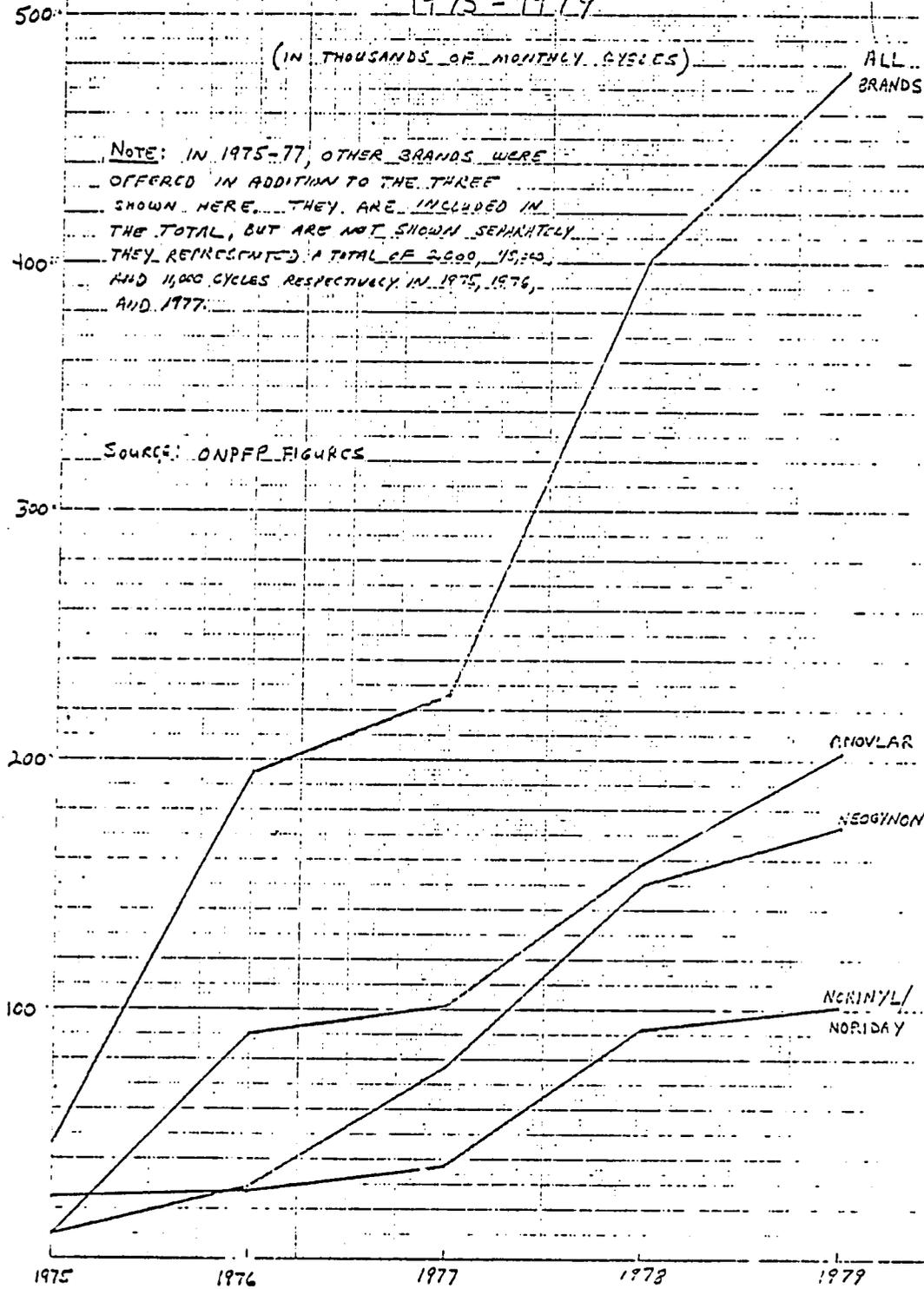


Source: Bernard/Charfeddine, Family Planning Monitoring(FPM) in Tunisia(1973-1979): Findings and Implications for the Next Five-Year Plan(1982-1986), April 1980, p. 6.

TUNISIA: EVOLUTION OF COMMERCIAL SALES OF ORAL CONTRACEPTIVES

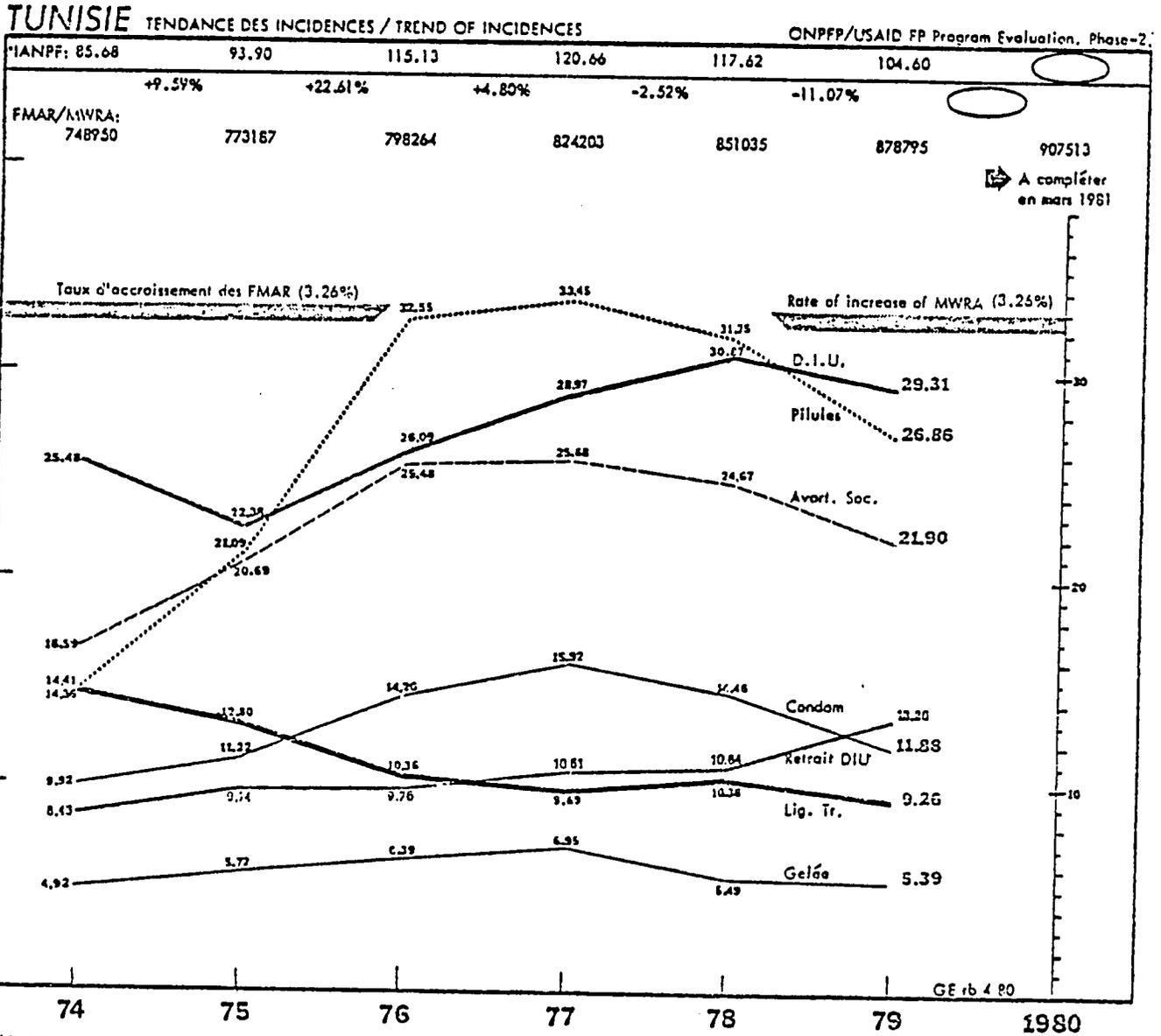
1975-1979

(IN THOUSANDS OF MONTHLY CYCLES)



NOTE: IN 1975-77, OTHER BRANDS WERE OFFERED IN ADDITION TO THE THREE SHOWN HERE. THEY ARE INCLUDED IN THE TOTAL, BUT ARE NOT SHOWN SEPARATELY. THEY REPRESENTED A TOTAL OF 2,000, 15,000, AND 11,000 CYCLES RESPECTIVELY IN 1975, 1976, AND 1977.

SOURCE: ONPFP FIGURES



* IANPF: Index d'Activité Nouvelle en Planning Familial : C'est la somme des 6 taux à l'exclusion du taux des retraits de DIU.
 PFPAL: Primary Family Planning Activity Index: This is the sum of the six input rates, excluding the rate of IUD removal.

Source: Bernard/Charfeddine, Family Planning Monitoring (FPM) in Tunisia (1973-1979): Findings and Implications for the Next Five-Year Plan (1982-1986), April 1980, p. 24/
 Note: For region-specific "method-specific trend profiles" see Figs. 9-1 to 9-15 in the Appendix (pp. 67-83).

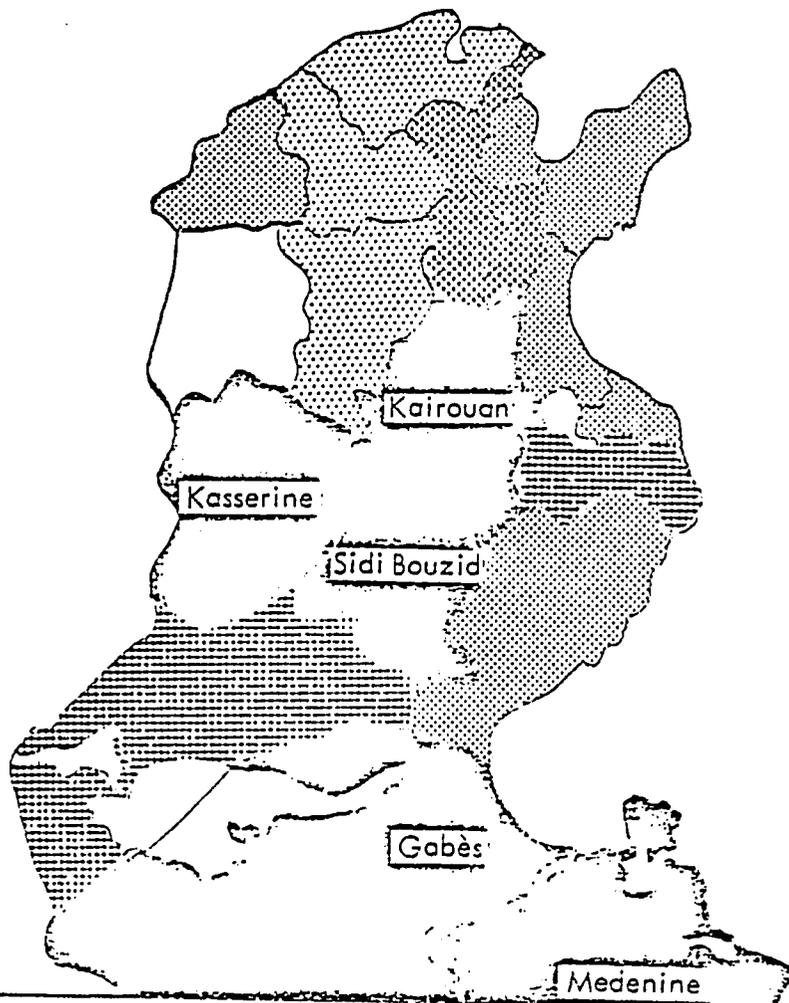
TUNISIE JAN. 1979

PREDOMINANCE DE PROTECTION EFFECTIVE (PPE): TOUTES METHODES, selon REGION
 EFFECTIVE PROTECTION PREVALENCE (ERP): ALL METHODS BY GOUVERNORAT

1 Janvier 1979

1 January, 1979

 Protection très faible / Very low protection rate
 ou
 Fécondité très forte / Very high fertility rate
 en 1979



	< 10 % FMAR	5 Gouvernorats
	10-14.9 % FMAR	3 Gouvernorats
	15-19.9 % FMAR	6 Gouvernorats
	20-24.9 % FMAR	3 Gouvernorats
	25-29.9 % FMAR	1 Gouvernorat

Source: Evolution Récente du Programme National de Planning Familial par A. Charfeddine
 Tableau F. Revue Tunisienne des Etudes de Population, 1ère Année, No 1, 1980.
 CNPFP, Tunis.

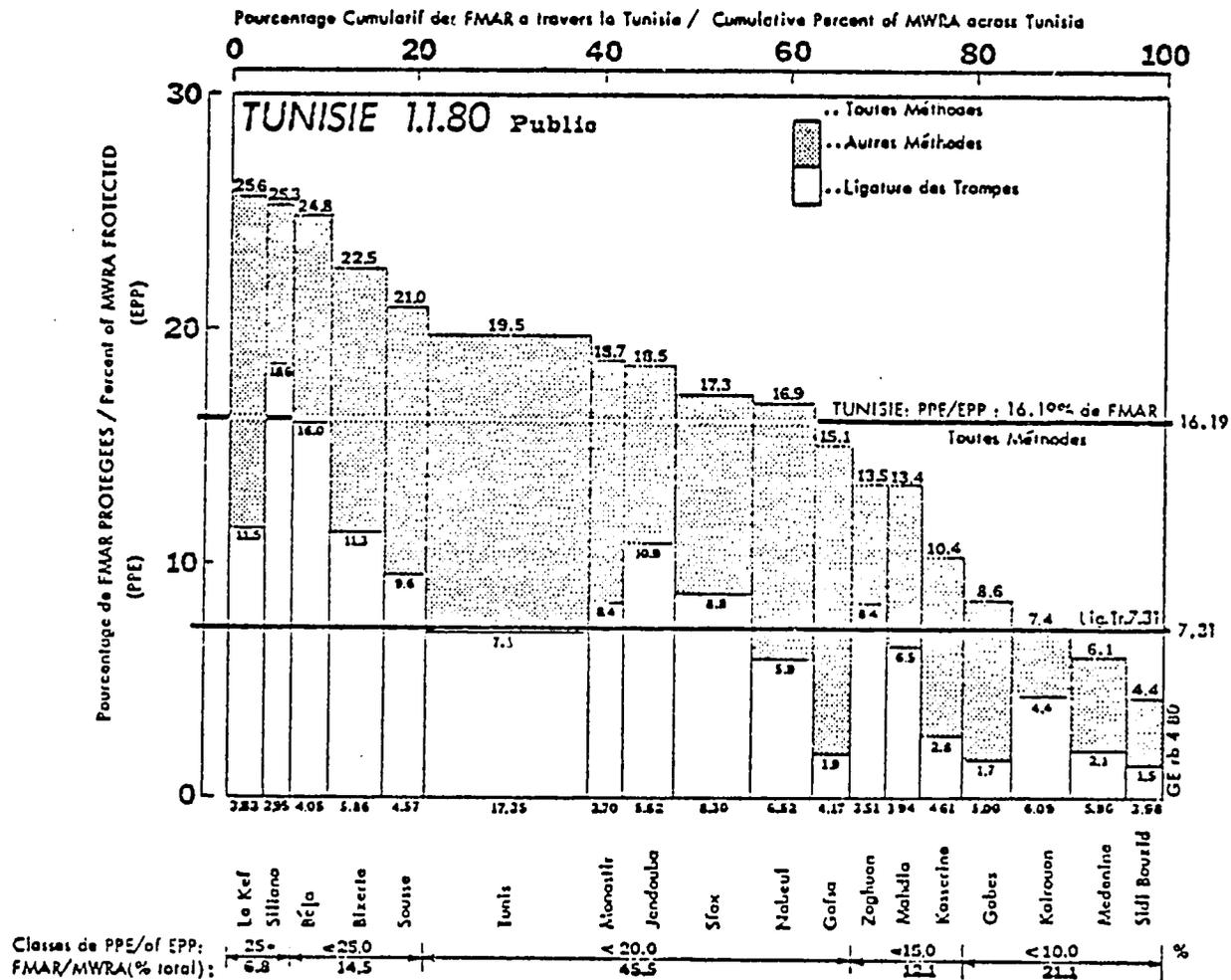
Reclassification des taux de protection: rb

GE rb 4 80

Source: Bernard/Charfeddine, Family Planning Monitoring (FPM) in Tunisia (1973-1980).
 Findings and Implications for the Next Five-Year Plan (1982-1986), April 1980, p. 11

Figure 2.

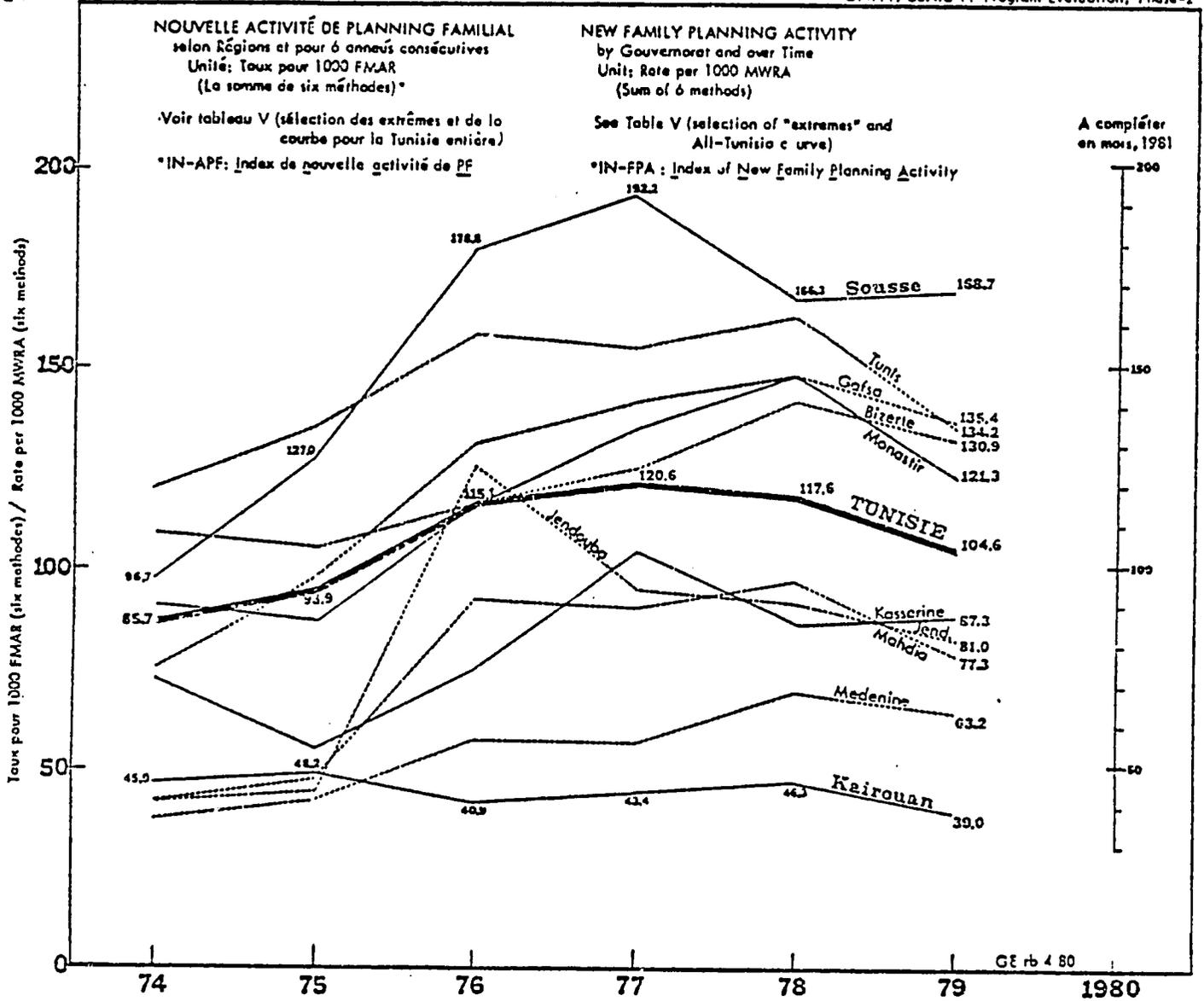
PREDOMINANCE DE PROTECTION EFFECTIVE (PPE): Selon Méthode de PF and Regions
 EFFECTIVE PROTECTION PREVALENCE (EPP): by Method of FP and Region
 Date: 1 January/Janvier, 1980



Source: Bernard/Charfeddine, Family Planning Monitoring (FPM) in Tunisia (1973-1979): Findings and Implications for the Next Five-Year Plan (1982-1986), April 1980, p. 9.

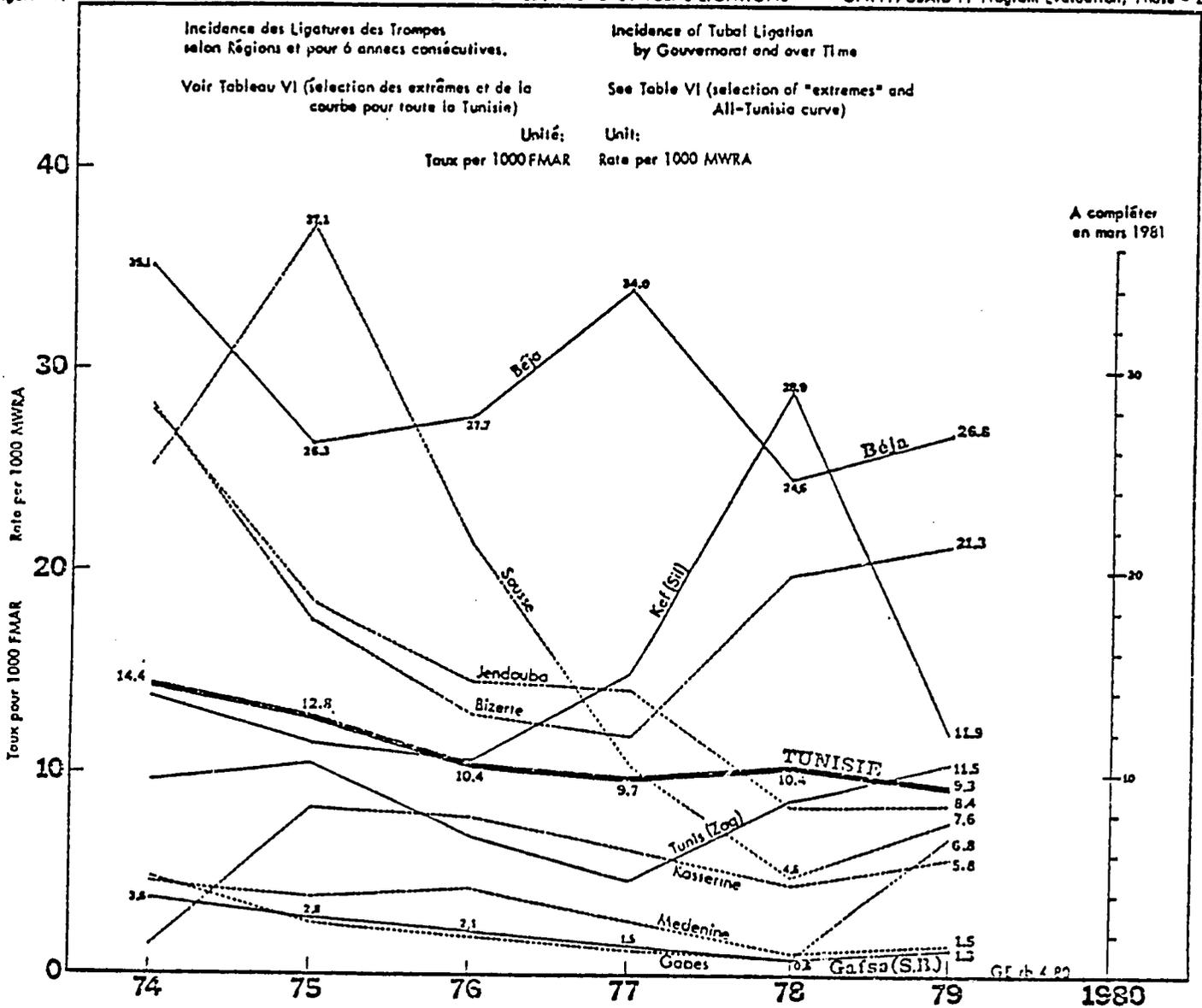
Figure 10. TUNISIE

ONFPF/USAID FP Program Evaluation, Phase-2



Source: Bernard/Charfeddine, Family Planning Monitoring (FPM) in Tunisia (1973-1979): Findings and Implications for the Next Five-Year Plan (1982-1986), April 1980,

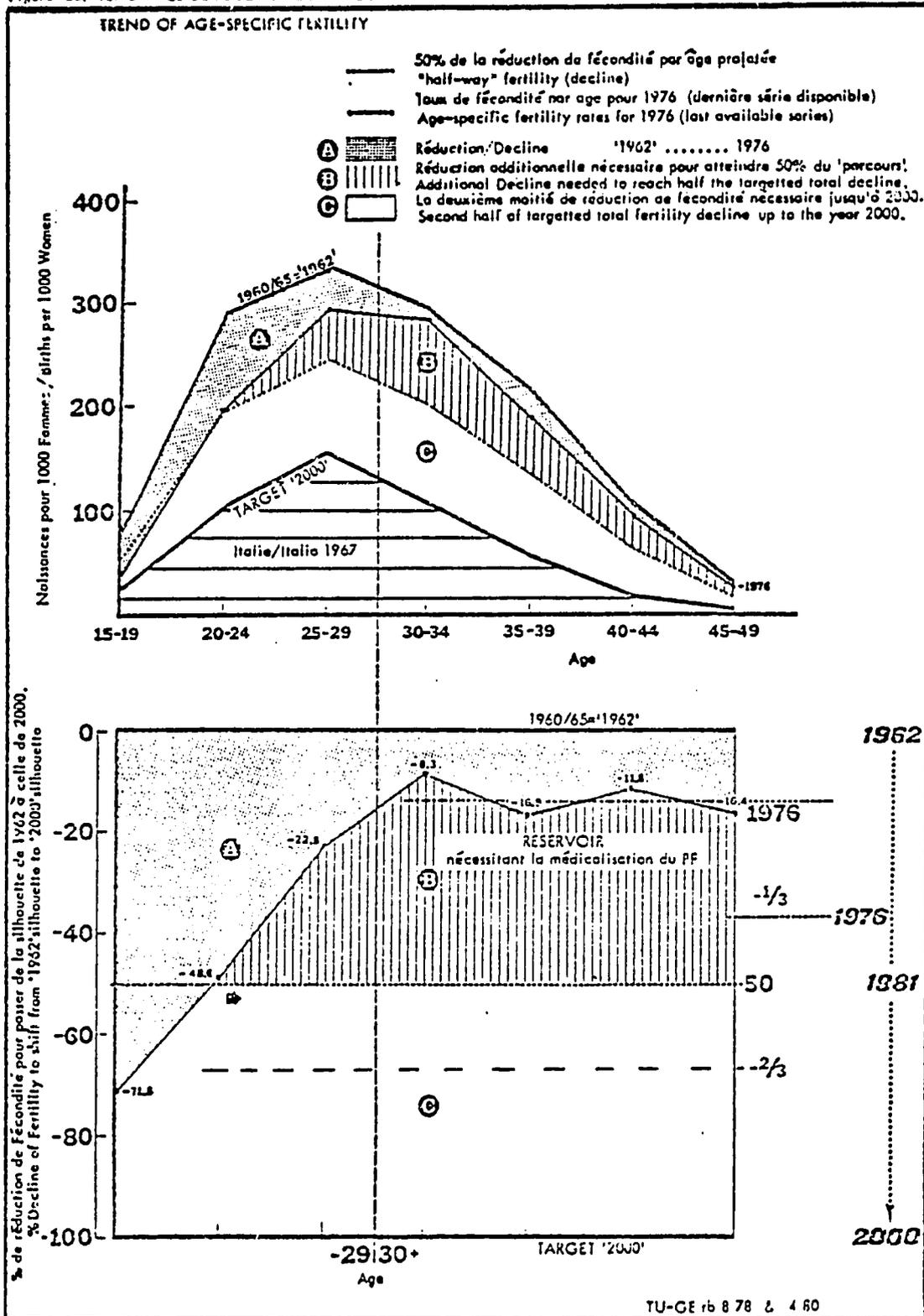
Figure 11. **TUNISIE** TENDANCE DES LIGATURES DES TROMPES / TREND OF TUBAL LIGATIONS ONPFP/USAID FP Program Evaluation, Phase - 2.



Source: Bernard/Charfeddine, Family Planning Monitoring (FPM) in Tunisia (1973-1979): Findings and Implications for the Next Five-Year Plan (1982-1986), April, 1980, p.31.

Figure 23: TENDANCE DE FÉCONDITÉ PAR ÂGE

ONPFF/USAID FP Program Evaluation, Phase - 2.



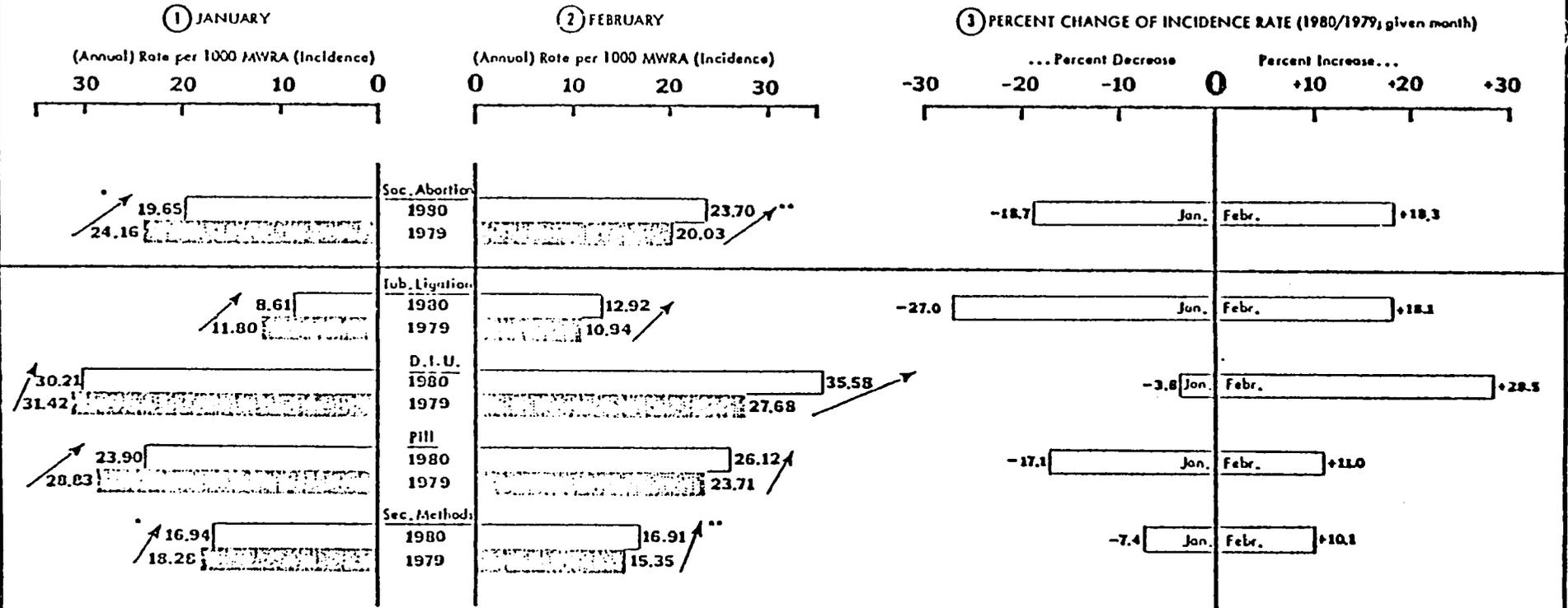
Source: Bernard/Charfeddine, Family Planning Monitoring(FPM) in Tunisia(1973-1979): Findings and Implications for the Next Five-Year Plan(1982-1986), April 198 p.63.

Figure 15.

CNPF PROGRAM PERFORMANCE: January and February, 1980 as compared with 1 year earlier (Jan, Febr. 1979).

Principles of Analytical Epidemiology applied to month-by-month FP Case Monitoring shows a Reversal of Trend (from decrease to increase) for all methods during the month of February, 1980.

- ① (Annual) Incidence of New Acceptors for the Month of January in 1979 and 1980
- ② (Annual) Incidence of New Acceptors for the Month of February in 1979 and 1980
- ③ Percent Change of Incidence in 1980 over 1979. Note: see below.

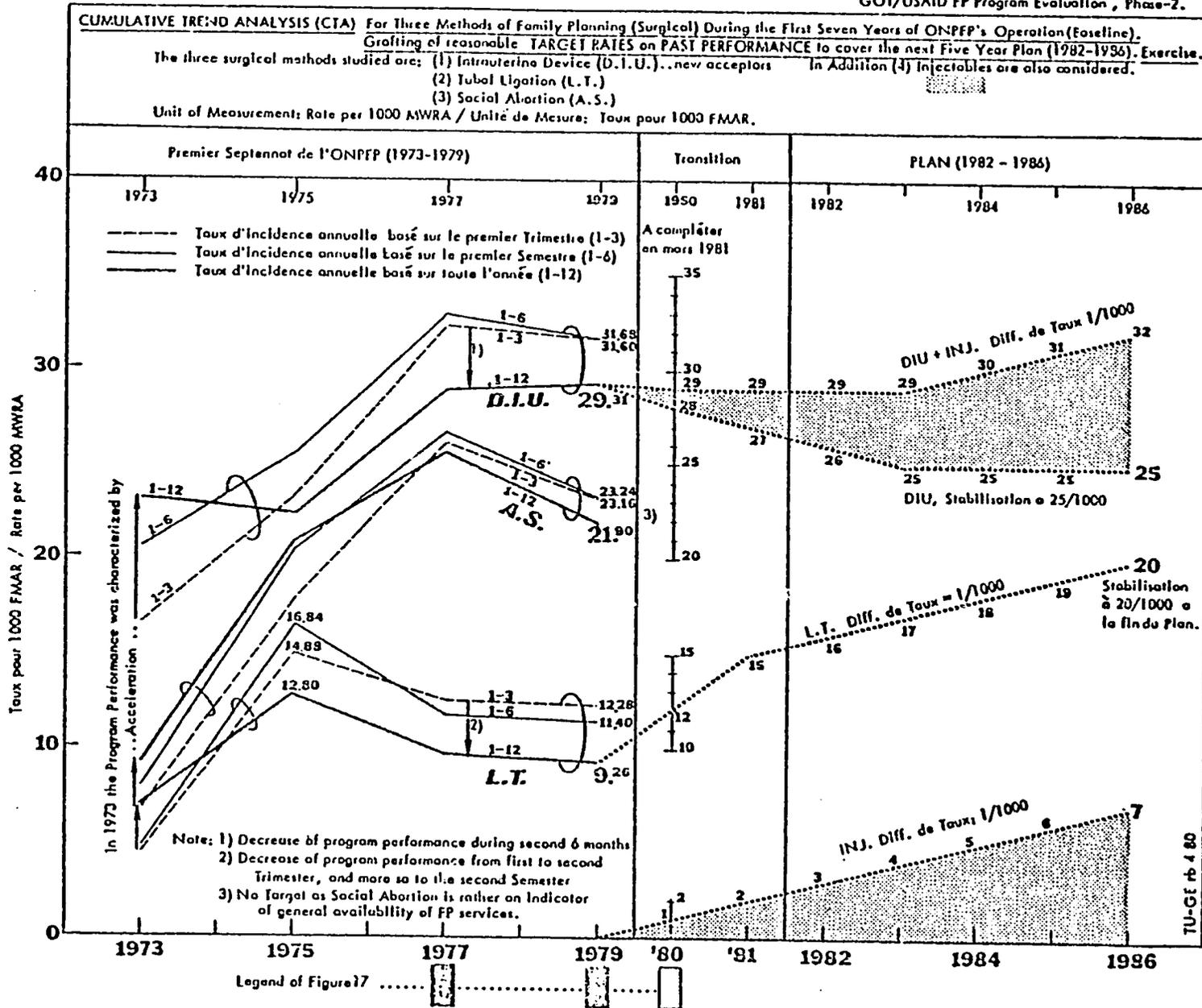


NOTE: While in January 1980 the incidence of all primary methods was still on the decrease, a sudden rise for all methods was noted in February, 1980. If this new trend were to be confirmed in March, then the National Family Planning Program would have reached an inflection point in February 1980. By comparing the %-changes with those derived from the "exercise projections" in Figure 4, it becomes obvious that the FP Program has considerable potential for rapid increase in performance. Note also that Social Abortions experienced an important increase in February, 1980.

* decrease
** Increase

TU-GE rb/ch 4 80

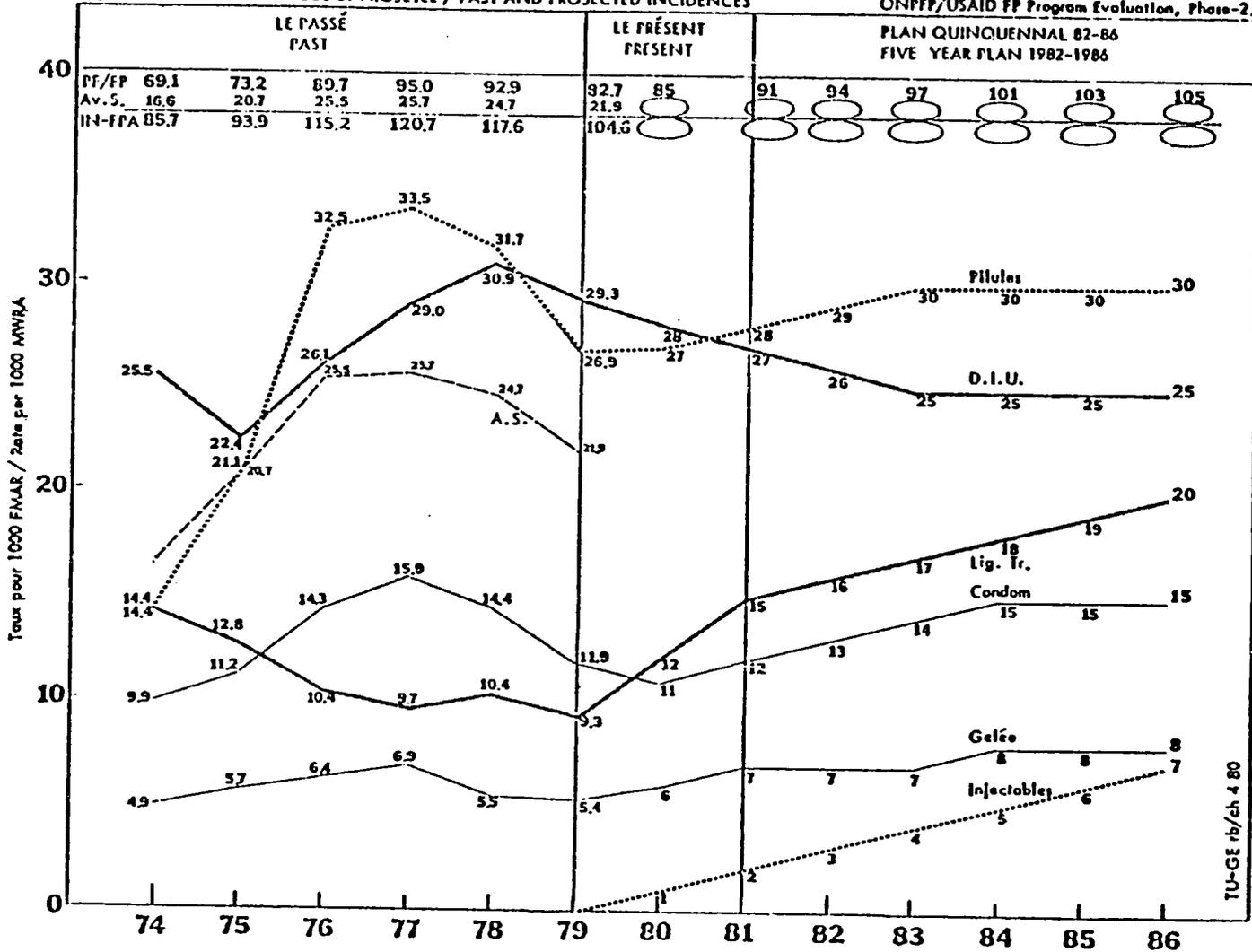
Figure 16



Source: Bernard/Charfeddine, Family Planning Monitoring (FPM) in Tunisia (1973-1979): Findings and Implications for the Next Five-Year Plan (1982-1986), April 1980, p. 44.

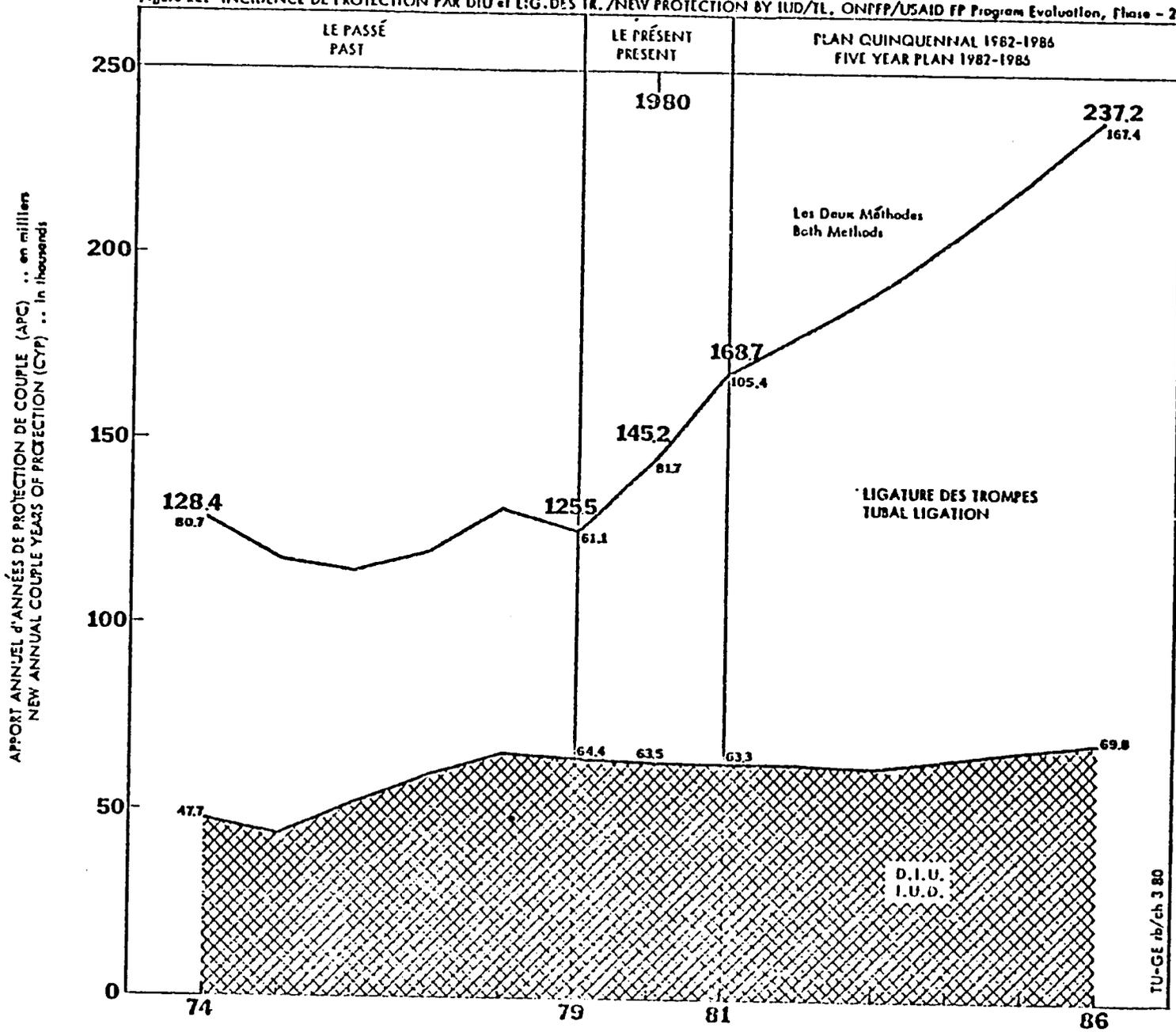
Figure 18. INCIDENCE VECUE ET PROJETÉE / PAST AND PROJECTED INCIDENCES

ONFPF/USAID FP Program Evaluation, Phase-2.



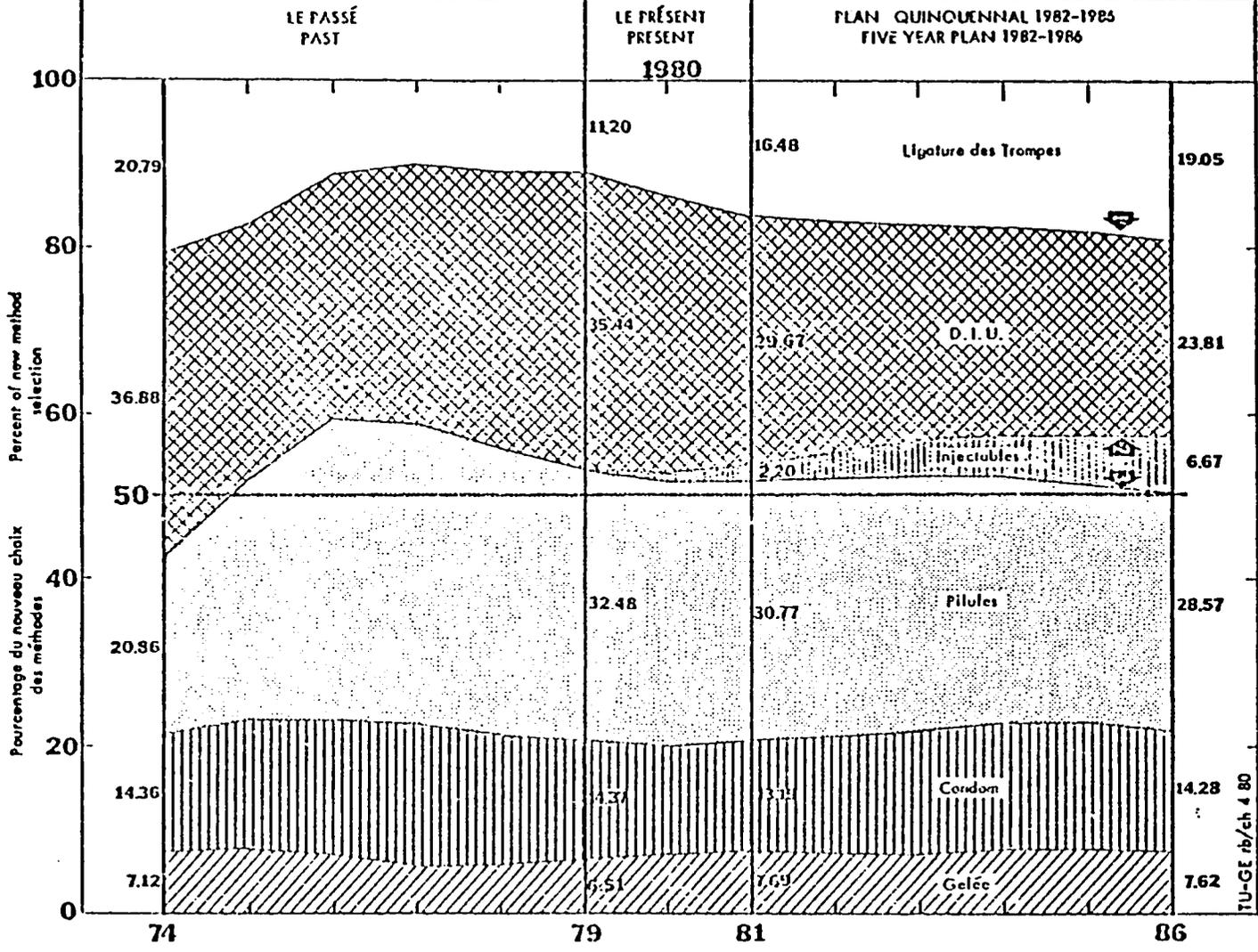
Source: Bernard/Charfeddine, Family Planning Monitoring(FPM) in Tunisia(1973-1979): Findings and Implications for the Next Five-Year Plan(1982-1986), April 1980, p.48.

Figure 22. INCIDENCE DE PROTECTION PAR DIU et LIG. DES TR. /NEW PROTECTION BY IUD/TL. ONPFP/USAID FP Program Evaluation, Phase - 2.



Source: Bernard/Charfeddine, Family Planning Monitoring(FPM) in Tunisia(1973-1979): Findings and Implications for the Next Five-Year Plan(1982-1986), April 1980, p.60.

Figure 19. ÉVENTAIL DES MÉTHODES / METHOD MIX PROFILE



Source: Bernard/Charfeddine, Family Planning Monitoring(FPM) in Tunisia (1973-1979):Findings and Implications for the Next Five-Year Plan,p.50.

- 1 Expansion of ligations at "expense" of multiparous IUD candidates.
- 2 Expansion of Injectables
- 3 Expansion of Injectables

APPENDIX E - Table I

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Tableau (1) et (2)

INDICATEURS DEMOGRAPHIQUES

INDICATEURS		1966	1973	1974	1975	1976	1977	1978
		1966	1973	1974	1975	1976	1977	1978
Population	Population tunisienne au milieu de l'année (1)	4 717.500	5.444 200	5.616.300	5.608.000	5 737 000	5.991.600	6.037 200
	Sexe masculin (1)	2 323.700	2.652 600	2 758.900	2.843 000	2.908 400	2 985 200	2.959 400
	Sexe féminin (1)	2.393 800	2.791.600	2.857 400	2.765 000	2 828.600	2 906.300	2.977 800
	Femmes en âge de procréation (15 - 54 ans) (2)	1.071 300	1.314 200	1.350.000	1.278 700	1 305.300	1 354.200	1 401 200
	Population communale (3)	40,0%	-	-	49,1%	-	-	-
Population urbaine (4)	-	-	-	-	-	-	-	
Population rurale (4)	-	-	-	-	-	-	-	
Structure	Répartition par âges (1)							
	- 0 - 14 ans	46,5%	44,3%	43,7%	43,3%	43,3%	42,5%	42,0%
	- 15 - 64 ans	49,9%	51,6%	52,1%	52,7%	53,2%	53,9%	54,4%
- 65 ans et plus	3,6%	4,1%	4,2%	3,5%	3,5%	3,6%	3,6%	
Etat civil	Naissances enregistrées (5)	206 730	194 764	194 600	202 820	208 730	205 123	204 800
	Décès enregistrés (5)	48 307	43 716	40 288	43 241	36 512	34 610	34 020
	Mariages enregistrés (5)	27 037	43 163	46 672	45 870	37 940	41 300	-
	Divorces enregistrés (5)	4 516	5 099	6 000	-	-	-	-
	Taux de natalité (5)	43,8%	37,7%	36,5%	36,2%	36,4%	34,8%	33,9%
	Taux de mortalité corrigé (5)	14,0%	11,0%	9,8%	10,3%	9,2%	8,4%	8,1%
	Taux de fécondité 15 - 54 ans (5)	193%	156%	152%	150%	149%	141%	136,3%
	Taux généraux de nuptialité (5)	5,7%	7,9%	-	-	6,6%	7,3%	-
Divorces pour 1000 mariages (5)	0,96%	0,93%	-	-	-	-	-	
Accroiss.	Solde migratoire (6)	- 12 637	- 12 768	+ 2 352	- 2 135	- 15 000	- 34 509	-
	Estim. nais. moins décès	140 556	145 128	149 653	145 341	155 999	155 688	-
	Taux d'accroissement naturel	29,8%	26,7%	26,7%	25,9%	27,2%	26,4%	25,8%
	Taux d'accroissement net (7)	27,1%	24,4%	27,1%	25,5%	24,5%	20,6%	-

(1) I.N.S. Perspectives d'évolution de la population fascicule (1), Septembre 1972, jusqu'en 1974. A partir de 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. A partir de 1975, Projections de la population de la Tunisie, 1976-2001, mars 1977.

(3) I.N.S. Recensement général de la population et des logements de 1966 et de 1975.

(4) Ministère du Plan, Aménagement du territoire - L'Armature urbaine en Tunisie 1973.

(5) I.N.S. - Statistiques de l'I.N.S., série démographique No 5 décembre 1974.

Les naissances et les décès enregistrés ont été majorés respectivement de 5% et de 27% jusqu'en 1974. L'INS estime cependant (a posteriori) que les naissances sont déclarées à 100% depuis 1973 et qu'il faut majorer les décès de 30%. Pour 1966 les naissances n'ont pas été corrigées. L'INS estime le taux de couverture à 100% pour cette année (il devient de 46,1% si on les majorait de 5%).

(6) Ministère de l'Intérieur, cité par l'INS (Economie de la Tunisie en chiffres de 1967 et 1971 pour les années 1966 et 1971 et dans le Bulletin mensuel des statistiques de novembre - décembre 1974, janvier 1975 pour les autres années.

(7) Les taux d'accroissement nets ont été calculés en tenant compte du solde migratoire.

APPENDIX E - Table II

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INDICATEURS DE PLANNING FAMILIAL

A. Infrastructure de la Santé Publique et de l'Office National du Planning Familial et de la Population

INDICATEURS	1966	1972	1973	1974	1975	1976	1977	1978
Total des visites	41.517	-	273.156	302.015	351.322	429.891	500.957	527.501
Total des contraceptrices	41.517	246.675	241.335	256.984	289.351	346.351	397.934	397.682
Nelles contraceptrices	16.176	43.665	43.640	50.001	58.052	75.323	66.021	81.149
Nelles acceptrices de :								
D.I.U.	12.077	13.250	16.790	19.084	17.307	20.850	23.679	26.273
Pilules	350	12.026	11.194	10.755	16.310	25.987	27.567	27.017
Ligatures des trompes	766	2.453	4.964	10.757	9.896	8.259	7.937	8.822
Avortements sociaux	1.326	4.621	6.547	12.427	16.000	20.341	21.162	20.999
Centres ayant eu une activité	-	330	309	392	420	482	617	N.D.
Femmes mariées (15-49ans) par centre	-	-	2.432	1.976	1.911	1.670	1.330	N.D.
Médecins spécialistes	-	-	-	69	N.D.	N.D.	N.D.	N.D.
Sages-femmes	-	-	-	92	N.D.	N.D.	N.D.	N.D.
Auxiliaires médicaux	-	-	-	265	N.D.	N.D.	N.D.	N.D.
Contraceptrices: médecin	-	-	-	1.724	-	-	-	-
Contraceptrices: sage-femme	-	-	-	2.793	-	-	-	-
Contraceptrices: aux. med.	-	-	-	170	-	-	-	-

B. Impact du programme

Années Nature du programme Indicateurs x	1975		1976		1977		1978		1979	
	Public	Natio- nal	Public	Natio- nal	Public	Natio- nal	Public	Natio- nal	Public	Natio- nal
Femmes protégées au 1er janvier	77.959	88.328	94.294	107.163	117.006	140.976	131.165	158.230	137.427	180.873
Taux de protection pour 100F. M.A.R. (15-49 ans) au 1er janvier	10,06%	11,5%	11,75%	13,5%	14,54%	17,5%	16,0%	12,4%	16,2%	21,3%
Naissances à éviter	26.250	-	34.350	-	45.000	-	52.000	60.000	63.084	72.809
Naissances évitées	29.720	32.720	35.578	38.800	44.509	52.750	48.630	58.092	50.106	63.643
Taux de natalité	35,3%	-	36,4%	-	34,0%	-	33,9%	-	-	-
Taux de fécondité (15-44 ans)	176%	-	176%	-	165%	-	161%	-	-	-
Taux de fécondité (15-49 ans)	150%	-	160%	-	152%	-	146%	-	-	-
Taux de fécondité (15-54 ans)	150%	-	149%	-	141%	-	136%	-	-	-

x Public : C'est la dimension du programme qui n'inclut que l'activité assurée dans les centres relevant de l'infrastructure du Ministère de la Santé Publique et de l'Office National du Planning Familial et de la Population.

National: C'est la dimension qui inclut à la fois l'activité publique de loin la plus importante et celle déployée ailleurs que dans l'infrastructure sus-visée et matériellement encouragée et guidée par l'Office National du Planning Familial et de la Population.

Source: Revue Tunisienne des Etudes de Population, No. 1
Office National du Planning Familial et de la Population,
1980.

APPENDIX E - Table III

TABLE II
EFFECTIVE PROTECTION PREVALENCE BY TUBAL LIGATION (EPP/TL): 1979 & 1980 (Beginning of Year),
BY GOVERNORAT. ONE-YEAR TREND.

Column	A	B	C	D	E	F	G	H	I	
	MWRA 1978	Q Protected by Tubal Ligation Number	Percent	MWRA 1979	Q Protected by Tubal Ligation Number	Percent	Diff(X) 79-78	EPP 1980	Percent Total EPP pertaining to Tubal Ligation(1980)	
1 ⁴	Siliana	25983	4482	17.25	26357	4893	+18.56	+1.31	25.29	73.4
2	Béja	35392	5316	15.02	36061	5766	15.99	+0.97	24.81	64.4
3 ³	Le Kef	33617	3574	10.63	34183	3937	11.52	+0.89	25.62	45.0
4	Bizerte	30477	5074	10.05	51819	5876	11.34	+1.29	22.52	50.4
5	Jendouba	47884	5077	10.60	48980	5335	10.89	+0.29	18.51	58.0
6 ²	Sousse	38490	3622	9.41	39952	3819	9.56	+0.15	20.97	45.6
7	Sfax	71135	5780	8.13	73209	6421	8.77	+0.64	17.30	50.7
8	Zaghuan	30013	2274	7.58	30928	2587	8.36	+0.78	13.45	62.2
9	Monastir	31231	2630	8.42	32393	2706	8.35	-0.07	18.72	44.6
	TUNISIE	851035	58056	6.82	878795	64274	7.31	+0.49	16.19	45.2
10	Tunis	145280	9196	6.33	151265	10664	7.05	+0.72	19.49	36.2
11	Mahdia	33151	1957	5.90	34410	2242	6.52	+0.62	13.43	48.6
12	Nabeul	54473	3241	5.95	56753	3372	5.94	-0.01	16.92	35.1
13	Kairouan	51590	2151	4.17	53398	2353	4.41	+0.24	7.35	60.0
14	Kasserine	39051	937	2.40	40444	1124	2.78	+0.38	10.38	26.8
15	Medenine	51246	1068	2.08	52658	1114	2.12	+0.04	6.06	35.0
16	Gafsa	35492	660	1.86	36629	707	1.93	+0.07	15.10	12.3
17	Gabès	42864	476	1.11	44475	760	1.71	+0.60	8.56	20.0
18	Sidi Bouzid	39051	541	1.39	40444	598	1.48	+0.09	4.35	34.0

- A Married Women of Reproductive Age for 1978
- B Number of MWRA Protected by Tubal Ligation in 1978
- C Percent of MWRA Protected by Tubal Ligation in 1978 (EPP/TL-1978)
- D Married Women of Reproductive Age for 1979
- E Number of MWRA Protected by Tubal Ligation in 1979
- F Percent of MWRA Protected by Tubal Ligation in 1979 (EPP/TL-1979) : ranked in descending order
- G Difference of: EPP/TL 1979 minus EPP/TL 1978
- H EPP: Effective Protection Prevalence by All Methods for 1980 (Beginning of Year)
- I Percent All Method EPP pertaining to Tubal Ligation (F/H)

¹ EPP/TL is significantly below 5% of all MWRA. = Identification of a seriously unmet need.
= The six governorats need stronger FP Programs with full availability of Tubal Ligation Services.

² EPP/TL ranges from 5.0 - 9.9% of all MWRA. While the trend is on the increase, three of the 7 Governorats, show no progress. They are:
Monastir (-0.07 %age points),
Nabeul (-0.01 "), and
Sousse (+0.15 "). They need to make available the ligation services.

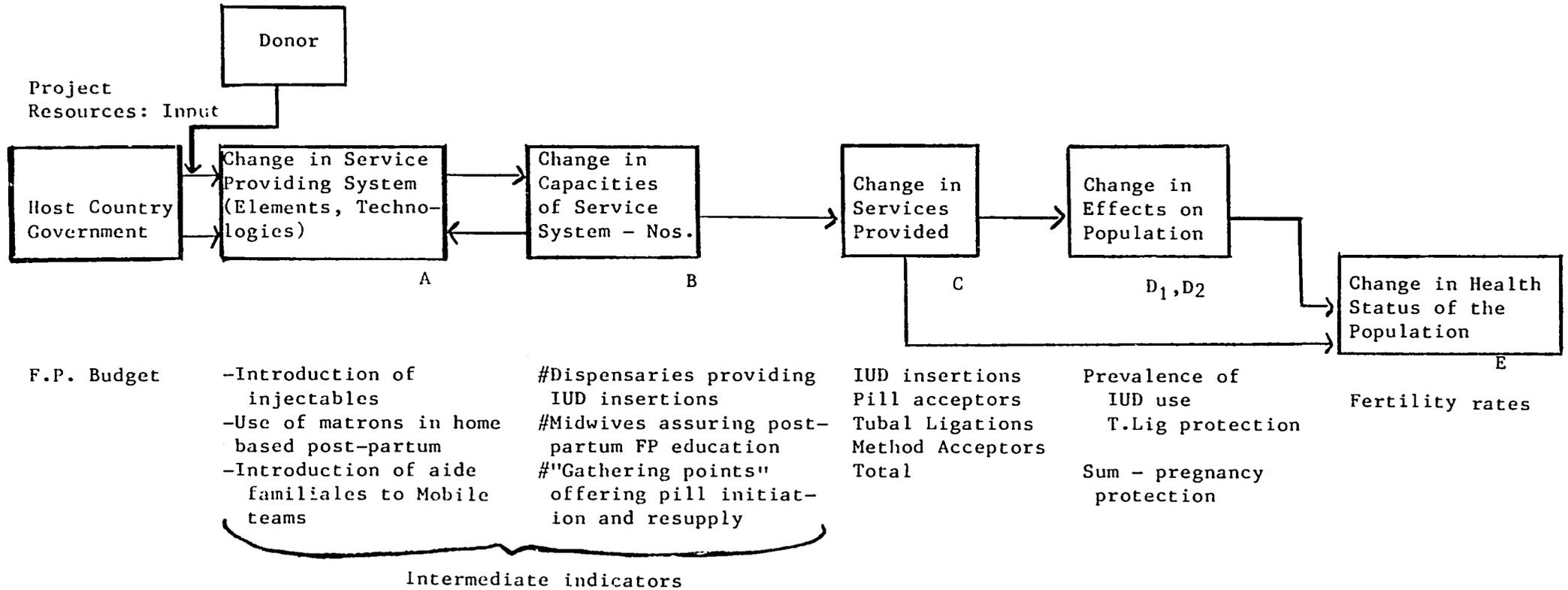
³ EPP/TL ranges from 10.0 - 14.9% of all MWRA. Of the three Governorats, Jendouba shows the smallest progression (+0.29 %age points). Ligation services need to be made available more broadly.

⁴ EPP/TL ranges from 15.0 - 19.9% of all MWRA. The two governorats have the highest prevalence of ligated women which further increase swiftly.
Siliana (+1.31 %age points)
Beja (+0.97 ");
Note the virtual 10-fold prevalence of Tubal ligation for Siliana and Béja over Gabès and Sidi Bouzid.

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APPENDIX F
PROJECT FLOW GRAM FOR EVALUATION

PROJECT FLOW GRAM FOR EVALUATION



APPENDIX G

FAMILY PLANNING EDUCATION ACTIVITIES IN A GOVERNORATE

NOTE SUR L'ACTION EDUCATIVE EN PLANNING
FAMILIAL DANS UN GOUVERNORAT

Pour procéder à une action éducative en matière de Planning Familial au niveau d'un Gouvernorat, il est d'abord nécessaire d'avoir certaines données de base concernant notre population cible, qui serait dans ce cas les couples mariés en âge de procréation. (Pour nos démographes ce groupe est représenté par le FMAR : femmes mariées en âge de reproduction).

Dans un Gouvernorat, cette population se trouve généralement éparpillée dans des lieux géographiques différents, qu'il faudrait délimiter. Il serait donc primordial, pour mener une action éducative appropriée aux différents groupements de la population, de diviser le gouvernorat en un certain nombre de zones d'action, chaque zone ayant ses propres caractéristiques géographiques, démographiques et socio-économiques.

Schématiquement, notre gouvernorat se présenterait comme suit :

ZONE A	ZONE B	ZONE C
ZONE D	ZONE E	ZONE F
ZONE G	ZONE H	ZONE I

Nos zones une fois délimitées, tout en ayant des données propres à chacune d'elles les caractéristiques géographiques, démographiques et socio-économiques, notre centre d'intérêt sera alors axé sur la population FMAR, et plus particulièrement sur le nombre de femmes qui sont dans le programme de Planning Familial et celles qui ne sont pas dans le programme.

.../...

L'étape suivante serait de chercher à connaître les raisons des reticences des femmes qui ne pratiquent pas et de programmer des activités d'éducation appropriées et susceptibles d'atténuer les reticences.

Pour avoir une idée plus claire de ce qui précède, nous allons prendre un exemple fictif d'une des zones d'action qui sera la zone E.

Exp. : Zone E

Population totale : 5.000 ^{lit}

Population cible (FMAR) : 1.000 femmes

% Population FMAR protégées par le P.F. : 180 femmes ou 18%

% Population FMAR non protégées : 82 %

Raisons pour lesquelles les 82 % ne sont pas dans le programme :

Maris s'opposent :	28 %	-Religion : 15 % - Tabous : 5 % - veulent un enfant ♂ : 5 %
car		
Femmes enceintes :	10 %	
Ne connaissent pas les horaires de consultants :	15 %	
Allaitantes :	12 %	
Ont peur des méthodes :	10 %	
Ont pratiqué mais ont cessé :	7 %	- effets secondaires 3 % - mauvais accueil
Total		: 78 %

Ainsi nous avons une idée précise des obstacles à l'adoption du Planning Familial. En plus, ce diagnostic nous permet de savoir quelles actions éducatives précises ont lieu d'être entreprendre dans le but de changer le comportement des individus, comme ce tableau nous le montre :

.../...

DIAGNOSTIC	ACTION EDUCATIVE
a. Maris d'opposent à cause de : - Religion - P.F. tabous - veut 1 enfant	Contacter ces maris individuellement ou en groupe pour parler de : - Islam et P.F. - P.F. et responsabilité parentale - Sexe est ce que l'on est non ce que l'on fait.
b. Femmes ayant cessé de pratiquer le P.F. car : - Effets secondaires - Mauvais accueil	Visites des femmes à domicile pour parler des : - méthodes de contraception et effets secondaires. - Programme de formation et recyclage en matière d'accueil pour le personnel du Centre.

Maintenant que nous avons une idée sur les problèmes ayant trait à l'Education et des remèdes à y apporter, l'étape suivante serait de programmer ces activités en fonction des moyens et des priorités, en vue de les réaliser dans le cadre d'objectifs pré-établis, ces objectifs étant de deux ordres, d'ordre éducatif et d'ordre démographique.

Le tableau suivant peut clarifier ce qui précède :

Exp. : Zone E

OBJECTIFS EDUCATIFS	OBJECTIFS DEMOGRAPHIQUES
<u>Obj.1:</u> Contacter 75 % des maris réticents et les motiver de telle sorte que 40 % de ceux-ci ne s'efforcent plus à ce que leurs femmes pratiquent.	Taux de protection $\frac{1980}{15\%} \rightarrow \frac{1981}{21\% \text{ (Obj.)}}$
<u>Obj.2:</u> Contacter 100 % des femmes ayant quitté le programme et les motiver de telle sorte que 50 % d'entre-elles réintègrent le programme.	

.../...

Obj. 3 : Programmer et réaliser 3 programmes de Formation et recyclage pour le personnel du Centre en matière d'accueil et relations interpersonnelles.

Le travail ainsi fait pour toutes la zone, nous amène à avoir des objectifs éducatifs généraux pour tout le gouvernorat pour l'année et ceci en additionnant les objectifs établis pour chaque zone.

Nous pourrons ainsi avoir le tableau suivant :

Population FMAR en dehors du prog.	Object. de cette population à contacter	Objectif à motiver	Taux de prof à atteindre.	Activités éducatives à réaliser.
76 %	70 %	95 %	22 %
58 %	75 %	4%	23 %
47 %	65 %	30 %	19 %
84 %	85 %	42 %	24 %
62 %	75 %	-	21 %	5 séances éducatives de groupe. 150 visites à domicile. 3 programmes de formation.
<u>Total Zone</u>				
x $\frac{\text{Total}}{\text{n. 2.22}}$ %				1 séance d'éducation 1 visite à domicile 1 Programme de Form.

.../...

Evaluation :

- a - évaluation par rapport aux objectifs projetés
- b - évaluation par rapport aux projections de la population à motiver.
- c - impact de l'action éducative : nombre de naissances évitées par l'éducation.

Le 31 - 3 - 1980

Abderrazak THRAYA

APPENDIX H
BIBLIOGRAPHY

APPENDIX H. BIBLIOGRAPHY

General

- L'Action de l'Office National du Planning Familial et de la Population 1976-1978: Objectifs, Réalisations, Résultats, République Tunisienne: Office National du Planning Familial et de la Population, 1979.
- L'Evaluation au Sein de l'Office National du Planning Familial et de la Population: Approche et Conception. (unpublished mimeo), 1979.
- Maguire, E.S., Johnson, P.R. and Bernard, R.P. Tunisia Family Planning Services: Mid-Term Evaluation, Phase One. American Public Health Association, Washington, DC. October 1979.
- Programme d'Activités, 1980, République Tunisienne: Office National du Planning Familial et de la Population.
- Project Paper: Tunisia Family Planning Services. Office of Population, Agency for International Development, 1977.
- Projections de la Population Tunisienne par Délégation, Sexe, Age et Année: 1975-1986. République Tunisienne: Office National du Planning Familial et de la Population, 1979.
- Rapport d'Activités, 1979, République Tunisienne: Office National du Planning Familial et de la Population.
- Résultats 1978, Programme 1979. République Tunisienne: Office National du Planning Familial et de la Population, 1979.
- Statistiques de Planning Familial, 1977. République Tunisienne: Office National du Planning Familial et de la Population, 1978.
- Statistiques de Planning Familial, 1978. République Tunisienne: Office National du Planning Familial et de la Population, 1979.
- Revue Tunisienne des Etudes de Population, No.1. République Tunisienne: Office National du Planning Familial et de la Population, 1980.
- Les activités démographiques et les activités de Planning Familial, Office National du Planning Familial et de la Population, 1980.
- Amy Ong Tsui, Tunisia: Illustrative Functional Projections, 1975-2000 (covering Urbanization, Education, Labor Force, Marital Status, Health, Food, Family Planning). Community and Family Study Center, the University of Chicago, 1979.
- Tunisie: Documentation de Base en matière de Population: Bureau du Coordonnateur du FNUAP, Janvier 1980.

Community based Distribution:

- Bchir, M. Avant Projet de l'Extension de l'Expérience PFAD (unpublished mimeo), 1976.
- Bchir, M., Messaoud, F. Family Planning in Tunisia: An attempt to evaluate different household distribution experiments. In Village and Household Availability of Contraceptives: Africa/West Asia (ed. J. Gardener et al). Battelle Population Study Center, Seattle, 1977.
- Chelbi, M. Expérience Pilote d'Intégration du Planning Familial à la Santé de Base en Milieu Rural: Projet PFPC - Délégation d'Ain Draham (unpublished mimeo). République Tunisienne: Office National du Planning Familial et de la Population.
- Enquête de Planning Familial dans le Gouvernorat de Jendouba. République Tunisienne: Office National du Planning Familial et de la Population, 1979.
- Gillespie, D.G. The Expansion of the Household Distribution Project (unpublished mimeo). Dec. 1976.
- Gillespie, D.G. ONPFP's Expanded Household Distribution of Contraceptives by ONPFP, Tunisia (unpublished mimeo) November 1976.
- Le Planning Familial en Milieu Rural (PFMR), 1978-1981. République Tunisienne: Office National du Planning Familial et de la Population, 1979.
- Le Planning Familial par le Couple (Jendouba): Expérience Pilote d'Intégration du Planning Familial à la Santé Familiale en Milieu Rural, 1977-1979. République Tunisienne: Office National du Planning Familial et de la Population, 1977.
- Le Planning Familial par le Couple (Jendouba): Enquête d'Evaluation: Délégation de Fernana (1978). République Tunisienne: Office National du Planning Familial et de la Population, 1979.
- Maguire, E.S., Trip Report: Tunisia, April 2-18, 1979 (unpublished mimeo).
- Maguire, E.S. Trip Report: Tunisia, September 11-25, 1978 (unpublished mimeo).
- Maguire, E.S. Trip Report: Tunisia, April 1-14, 1978 (unpublished mimeo).

Maguire E.S. Trip Report: Tunisia, November 9-25, 1979 (unpublished mimeo).

Maguire, E.S. PFPC Project: Second Household Visit-Ain Draham Delegation (unpublished mimeo) May 1979.

Maguire, E.S. and Gillespie, D.G. PFPC Integrated Family Planning/Basic Health Care Delivery System for Ain Draham (unpublished mimeo), July 1978.

Maguire, E.S. and Gillespie, D.G. Tunisia Household Distribution Project, Planning Familial Par le Couple (PFPC) (unpublished mimeo), October 1977.

PFAD, Planning Familial à Domicile: Household Distribution of Contraceptives in Bir Ali Ben Khalifa, Tunisia. International Fertility Research Program, 1979.

PIO/T Family Planning Operations Research: Le Planning Familial par le Couple en Milieu Rural. Office of Population, Agency for International Development, 1977.

Project Agreement, Family Planning, Operations Research. USAID Tunis, 1979.

Project Agreement, Family Planning, Operations Research. USAID Tunis, 1978.

Project Agreement, Family Planning, Operations Research. USAID Tunis, 1977.

Central Tunisia

Ayad, Carole Steele. Baseline Data in Health, Nutrition and Family Planning for the C.T.R.D. Project Zone, July 17, 1968. (unpublished mimeo)

Family Health Care. Design Study II. 1977.

Fort, C. and Johnson, P. Background and Analysis of Proposed Health Sector Activity in Central Tunisia, A.P.H.A., 1979.

Population du Gouvernorat de SFAX: Caractéristiques socio-démographiques. République Tunisienne: Office National du Planning Familial et de la Population, Mars 1979.

Integrated Medicine:

- Document Final de la Seminaire de Tabarka sur la médecine intégrée.
République Tunisienne: Ministère de la Santé Publique, Juillet 1979.
- Projet Tunisien de Médecine Communautaire. Rapport Annuel, 1978 (Medjez el Bab).
- Rapport Annuel du projet Tuniso - Belge de médecine intégrée au Cap Bon, Tunisie, 1976-77.
- Van Vlaenderen, P. Projet-Tuniso - Belge de Santé familiale: La Santé familiale dans la délégation de Metlaoui.

IE&C:

- Bertrand, J., I.E. and C for Family Planning: The ONPFP Program. 1978.
- Rothe, M. and MacMahon, T. ONPFP IE&C Program: Assessment and Some Recommendations, 1976.

Phase II Evaluation Sector Reports

- Maguire, E., Bernard, R., Charfeddine, A., Ayad, M., Kilani, T. Programm de Recherche, Evaluation et Statistiques: Observations et Recommendations de la Mission d'Evaluation Tuniso-Americaine, Phase II, du 14 au 29 mars 1980. Office National du Planning Familial et de la Population. Tunis, Avril 1980.
- Echols, J.R. and Kouniali, S. Evaluation of the Tunisian Family Planning Program (Phase II): The Communication Sector. Tunis, March 31, 1980.
- Thorne, M.T. and Dali, R. Evaluation of the Tunisian Family Planning Program (Phase II): Medical Team Report. Tunis, April 1980.
- Trayfors, W.H. Evaluation of the Tunisian Family Planning Program (Phase II): Report of the Health Management Specialist. Tunis, March 26, 1980.
- Bernard, Roger P. and Charfeddine, A. Family Planning Monitoring (FPM) in Tunisia (1973-1979): Findings and Implications for the Next Five-Year Plan (1982-1986, April 1980.