

664 0 295



AMERICAN PUBLIC HEALTH ASSOCIATION
International Health Programs
1015 Fifteenth Street, N.W.
Washington, D.C. 20005

Tunisia Family Planning Services:

Mid-Term Evaluation, Phase One

6640295

A Report Prepared By:

Elizabeth S. Maguire, M.A.

Pamela R. Johnson, Ph.D.

Roger P. Bernard, M.D.

During the Period:

September 20 - October 4, 1979

Under The Auspices of The:

AMERICAN PUBLIC HEALTH ASSOCIATION

Supported By The:

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT
OFFICE OF POPULATION, AID/pha/C-1100

AUTHORIZATION:

Ltr. POP/FPS: August 29, 1979
Assign. No. 1100-178

Agency for International Development
Library
Room 105 SA-18
Washington, D.C. 20523

TABLE OF CONTENTS

	Page
SUMMARY	ii
PART ONE	
I. Introduction	1
PART TWO 3	
II. The Tunisian Family Planning Program: Discussion Topics	3
A. Government Family Planning Policy and Programming in Rural Tunisia	3
B. Program Performance	5
C. The ONPFP Administrative Structure	10
D. Program Monitoring, Research and Evaluation	12
E. Rural Community-Based Family Planning/MCH Delivery Systems: Pilot Experiences	15
F. Medical and Paramedical Manpower Needs	19
G. Information, Education and Communication	22
H. Training	25
I. AID Assistance	27
PART THREE 40	
III. Conclusion	40
FIGURES, TABLES, MAPS	
APPENDICES	
Appendix A - Evaluation de Mi-Projet en Deux Phases .	
Appendix B - ONPFP Report of Mid-Project Evaluation .	
Appendix C - List of Persons Contacted	
Appendix D - ONPFP Organization Chart	
Appendix E - Bibliography	
Appendix F - Sources of Support for Tunisia's Family Planning Program	

SUMMARY

The Tunisian Family Planning Program began as a small pilot project in 1964. Over the past 15 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 18 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 UNESCO 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 AID Involvement: There has been substantial AID assistance to the Tunisian family planning program since 1965, totaling 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 FY 77, 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 18 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 midpoint 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. increased decentralization of decision-making so that existing resources, human and material, are more 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 ongoing 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.

PART ONE

I. INTRODUCTION

In collaboration with the GOT, AID is undertaking a comprehensive, in-depth evaluation of the Tunisia Family Planning Services Grant to assess the strengths and weaknesses of the current project as a guide to future program directions and assistance. Scheduled at the midpoint of the 1978-1981 GOT/USAID bilateral agreement, the evaluation is being carried out in two stages. The first phase, conducted September 20-October 4, was designed to collect, review and synthesize relevant data and to establish an agenda of issues for consideration during the second phase, planned for early 1980. The second phase will focus on establishing new program priorities and directions for the remaining two years of the bilateral agreement and subsequent assistance efforts. The evaluation comes at an important juncture in the evolution of the Tunisian family planning program. First, the Ministry of Public Health (MOPH) and the ONPFP are in the process of defining the objectives and formulating the policy which will inform the health and population components of the Sixth Five-Year Economic and Social Development Plan (1982-1986). This policy will be oriented by a national concern for the delivery of basic integrated health care to rural areas. Second, as part of that process, the MOPH is taking a careful look at the mandate of the ONPFP and its institutional capacity to meet its goals. Third, as a result of new directives from the MOPH and an increased awareness of its own capabilities and limitations, the ONPFP is looking at its future role in Tunisia's population policy from a new and broader perspective.

The Phase One team was successful in accomplishing and even exceeding its original mandate. Most significant is the fact that this has been a joint and collaborative effort. The evaluation began and ended in joint ONPFP/USAID meetings at which views were freely exchanged (Appendix A). Dr. Dali, Special Advisor to the P.D.G., was a member of the team in every sense, participating in all meetings and contributing his observations and suggestions. During visits to the family planning programs in five rural provinces, the team was fortunate to be accompanied by Sadok Kouniali, the newly appointed Director of Regional Services. Not only was the evaluation a joint USAID/ONPFP effort, but it also evolved into an expanded dialogue, including for the first time high-ranking officials in the Ministry of Health, in other ministries and government agencies, professors of OB/GYN and pediatrics, and the Dean of the Sousse Medical Faculty.

Furthermore, the team was able to establish the evaluation as part of a continuous process rather than an external and isolated event. The first phase, as has been noted, took the form of a rich exchange of ideas and information. In the period between Phase One and Phase Two, additional actions have been recommended and are under way so that the evaluation exercise can best serve the needs of the GOT and USAID. Part of this report, graphs prepared by Dr. Bernard showing recent trends in family planning acceptor rates, has already been sent to the ONPFP with a view to enabling the administration to act on these indicators of program performance and direct activities effectively in the

remaining months of 1979. In preparation for the upcoming discussion on strategies for increasing the availability and effectiveness of family planning services in rural Tunisia, the team has recommended a field observation trip of key leadership to visit successful rural family planning programs in Asia. Expected to accompany the P.D.G., Mr. Chekir, are: Dr. Boukhris, Director of the Center for Applied Research; Dr. Nacef, Head of Preventive and Social Medicine, MOPH; and Mr. Getson, USAID Population Officer. Finally, to encourage a more responsive AID assistance program, the team has also made some recommendations for consideration in the Pro Ag for FY 1980, to be signed in December 1979.

The most significant accomplishment of Phase One was, without question, the cooperative and broad dialogue that was established. We are especially grateful to the personnel of the ONPFP, led by the P.D.G. and to the various public officials, members of the medical faculties and the field staffs, who all offered their valuable time and ideas to make this initial phase of the evaluation a success. We would like to express our appreciation as well to the USAID Mission Director and to the family planning and health staff for their active support and participation. The discussion topics and agenda of issues presented in this report are a fruit of the dialogue which was established.

Report Outline

Based on only two weeks of meetings in Tunis and in the field, the Phase One Evaluation report is a necessarily preliminary assessment of a complex project with a long history and many components. The background presented is not intended to be exhaustive but to serve as a guideline to areas of concern and for more in-depth discussions of the various issues during the second phase of the evaluation.

Part Two consists of nine discussion topics concerning the Tunisian family planning program and AID assistance efforts. In each of these areas, an attempt is made to assess current strengths and weaknesses, to raise issues which will be relevant to future program performance and to identify actions which can be taken to affect both the tangible and intangible aspects of the program. Some issues address the long-term needs of a program which aims to be increasingly independent of foreign donor support. Others are issues which will affect the direction of the program and its accomplishments in the next few years. Finally, several recommendations are presented for immediate implementation to increase the usefulness of this two-part evaluation and to stimulate improved program performance and more responsive and flexible assistance.

Part Three is a summary of the major issues presented and suggestions for Phase Two activities in redirecting future programming and assistance efforts. The tables and graphs prepared by the ONPFP and Dr. Bernard are an integral part of the report. In addition to a list of contacts and a selected bibliography of background documents, the appendices contain valuable material important to a fuller understanding of the program and its future development. Appendix B is a summary of Dr. Dali's observations and recommendations and includes the agenda and highlights of the meetings during the period September 20-October 4. In addition, the ONPFP has prepared an excellent overview of its current activities and recent accomplishments, part of which is summarized in this report. The Phase Two team should consult the complete document.

PART TWO

II. THE TUNISIAN FAMILY PLANNING PROGRAM: DISCUSSION TOPICS

A. Government Family Planning Policy and Programming in Rural Tunisia

The government of Tunisia has long been committed to an active program of family planning as a part of its global efforts to achieve social and economic development. As a recent ONPFP document notes: "Le programme tunisien de P.F. n'implique pas une action de limitation des naissances ni une action de contrôle de naissances. C'est plutôt et surtout une action sociale faisant partie intégrante de la politique générale de développement économique et social du gouvernement." This national commitment to family planning, led by President Bourguiba, has recently been reiterated by Prime Minister M. Hedi Nouira at the 10th Congress of the Destourian Socialist Party.

On the highest levels, in policy formulation, population concerns should inform policies in agriculture, health, education, planning, economic development and other areas. Current top national priorities of the GOT are housing and employment. This does not represent a lessening of commitment to family planning but it does mean that it is important to emphasize the relevance of population issues to national, economic and social objectives. The increased collaboration of the ONPFP with I.N.S. and C.E.R.E.S., envisioned by the P.D.G., will assist in defining demographic trends relevant to long-range planning and evaluating their socio-economic significance. Making such information available to policy makers is a critical activity in 1990 while the sixth Five Year Plan is being developed.

The effective utilization of resources to solve a range of health-related problems in rural Tunisia poses a particular challenge to government-wide coordination and collaboration. Limited infrastructure as well as material and human resources must serve a dispersed and disadvantaged population. Recognition of the importance of this challenge is leading to new approaches and greater cooperation.

A special working group, Comité de Réflexion, with representatives from seven ministries as well as from the ONPFP, has been charged with developing a strategy for the delivery of integrated health care in rural Tunisia. The rural areas of the country have been divided between the three medical faculties, with Tunis having a special responsibility for the north, Sousse for the central region, and Sfax for the south. Sousse, now developing a program in community medicine, is placing interns in rural areas. There are also encouraging signs of increased cooperation between OB/GYNs, the pediatric community and the ONPFP in looking at the problems of maternal and child health in rural areas. Perhaps most important, there are a number of ongoing projects in the delivery of integrated health care in rural areas, at Le Kef, Medjez el Bab, Nabeul and Gafsa.

The major theme of planning for rural health care in the 1980s is an integrated approach to basic health needs, an approach that the ONPFP has actively

endorsed. However, there is some concern that the significance of family planning as an essential element of integrated health care has not been recognized fully nor incorporated adequately into pilot projects, apart from the very successful Kef project. In addition, family planning needs to be given an increased emphasis in the Faculties of Medicine, particularly in the context of community medicine.

Cooperation and collaboration cannot be restricted to the national level. Means to encourage this same spirit on the regional and local level must be found if the efficient and effective use of resources is to become a reality in rural Tunisia. Currently, rural sites frequently suffer from irregularity and interruption of key services, personnel and sometimes of stocks and competition for limited resources. While some of these problems can be alleviated by improving centrally-supplied services and regional/central communication, many can only be solved by decentralized decision-making and increased cooperation in the field between workers in various ministries and local political officials.

Family planning officials have been able to develop solutions in individual provinces and to achieve working relationships with other local officials. An example is Beja where the regional delegate has trained Assistantes sociales from the Ministry of Social Affairs to work in family planning education with counterparts from the Ministry of Health. Family planning programs face difficulties where a close working relationship has not been established with the outreach personnel of other ministries and the medical personnel of the Ministry of Public Health. In addition, since some methods of contraception are performed only by medical personnel in medical facilities, the effective delivery of family planning services can be adversely affected by competition for resources, material, personnel, and transport, as well as by a lack of motivation of non-ONPFP personnel. Greater collaboration and a clarification of the relationship between ONPFP and Ministry of Public Health personnel on the local level needs to be encouraged to insure long-term program improvement and better family planning service delivery in the rural areas.

Issues For Phase Two Evaluation

- As background for the Sixth Economic and Social Plan, define the demographic and socioeconomic significance of population issues and the role of family planning as an essential element of integrated health care.
- Examine ways of increasing intra-governmental and inter-agency coordination and collaboration to maximize the effective use of resources in the delivery of family planning services in rural Tunisia.

B. Program Performance

Quantitative and qualitative indicators point to the solid progress of the family planning program in Tunisia since the first pilot project in 1964 and especially during the six years since the founding of the ONPFP. As a result of the efforts of the ONPFP in combination with various socioeconomic and political factors, Tunisia's 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. In the years from 1975 to 1978, the marital fertility rate dropped 8.3 percent, from 262.3 to 240.6 per thousand. Contraceptive prevalence estimated at 10.1 percent in 1975 reached 21.3 percent of MWRA in January 1979. (See Tables 1 and 2). According to early results from the 1978 National Fertility Survey, 47 percent of MWRA have used or are currently using a modern method of contraception.

Family planning achievements can be measured in other ways as well. In less than six years, the ONPFP has created a nationwide organization to deliver family planning services through a network of clinics and to educate and motivate the citizens of the country in the importance and use of family planning. Together with other government ministries and agencies, and with marked sensitivity to cultural and religious values, the ONPFP has brought about a transformation of both behavior and attitudes of many people, from hostility or indifference towards family planning to acceptance and use of contraceptive methods. Tunisia's leaders have been consistently supportive of family planning, expressing their commitment by creating the necessary legal structure, by establishing and funding the ONPFP and in public expressions of support of the program's goals.

In addition, the program's significance has gone past the boundaries of Tunisia. It has come to serve as a model for family planning programs in Francophone Africa and the Arab world and as a training ground for their personnel. In the past two years, physicians and other medical and paramedical personnel from 15 African and Near Eastern countries have been trained at the clinic.

These accomplishments were recognized in 1978 when the ONPFP, under the dynamic leadership of Mr. Mezri Chekir, the P.D.G., was awarded the International Humanitarian Medal by UNESCO.

The ONPFP has managed to overcome a number of obstacles which have handicapped other programs. It has worked successfully with religious leaders to develop legislation, policy and programs which are consistent with the tenets of Islam and supported by its leaders. It is thus the most advanced and comprehensive family planning program in the Arab world. Nevertheless, although enjoying high level commitment to its goals, the program has been plagued with frequent changes in administration which have disrupted the continuity of public health policy, personnel, and programs.

It is in the context of these accomplishments and constraints that one must assess program performance and needs. A study of patterns and trends, from an epidemiological point of view, permits a careful evaluation of current performance and thus sets the stage for determining priorities, recommendations, and redirecting programs and assistance if necessary during the second stage of the GOT/USAID evaluation.

1. National Family Planning Acceptor Trends

Graphs prepared by Dr. Roger Bernard illustrate the major areas of concern (see Attachment, Figures 1-9). They are an analysis of service statistics, collected routinely and published annually, and projections of the Tunisian population prepared by the ONPFP, "Projections de la Population Tunisienne par Délégation, Sexe, Age et Année, 1975-86." The graphs display a wealth of information using the most current data. They can best be interpreted by those who have an intimate understanding and familiarity with the day-to-day operation and problems of the program. Certain trends, however, are not worthy and deserve comment.

The growing number of new family planning acceptors since 1975 is illustrated in Figures 1 and 2. Overall, using all methods there has been a 25.2 percent increase in the rate of acceptors among married women of reproductive age (15-49) in the years between 1975 and 1978. This increase is reflected in the 8.3 percent decrease in Tunisia's marital fertility rate (Figure 2). However, one notices a marked downward turn in four of the six methods depicted, a small increase in one method, tubal ligation, and the deceleration in the rate of increase of another method, IUD. To understand these most recent trends, a six-month "window" can be used which permits the comparison of the first six months of the current year, 1979, with the first six months of earlier years. (It should be noted that the first semester is always the higher since it does not include the decline in activity characteristic of the summer months).

Using this six-month "window", we note that there has been an overall decline in the rate of all methods since 1977. (Figures 3 and 4). The decline of every method has resulted in an overall decline in the rate of new acceptors, from 67.0 per thousand in 1977 to 56.8 in 1979. Secondary methods, jelly and condoms, have declined the most, down 29.1 percent and 27 percent respectively. New oral contraceptive acceptors are also down significantly, minus 21.7 percent. This latter decline, however, is misleading since it does not reflect private sector activity which has steadily increased.

Tubal ligation has shown an almost continuous decline since 1975. Only a slight increase in 1978 has interrupted a drop of more than 30 percent in the years 1975-1979. This is disturbing because of the effectiveness and efficiency of tubal ligation, its relative safety for target populations in rural areas, its

appropriateness for high parity women, and thus its importance in a complete and balanced family planning program. It is particularly disturbing when one considers the magnitude of the recent ONPFP, JHPIEGO and AVS efforts in expanding this aspect of the Tunisian program.

Nevertheless, despite fluctuations, and in contrast to the other methods which "peaked" in 1977, the two most effective surgical methods of contraception, IUD and tubal ligation, have been performed at a relatively consistent level. A plateau between 20 and 23 percent use among MWRA has been maintained. In other words, this subsystem of efficient surgical methods has shown both considerable inertia to inputs but also resilience over this five-year period.

In seeking to understand the decline in tubal ligations and other contraceptive methods, a number of explanations have been advanced. One asserts that the reservoir of women for whom certain methods are appropriate has been used up. To answer this question, it is essential that fertility rates be determined which are both age- and parity-specific. It is clear from existing calculations, that there is a considerable reservoir of women who are over thirty and are not practicing contraception. The program needs to be expanded to serve more effectively older, high parity women for whom infant and maternal mortality and morbidity are the highest. (Figure 10).

While rates have declined 12.7 percent since 1977, abortion remains a major element of the Tunisian program. In view of the serious impact of repeated abortions on maternal health, the interaction of the following contributing factors needs to be carefully examined:

1. failure of contraceptive method;
2. lack of full access to contraceptive services;
3. inadequate education on the health risks of repeated abortions;
4. persistent cultural factors favoring abortion as a preferred means of contraception.

It is hoped that these issues will be addressed fully in the ONPFP's study of abortion in the coming calendar year.

Figure 5 shows program performance on the level of the province. Although some women obtain services outside of their own region, these figures remain a good index to the effective distribution of family planning services. While the country as a whole shows a decline, performance is remarkably uneven on the provincial level based on an analysis of two methods -- IUD and tubal ligation for the first semesters of the years 1977-79. Certain regions have shown spectacular increases, notably Sousse in IUD insertions, and Bizerte in tubal ligations. Other regions show a somersault-like evolution, with dramatic increases followed by dramatic declines (Bizerte in IUD's, Le Kef and Monastir in

tubal ligations). Decreases characterize the rates of ligations in Beja, and Nabeul and both methods in Sfax. Finally, other regions show consistently low rates, notably Kairouan and Medenine. The disparity between rural and urban areas of Tunisia, which was noted in the 1975 AID Evaluation Report of the Family Planning Program and in the background document for the current bilateral program, is still very much in evidence. (Figures 5-9, 11). Areas in central and southern Tunisia are still without adequate access to family planning services and the continuing low prevalence reflects this. As will be discussed elsewhere in the report, pilot projects in Bir Ali and Jendouba, have shown the effectiveness of a CBD strategy in areas where the population is widely dispersed and the existing clinic infrastructure is extremely weak.

2. Role of the Private Sector

In an assessment of overall performance of the Tunisian family planning program and impact on fertility, private sector activities must be taken into consideration. Although these activities are normally not reflected in ONPFP service statistics, the private sector is responsible for an estimated 50 percent of oral contraceptive and condom use, 10 percent of IUD insertions and 17 percent of social abortions.¹ The contribution of the private sector has been supported and encouraged by ONPFP programs and policies, including: the distribution of contraceptives at no cost to pharmacies; mass education activities; and training programs directed at private gynecologists, doctors and pharmacists. Nevertheless, only limited information on the nature, scope and distribution of private family planning activities has been gathered. ONPFP annual estimates of the impact of the private sector are based largely on figures supplied by the Central Pharmacy on the number of contraceptives distributed. The P.D.G. has proposed that a special study be undertaken to determine more accurately the contribution of the private sector and its future relationship with the ONPFP.

3. Issues for Phase Two Evaluation

All of the issues raised in this report will have important effects on program performance, notably the issues pertaining to management, community-based distribution of contraceptives and information and education activities. The following are added here for their relevance to the improvement in the provision of needed services and the consequent effect on performance.

- Discuss the strengthening and expansion of ONPFP's hospital and clinic-based postpartum program activities and the development of ways to extend postpartum care, education and family planning services to the large proportion of rural women who deliver at home.
- Assess the current availability and regularity of family planning services (oral contraceptives, secondary methods, IUD's and tubal ligations) in each province.

¹These figures may be revised downward by the results of the Tunisian Fertility Survey.

- Determine the most appropriate method mix in the rural areas discussing such issues as the need for guidelines for dealing with pregnant and lactating women, ways to increase acceptability and use of secondary methods, and the possible introduction of injectables as a means of dramatically increasing contraceptive use.
- Review the current status of the commercial distribution of contraceptive commodities and private sector activities in general; discuss the future role and intensification of commercial activities (including the distribution of contraceptives through non-pharmaceutical retail outlets) as well as plans for a study of the private sector contribution in the provision of family planning services.

4. Recommendations for Immediate Implementation

Discuss the recent analysis of performance statistics (see graphs prepared by Dr. Bernard) with the ONPFP regional delegates and secretaries in order to direct intensified program efforts to areas of greatest need during the last quarter of 1979.

C. The ONPFP Administrative Structure

The ONPFP was created in 1973 as a semi-autonomous government agency within the Ministry of Public Health. It functions as an independent office, cooperating with Ministry of Public Health officials and staff, personnel of other ministries and national governmental and private agencies such as the Union Nationale des Femmes Tunisiennes, the Destourian Socialist Party, labor unions and the local family planning association (IPPF affiliate) to develop and implement programs. The autonomy of the ONPFP has enabled it to program independently, attract and administer foreign donor assistance and to field its own national and regional staffs.

From its headquarters in Tunis, the ONPFP administers the national program, directed by Divisions of Family Planning, Population, and Administration and Finance as well as Offices of Program and Synthesis, Cooperation and Special Projects. The strength of the program lies in the dynamic leadership of the P.D.G., Mezri Chekir, and his dedicated staff. (Appendix D, organizational structure).

If there is a weakness in this national structure, it is in the need for the recruitment of personnel with mid-level technical skills and the development of a strong planning unit under the P.D.G.'s direction. The former would facilitate the implementation of plans and permit closer monitoring of special projects, often difficult with the current over-burdened staff. The latter could encourage intra-office communication in planning and evaluation and determine realistic management objectives, responsive to the regular analyses of trends and patterns prepared by the Population Division.

To extend family planning services nationwide, the ONPFP has created a Regional Center for Family Planning and Education in each of Tunisia's eighteen provinces. Each center is administered by a delegate who also directs educational and training activities on the regional level and serves as the liaison with the officials of the Ministry of Public Health and other regional and local authorities. He is assisted by a midwife who supervises the delivery of family planning services and medical follow-up. In addition, there is an administrative secretary who is responsible for the collection and reporting of service statistics. Finally, mobile teams extend the provision of family planning services into more rural areas -- visiting dispensaries, clinics and other gathering points for periodic service delivery, education and follow-up, supplementing the services available on a regular basis at the regional center and at health facilities.

The problems which now face the ONPFP are those inherent in any medium-sized bureaucracy having a field structure, namely, communication between the central bureau and regional offices, field office support, and supervision of field personnel. Recently, in recognition of the enormity of the task of administering the national program, this responsibility has been divided between the

Medical Division, responsible for the delivery of medical services, and an administrative arm, the Division of Regional Services. This change should bring a continued improvement in the management and administration of the regional activities. The major challenge confronting the reorganized regional administration is strengthening the channels of vertical communication since effective administration, support and supervision all depend on regular and rapid feedback of service statistics to guide management and program direction, and responsiveness to field problems. The potential source for dynamic feedback of performance statistics to the field lies in the close cooperation of the Medical, Population and Regional Services Divisions. The interaction of these Divisions is the backbone of an effective, evolving program. The efficient operation of the newly created Division of Regional Services will improve the responsiveness of the central office to requests for routine administrative services, and, with frequent site visits by ONPFP staff, create a structure which can supervise field operations and respond to needs in rural areas more effectively.

Issues for Phase Two Evaluation

- Discuss ways of expanding the ONPFP's planning and programming capability and strengthening the Medical and Population Divisions.
- Examine current staffing patterns (duties and responsibilities) and plans to recruit mid-level technical personnel (statisticians/demographers, IE&C and management-information specialists, etc.) to facilitate program planning and implementation.
- Explore the present and future administrative needs of the ONPFP to administer intermediary-funded programs and to assure a smooth transition to independence from bilateral support.
- Assess the effectiveness of recent measures to strengthen regional-central channels of communications designed to provide greater central office support of and responsiveness to the field operations.

D. Program Monitoring, Research and Evaluation

ONPFP activities in the area of research and evaluation have expanded considerably in the past several years. In addition to the routine collection and processing of service statistics, the ONPFP has sponsored studies ranging from an updated IUD and pill continuation study, national fertility survey and sub-national contraceptive prevalence survey to special projects such as PFAD, PFPC and PFMR. The current portfolio also includes studies of the components of population change -- fertility, mortality, migration, nuptiality and divorce -- as well as examination of such issues as family size, cost and value of children, law and population and the implications of rapid population growth for education, employment and housing.

Results of a number of these studies are already available; data processing and analysis of the remaining studies should be completed in the next six months. By mid-1980, the ONPFP will have a wealth of up-to-date information on married women of reproductive age by: use of different family planning methods (continuation and prevalence rates), socio-demographic characteristics, knowledge and attitudes towards family planning and reasons for discontinuation or non-use of contraception. The Contraceptive Prevalence Survey in Jendouba will provide information on availability of family planning services as well as current contraceptive use. From the National Fertility Survey, the impact of the program on fertility decline can be assessed.

1980 will be a critical year in terms of an overall assessment of ONPFP activities. During the first six months there will be a comprehensive evaluation of research findings along with the development of a socio-econometric model. The ONPFP is planning to host a special workshop in which the results of major studies will be discussed and future program objectives and research strategies will be outlined. Officials from several ministries and national organizations as well as international population and family planning experts are expected to participate.

A review of ONPFP's research and evaluation strategy -- its strengths and weaknesses -- is provided in the June 1978 Omran-Bernard report (see Bibliography, Appendix E). Some of the recommendations presented have already been implemented and recent positive developments can be noted: a maternity record study has been initiated at the Aziza Othmana Hospital, the first of its kind in Tunisia; and an updated abortion and tubal ligation study will be conducted in early 1980. The Center for Applied Research (Ariana Clinic) promises to be the spearhead for a number of important activities in the coming year. A new committee has been created in an effort to promote coordinated research activities in human reproduction and family planning. Just published is a detailed review of ongoing and completed biomedical and epidemiological research as well as a list of priority studies in the future. A recent 10-day trip to U.S. research institutions by Drs. Boukhris and Dali provided inspiration for some of the new directions being proposed.

The challenge now facing the ONPFP is threefold: to ensure that 1) the latest family planning research findings and demographic objectives are incorporated in the 6th Economic and Social Development Plan; 2) all new research activities will have an operational goal; and 3) the data currently being processed and analysed will be used in an efficient and effective manner to guide new program action. While the ONPFP has collected an enormous body of data over the last six years, there has been a marked underutilization of existing information for program management and planning. This weakness was first highlighted during the 1975 AID Evaluation which recommended the ONPFP establish a "continuing program of operationally oriented research to improve the quality and accuracy of statistical reporting required for program development...to evaluate progress, an accelerated management monitoring system should be instituted." Although some progress has been achieved over this period, the ONPFP still lacks a planning and evaluation unit whose purpose is to analyse trends of method-specific performance at the regional level and provide rapid feedback of findings to the field in an effort to improve program performance.

ONPFP statistical reporting has concentrated on the annual number of family planning consultations and new acceptors by place and method. Measurement of program impact has been based on the number of births averted. These measures, however, are not suitable for efficient program steering. Rather, the focus in the future must be on contraceptive continuation and prevalence. A far more effective measurement tool than just the total number of family planning acts is provided by contraceptive acceptor rates per 1,000 MWRA (as illustrated in the appended graphs). These program performance statistics can indicate interruptions and uneven distribution of family planning services, alert program managers to under-served populations and identify imbalances in the mix of services that are offered.

Periodic national contraceptive prevalence surveys are essential to supplement ONPFP service statistics and provide a more accurate measurement of overall program performance, including the impact of the private sector. During this critical stage of the Tunisian family planning program such a survey should be conducted every three years, beginning in 1981. It is recommended that the first national contraceptive prevalence survey be a collaborative effort between ONPFP and INS, using the resources and expertise of INS for the sampling and field work while ONPFP's role would be one of supervision and final report preparation. Consideration should also be given to using Maternity Record studies as a valuable resource for program planning and evaluation in maternal and child health and family planning. In addition to the pilot effort at Aziza Othmana Hospital, studies should be conducted initially in three or four maternities, nationwide. Not only can this tool serve to set standards for improved maternity care but also to measure the impact of family planning on maternal and child health.

Issues for Phase Two Evaluation

- Discuss the status and early findings of the "evaluation and synthesis" study being directed by the Population Division to guide new program strategy.
- Examine the ONPFP's data system and the need for a simpler, more management-oriented system rather than one which is used primarily for demographic analysis including the advantages for effective program management of expressing demographic objectives and family planning program impact in terms of contraceptive prevalence rather than number of births averted.
- Discuss plans for supplementing and complementing the routine collection of service statistics through the use of:
 - a) periodic contraceptive prevalence surveys, in collaboration with INS;
 - b) maternity record studies in selected hospitals and clinics;
 - c) survey of private and commercial sector activities.
- Assess ONPFP needs in research, evaluation and program monitoring, in terms of:
 - a) personnel
 - b) in-service training
 - c) technical assistance
 - d) equipment (computer soft and hard ware).
- Discuss the current status of age-specific fertility including the "reservoir" of high parity older women, and the development, in collaboration with INS, of new age and method-specific goals for the Sixth Economic and Social Plan.

E. Rural Community-Based Family Planning/MCH Delivery Systems: Pilot Experiences

A primary goal of the ONPFP in the last several years has been to strengthen and expand family planning services in rural areas where over one-half of the total female population of child-bearing age resides but where contraceptive prevalence lags far behind the levels of the urban coastal areas. Recognizing the inability of the traditional clinic-based system to serve a rural population which is widely dispersed and hampered by difficult terrain and inadequate transportation, the ONPFP has concentrated on increasing the number of mobile teams as well as testing new approaches to making family planning services fully available to rural families: distribution at the household level. The first such experiment, PFAD (Planning Familial à Domicile), was launched in April 1976, with the support of USAID, in the delegation of Bir Ali Ben Khalifa (pop. 30,000), Sfax Governorate. Under the supervision of a physician, eight locally recruited and specially trained extra medical female workers visited all eligible women in the delegation a minimum of three times over a two-year period offering family planning information and services (oral contraceptives and referrals for IUDs and sterilization).

Building on the early success of the PFAD experiment, a number of innovative contraceptive delivery systems have been developed in other parts of Tunisia. These are generally larger in size and scope, designed to be more cost-effective and provide integrated family planning and maternal and child health (MCH) services. The PFPC (Planning Familial par le Couple) project was started in April 1977 in three delegations of Jendouba Governorate (study population 144,000), using only five field workers, greater contraceptive mix including the addition of a health component, and various resupply mechanisms. Another three-year project, PFMR (Planning Familial en Milieu Rural) was officially launched in January 1979 in a total of 12 delegations in the governorates of Kasserine, Sidi Bouzid, Siliana and the health region of Menzel Bourguiba (study population of approximately 400,000). The objective is to measure the impact and cost-effectiveness of an integrated family planning/MCH project using mobile clinical services together with outreach workers providing information and motivation on the household level.

Community-based distribution (CBD) projects are also underway in Le Kef, Béja, Cap Bon/Nabeul, Medjez el Bab and Mahdia. These are, for the most part, primary health care experiments with a weaker family planning component. A key feature of the PFAD, PFPC, PFMR and some of the other CBD projects is the use of a new kind of outreach worker (aides familiales), young girls recruited from the community with generally 2 to 3 years of secondary school education who receive an average of six weeks' training in family planning/MCH and who serve as a vital link between the family and the public health infrastructure.

1. Significant Findings

The PFAD project was completed in April 1979 and a wealth of data is available from the cross-sectional surveys conducted at the beginning and end of the two-year intervention period (see Summary Tables 3-6). This pilot project is the first scientific study in Tunisia of the impact of a community-based

distribution program on contraceptive prevalence. A number of important conclusions can now be drawn based on the results of PFAD as well as some of the other more advanced pilot family planning/MCH experiments:

- Household contraceptive distribution in rural Tunisia is both socio-culturally acceptable as well as logistically and administratively feasible. It can overcome geographic, cognitive and administrative barriers to family planning acceptance imposed by a clinic-based system.
- Family planning knowledge and use can be significantly increased through a community-based delivery system using locally recruited female workers to provide contraceptive information/services. Nearly 80 percent of the women contacted in Bir Ali Ben Khalifa delegation reported that they had first learned about family planning from the PFAD field workers. In the PFPC project, 63 percent of the women surveyed (Fernana delegation) said they received a family planning method for the first time through the project.
- The demand for family planning (particularly tubal ligation) is strong even among an isolated rural population with a low level of socioeconomic development. Acceptance of family planning, according to PFAD and PFPC surveys, is unrelated to educational level of the husband or wife and husband's occupation.
- Household distribution of contraceptives can result in a dramatic increase in contraceptive prevalence. In the PFPC project, after one year, the proportion of women practicing family planning more than doubled, from 10.9 percent to 23.7 percent. Results from the final PFAD survey showed a relative increase in contraceptive prevalence of 168 percent, from 6.6 percent to 17.7 percent in two years. In some sectors, the proportion of women contracepting at the time of the final survey was over 30 percent. A decline of one-sixth was reported in the pregnancy rate while the proportion of women at risk of pregnancy decreased by nearly one-third. In only two years, a significant change occurred in both the contraceptive and fertility behavior of the population of Bir Ali Ben Khalifa delegation.
- Household distribution of oral contraceptives to eligible women is an excellent means of introducing family planning in rural areas and results in an initial increase in prevalence. However, as the pilot projects have demonstrated, the discontinuation rate is relatively high: PFAD - 46 percent after six months; PFPC - mean duration of use of four months. The principal reasons cited for abandoning the method include: desired pregnancy, fear of or experienced side effects and husband's opposition.
- With a broader mix of contraceptive methods offered, contraceptive prevalence will rise substantially. In the PFAD project,

there was an initial concentration on oral contraceptives followed by full availability of IUDs and tubal ligations one year later. At the final survey, over one-half of all women practicing contraception had received a tubal ligation. Both PFAD and PFPC projects have shown a strong interest among the rural target population in permanent methods of contraception -- tubal ligation -- after desired family size has been reached. There is less interest in contraception as a means of spacing births, particularly among higher parity women who want at least half of their children to be sons. This trend appears to be changing, however. During the PFAD final survey, more than one-fourth of the women who indicated that they still want more children had used contraception.

- Use of secondary methods is extremely low: 0.2 percent - PFPC project (Fernana delegation) and 1.1 percent - PFAD project (final survey).
- The approval and active support of local leaders is key to gaining the confidence of the population in the program and to achieving favorable results. In one sector of Bir Ali Ben Khalifa delegation, the wife of the sheikh had a tubal ligation, triggering a dramatic increase in the use of this method. At the end of two years, 30 percent of all women in the sector had opted for and received a tubal ligation.
- While contraceptive resupply can be handled by male nurse-hygienists and the existing health infrastructure, the PFAD and PFPC projects have demonstrated the effectiveness of using a new type of female outreach worker (aide familiale) to make the initial contacts at the household level to discuss family planning. Under medical supervision, these locally recruited, specially trained young women can provide family planning information and contraceptives safely and effectively to eligible women. As the Medical Director of the PFAD project stated in the final report: "The interviewers, non-medical personnel, played a substantial medical role during the course of the project. Despite their limited knowledge and education, their action as intermediaries was important in giving needed advice concerning side effects, diet and general health...Can a non-medical staff be used in such a project without generating serious problems if a medical backup is available and a regular gynecologic consultation is provided? We would answer yes, because in no instance was it necessary for a nurse-midwife to confirm the work of the lay staff making home visits. The interviewers' training in anatomy, physiology and contraception proved to be adequate to cope with the problems they faced.

The major problems experienced in these pilot CBD programs have been ones of management and transportation. Coordination and supervision of special project field activities by the ONPFP central office has been weak, particularly

for the PFPC and PFMR projects. The situation has been aggravated by shifts in personnel assigned to monitor these projects. As a result of difficult terrain and inadequate maintenance, project vehicles have periodically broken down. Services have at times been disrupted for an extended period due to delays in obtaining spare parts and making the necessary repairs. Program progress has also been hampered periodically by shortages of non-contraceptive supplies.

2. Issues for Phase Two Evaluation

- Develop a national strategy of efficient and cost-effective family planning/MCH care service delivery for rural Tunisia to be incorporated into the sixth Economic and Social Development Plan.
- Based on the findings of the pilot CBD projects, determine the most appropriate family planning and health interventions, personnel, contraceptive resupply systems and referral mechanisms for IUD and tubal ligation candidates for use in a nationwide program.
- Examine means of improving coordination and maximizing use-effectiveness of existing rural health/family planning infrastructure and resources (personnel, supplies, equipment, vehicles, etc.) to support outreach contraceptive delivery programs.

3. Recommendations for Immediate Implementation

- Prepare an inventory of family planning/MCH CBD projects in Tunisia (PFAD, PFMR, Le Kef, Medjez el Bab, Cap Bon/Nabeul, Mahdia, Gafsa, Béja) and begin work on a synthesis of findings in preparation for the seminar to be held in Sousse in early 1980.
- Work out a plan to continue employment of the five PFPC project workers following termination of the pilot activities in December 1979 so that their training and two-and-one-half years of experience providing family planning information and services to families in one-half of Jendouba province will not be lost.

F. Medical and Paramedical Manpower Needs

The bureaucratic autonomy of the ONPFP within the Ministry of Public Health has given it a freedom in program design and implementation over the years. This flexibility has meant that the ONPFP has been able to respond to the difficult problems of staffing, particularly in the rural areas, drawing on foreign medical personnel to supplement an overtaxed Tunisian medical community, experimenting with the use of paramedical personnel for certain educational and distribution functions, and deploying medical personnel on an ad hoc basis to meet special needs and situations as they arise.

Despite the creativity and the commitment with which the ONPFP has approached the challenge of staffing, four fundamental problems remain: the number of OB/GYNs, other physicians, and midwives are insufficient to meet current as well as future needs; the lack of medical and paramedical personnel is most severe in the rural areas of the country; rural health efforts require an outreach component to complement the medical infrastructure (see the discussion of Community-Based Distribution); and efforts to meet pressing rural needs with too small a staff have led to irregularity in the deployment of personnel and consequently in the availability of services, affecting the credibility of the program itself in some areas.

Since the success of the family planning program is, in large part, dependent upon acts (tubal ligation and IUD insertions) performed by trained medical and paramedical personnel, the single most important limiting factor has been the scarcity of OB/GYNs and midwives particularly in rural areas. Today, two of the provinces lack a gynecologist altogether (Siliana and Sidi Bouzid). Patients wishing a social abortion or a tubal ligation in these areas are transported to an adjoining province. Furthermore, of the 60 OB/GYNs serving in Tunisia, two-thirds are foreign physicians on contract. There is, therefore, justifiable long-term concern that when current contracts expire, the lack of personnel may be exacerbated because of increasing competition from other countries for the services of these doctors.

There does not seem to be an adequate provision at present for the training of Tunisian gynecologists to meet future needs. The general expectation is that rural needs for doctors will be met as the number of licensed physicians increases and as some, faced with diminishing urban opportunities, will opt for rural services. This argument seems particularly difficult to apply to specialties such as gynecology where the numbers planned, through the mechanism of a limited number of concours, seem insufficient to meet even future urban needs, much less to create a surplus which will overflow into rural areas.

The leading OB/GYNs at the Medical Faculty of Tunis are increasingly aware of the seriousness of personnel problems in rural areas and of their critical responsibility for planning and training for the future needs of their country. A promising dialogue has been opened between the leading OB/GYNs and the ONPFP to address problems of joint concern, including the possibility of increasing the number of concours in gynecology and to orient medical training for gynecologists as well as generalists to meet future needs. One of the OB/GYNs has suggested as a goal, two OB/GYNs in each province by the end of the Sixth Five Year Plan.

Additional paramedical personnel, particularly midwives are required in rural Tunisia. During Phase Two there needs to be an assessment of paramedical training levels nationwide, future needs, and plans to meet those needs.¹ It is hoped that the medical community will take steps to redress this shortage.

The problems of meeting immediate needs in staffing suggest a number of short-term solutions which require careful examination to maximize program effectiveness while assuring continued good medical practice. Measures which should be considered include:

- The introduction of a system of compensation to OB/GYNs, as a means of increasing tubal ligation performance.
- Where there is no OB/GYN in rural areas, the authorization of specially trained physicians (surgeons and generalists) to perform surgical contraceptive acts.
- The use of paramedical and extra-medical personnel to distribute contraceptives under close medical supervision.
- Required rural service for graduates of the three Faculties of Medicine.

Experience in several rural projects, including those by U.N.F.T., Le Kef A.S.D.E.A.R., and the pilot projects at Bir Ali and Jendouba, have shown the importance of female family planning outreach workers. However, this category of worker has not yet been institutionalized, nor have existing outreach personnel, most of whom are male and thus less effective in family planning, been deployed on an extensive and regular basis. Ironically, the most effective workers, females who are locally recruited, rarely meet the minimum education requirements for government employees. This is a problem which requires careful examination during Phase Two.

Finally, because of efforts to respond to overwhelming needs with limited personnel and without full coordination with the Ministry of Public Health and its regional representatives, family planning personnel and services are sometimes deployed and available irregularly. This may result in an inefficient use of existing personnel, required to function without adequate staff support, and a consequent inability to provide expected services on a regular and high quality basis. Increased inter- and intra-ministerial collaboration on the regional level and more decentralized decision-making concerning the allocation of personnel and services may help to alleviate such problems.

Issues for Phase Two Evaluation

- Assess long-term needs for medical and paramedical personnel and develop plans, in cooperation with the medical community and faculties, to meet those needs.

¹ Additional information on this topic was gathered during a subsequent visit by one of the team members. See report on Expansion of Rural Community Health Project to Kasserine, Fort and Johnson, December 1979.

- Examine alternative solutions for meeting immediate staffing needs to ensure greater availability and regularity of services to the rural population: the use of paramedics for distributing contraceptives; the training of surgeons and generalists to perform acts of surgical contraception, etc.
- Discuss the means to institutionalize a female family planning outreach worker (aide familiale) to serve as a vital link between rural households and the health infrastructure. Issues to resolve include: eligibility standards, duties and responsibilities, training and supervision, transportation needs, and budget requirements.

G. Information, Education and Communciation

The ONPFP estimates that 90 percent of Tunisia's citizens are aware of family planning. In the years since the beginning of the family planning program, the attitudes of many people have shifted from open hostility to awareness and receptivity. This change can be attributed to Tunisia's strong national commitment to family planning and the incorporation of information about its significance into the activities and training of virtually every ministry and national organization. The ONPFP has worked across a broad spectrum of national agencies to train and inform key workers in Health, Agriculture, Sports and Youth, Education, Social Affairs, the political party, the women's organization, and labor unions. In addition, the ONPFP has pursued an active media program, popularizing family planning in television and radio broadcasts and in newspaper and magazine articles.

Nevertheless, as the P.D.G. noted in his initial remarks to the Phase One Team, education and information programs are required now in order to dispell confusion about contraceptive techniques, fears of possible side-effects and ignorance of method availability. These tasks are particularly important in rural areas where widespread confusion, rumors, misinformation, and fears persist. Face-to-face contact is an effective means of education, but is limited in outreach by cost and the need for supporting material.

The IE&C program has found it difficult in the development of educational activities and materials to shift from national to regional and local concerns, from urban to rural problems, and from organized contexts and government intermediaries to individual citizens. Existing materials speak to the global implications of family planning and do not effectively address the specific fears and need for information of rural populations. Based on the earlier evaluations by Bertrand and Rothe and McMahon and on a preliminary assessment by Phase One, the following is urgently needed:

- (1) Audiovisual educational materials are needed to explain family planning and contraceptive techniques in culturally appropriate and effective ways so as to permit men and women to make informed decisions. Materials are needed for use in the regional family planning education centers, by midwives and other paramedical personnel and outreach workers, and for handouts to women and men receiving family planning services. For example, the models and diagrams of the human body currently supplied and used by family planning workers may be confusing because they are inconsistent with popular ideas held about the body and the reproductive system. Existing pamphlets, explaining the various methods, their proper use and side-effects, depend too heavily on the written word for effective use in a population with low literacy levels. Basic educational material, then, reflecting the concerns and education of the target population, needs to be developed, tested and made available in rural areas.

- (2) While certain educational materials may be developed nationally, regional delegates should also be given considerable latitude and support to design programs and materials which are responsive to local needs, interests and resources. The creation of murals by school children, use of still photographs of local children, and recording of appropriate oral literature, songs and poems, traditionally sung and recited by women, are possible projects which could be developed on a regional basis. Since the regional delegates are, for the most part, trained as health educators, financial support, encouragement and recognition of accomplishments should bring results. As a part of Phase Two, the team should survey existing materials and equipment in the rural areas.
- (3) The excellent work of the ONPFP among male workers and, more recently, migrants, needs to be extended among male heads of households in rural areas. This is particularly true since men, in more traditional areas, exercise considerable control over the physical movements and decisions of women. According to results of the Bir Ali PFAD study, 22 percent of the women who accepted but did not use oral contraceptives cited the opposition of the husband as the principal reason.

The ONPFP recognizes the need for expanded programs in the IE&C area. The P.D.G. has proposed developing a production unit to meet the pressing educational and informational needs of the Tunisian program and, in the long view, to produce material for the Arab world and Francophone Africa. Solutions to these issues and the development of effective rural IE&C programs demand the serious attention of Phase Two.

Issues for Phase Two Evaluation.

- Review the results of recent surveys, KAP studies and the written literature on attitudes towards contraception and reproduction. Determine if additional studies are needed in order to provide the necessary background information for the development of culturally appropriate and responsive educational material and programs.
- Develop policy and design a pilot project to strengthen the rural educational programs and the capacity of the regional delegates to develop locally responsive programs.
- Develop a pilot project involving the design and testing of educational material for women and male heads of households in rural areas.
- Discuss ways of involving male heads of households in rural areas more fully in family planning activities (e.g., information days, special condom distribution at markets, cafes and other gathering places for men).

- Review Division of Communication staffing needs and discuss and define the stages needed to increase the ONPFP's production capacity, including the potential for contracting with other ministries, agencies and private Tunisian companies and individuals while developing a self-sufficient production unit.

H. Training

Training activities by the ONPFP consist of four major thrusts: the National Training Center at Ariana, seminars, in-service training, and information days held in various locations; a training program in laparoscopy at the Ariana Clinic; and the regional education and training program conducted by regional delegates.

The National Training Center, located in a villa outside of Tunis, is well-equipped with meeting rooms, dormitory and kitchen facilities for students and participants. Operational since March, it has pursued activities since the beginning of the year, training physicians, midwives, nurses' aides, social workers, and pharmacists. In-service training programs are also offered for the regional ONPFP staffs, the regional health educators and secretaries.

There is considerable attention paid to the curriculum of the training programs. The director is concerned with the effectiveness and relevance of the training offered and has initiated a system of course evaluation to monitor training efforts. In addition, there is an ONPFP advisory committee which noted in a June meeting a need for strengthened clinical instruction and increased use of audiovisual materials in training programs for midwives. The Phase One Team was able to attend one training session, a conference in Monastir, which accounted for much of September's training activity. The program was interesting and broad but might have had more practical use for the midwives attending if it had been smaller and had a curriculum more closely tied to the midwives' practical needs.

Of some concern to the ONPFP and to the Phase One Team is the level of training activity which has not increased substantially over 1978. In the first three quarters of 1979, the center has trained 28 Tunisian and 31 foreign physicians, 115 midwives, 158 social workers, three nurses' aides, 19 regional delegates and 20 regional secretaries, and conducted information days for 60 physicians and 60 pharmacists (Quarterly Report, ONPFP). In each of the medical and paramedical categories, the achievement falls short of the Program Goals for 1979 (Résultats 1978, Programme 1979, ONPFP, p 18), where training programs for 60 physicians, 230 midwives and 170 nurses' aides and information days for 300 physicians and 200 pharmacists were envisioned.

An additional problem is the geographic representation in the training programs. While many of the sessions are directed at groups from all over the country, the greatest effort appears to be directed at training personnel from the Tunis area. As a major focus in 1978, the program trained 140 social agents who were from the greater Tunis area. While staff for special regional projects, such as the F.P.I.A. family aides and midwives are brought into the center, the majority of rural training programs appear to be conducted by the regional health educators. As the center's director notes, the increased burden of administrative responsibilities falling on the regional delegates may interfere with their ability to adequately serve regional educational and training needs. Given the goals of AID assistance and the national significance of the training center, it should be determined whether the center should play a more active role in direct training of rural health workers.

The Training Center cooperates with the Medical Division in training physicians and midwives in contraceptive techniques, including laparoscopy, at the Ariana clinic. This training program is playing a significant international as well as national role. In the 15 months between June 1978 and September 1979, the laparoscopy program trained medical and paramedical personnel from 15 Francophone countries in Africa (Morocco, Togo, Zaire, Senegal, Mali, Benin, Ivory Coast, Madagascar, Niger, Rwanda, Gabon, Comoro Islands, and Chad). Since so many of the program training outputs are outside Tunisia, approximately half, it seems appropriate that the program be evaluated on a wider basis rather than simply on performance statistics in Tunisia. Because of this significant international role, the program requires close monitoring and administration, both on the part of ONPFP and of the funding agencies, JHPIEGO and IPAUS.

Issues for Phase Two Evaluation

- Identify future Tunisian training priorities and draw up plans to meet these needs.
- Determine the future role of the National Training Center in continuing and expanding in-service training directed at rural family planning and health workers.
- Discuss ways to strengthen the clinical and audiovisual content of training programs.
- Develop mechanisms for closer administrative and monitoring of training programs with international participants by the ONPFP and the grantors.

I. Aid Assistance

Since 1965 AID assistance to the Tunisian family planning program has totaled more than \$26 million. 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 FY '77, the results of a 1975 evaluation recommended continued AID assistance. A current four-year \$6.6 million bilateral assistance grant was initiated in 1978.

The primary purpose of the current program is "to assist the GOT to strengthen and expand family planning services primarily in rural areas." The grant agreement has focused on budget support and program development in six major areas.

- a. Pilot Contraceptive Distribution programs
- b. Training
- c. Family Planning Service System Support
 - 1) Contraceptives
 - 2) Medical equipment and drugs
 - 3) General support
- d. IE&C
- e. Research and Evaluation
- f. Short-term technical assistance and Participant training

In addition to bilateral support of these areas, AID has centrally-funded projects through contracts with FPIA, IPAVS, International Statistical Institute (WFS), JHPIEGO, Syntex and Westinghouse Health Systems.

With this assistance, the ONPFP has taken major steps towards realizing the objectives of the current project. Accomplishments over the last two years include:

- A strengthened nationwide educational and administrative structure with offices, staff and programs in each of Tunisia's 18 provinces.
- Pilot projects testing different household and community-based distribution systems with the goal of developing an appropriate model for a national 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.
- 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.

1. Status of Bilateral Program Components

a. Pilot Contraceptive Distribution Programs

The experimentation in innovative non-clinical approaches to the delivery of family planning services in rural Tunisia, through the PFAD and PFPC pilot projects, has been a highly successful component of the current AID bilateral agreement and one which has important implications for the future of the national family planning program. When the PFAD (Planning Familial à Domicile) project was launched in April 1976, it represented a bold initiative by the ONPFP and the first real test in Tunisia of making family planning services fully available to a rural population. Locally recruited and specially trained non-medical female workers, under the supervision of a physician, were used for the first time to distribute house-to-house oral contraceptives (without a doctor's prescription) to eligible women and provide referral for surgical contraceptive services.

From the outset, the logistical and communication challenges facing the project were enormous. The site, Bir Ali Ben Khalifa delegation (60 kms west of Sfax), is typical of much of rural Tunisia--difficult terrain, a sparse network of dirt roads, widely dispersed population with limited previous knowledge of and access to family planning services. Yet the fieldworkers were able to overcome all of these obstacles. In a period of two years, every eligible woman in the delegation (pop. 30,000) was contacted at least three times; contraceptive prevalence increased dramatically from a baseline average of 6.6 percent to 17.7 percent. In some sectors, prevalence reached a level as high as 30 percent.

Following the termination of household visits in August 1978, a permanent contraceptive resupply system was established. The eight fieldworkers were replaced by a mobile team, visiting on a weekly basis each of the eight dispensaries in the delegation and periodically 14 other locations as well. The PFAD project ended in April 1979 after a final survey was conducted of all MWRA in the delegation. Complete results of the household visits and final survey, together with a detailed description of the project background and setting, study design and implications of PFAD for the national program, are provided in the final project report, published in August 1979. Also included are a medical report, a qualitative assessment with excerpts of interviews with people associated with PFAD and a preliminary cost analysis of the project.

While retaining many of the key features of PFAD, including the use of local female workers, a second and much larger pilot household contraceptive distribution project was launched in April 1977 in three delegations of Jendouba Governorate (total study population of 144,000). The primary purpose of PFPC (Planning Familial par le Couple) was to develop a cost-effective family planning delivery system which had the potential for replication on a national scale. The experiment used fewer field workers than PFAD, greater contraceptive mix (including several secondary methods) and a variety of resupply mechanisms. In one of the three delegations, an integrated family planning/MCH distribution system was tested. Family planning information and services, including referral for IUD and tubal ligation, were provided to all eligible women, as well as several health interventions (weighing of all pre-school children, detection of diarrhea and certain eye, skin and parasitic diseases, distribution of ophthalmologic tetracycline, vaccination referral, etc.). Originally, the principal health component of the PFPC project was to be oral rehydration. However, due to poor coordination and management by ONPFP in the handling of the Oralyte procurement (both from the Central Pharmacy and from UNICEF), sufficient quantities were not available until after project activities had ended. Oralyte was distributed in only two out of the nine sectors in the delegation.

Household distribution for the PFPC project terminated in September 1979 and contraceptive resupply systems are currently functioning in all three delegations. There will be a comprehensive evaluation of the pilot program which will analyse the results of: the 1973 contraceptive prevalence survey in Fernana delegation as well as the recently completed Governorate-wide survey (see section on Westinghouse Health Systems), a special survey of Oralyte and neosampoon acceptors, and interviews with project personnel. The final report, expected in March 1980, will include a quantitative and cost analysis as well as assessment of the effectiveness of the resupply systems tested and the family planning-only delivery system versus the integrated family planning/MCH system.

Although both PFAD and PFPC were primarily demonstration projects, a rich body of data has been collected, providing demographic-socioeconomic characteristics, pregnancy histories and contraceptive behavior of women of reproductive age in these two areas. The quantitative as well as qualitative information obtained are valuable to the ONPFP in its effort to develop the most cost-effective delivery system for all of rural Tunisia. As indicated in an earlier section of the report, many important lessons have been learned from these two projects. Most significantly, these experiments have demonstrated that household contraceptive distribution is both acceptable and feasible in rural Tunisia and can have a dramatic impact on contraceptive and fertility behavior.

The challenge now facing the ONPFP and the MOPH is to move from these pilot experiences and develop a coherent and cost-effective strategy of family planning/basic health care delivery for rural Tunisia. To support a large scale integrated community-based distribution program, however, will require better management and monitoring by ONPFP staff, closer coordination with MOPH personnel, along with strong promotional efforts and sufficient supplies, equipment and vehicles.

b. Training

Under the bilateral program, AID supports a variety of training-related activities including regional meetings, participant support costs, honoraria for lecturers, costs of training materials and in-service training.

Through intermediary organizations such as IPAVS and JHPIEGO, AID supports the training of paramedical personnel, physicians in laparoscopy and underwrites the National Training Center (see section on assessment of intermediary activities below). Areas of concern in the training program are elaborated upon in those sections and in Section H above.

c. Family Planning Services System Support

This is a major component of AID assistance. It includes the supply of contraceptive commodities (orals, condoms, IUDs, creams, jellies, foams), an estimated \$213,000 from FY '79 AID/Washington funds; medical equipment, drugs and supplies for provincial hospitals, clinics and dispensaries, totaling \$316,000 in FY '79; and general support funds (\$412,000 in FY '79) to cover in part operating expenses and maintenance support costs for family planning centers, mobile teams and surgical contraceptive services.

The latest information available from USAID/Tunis on commodities indicates that two unfunded PIO/Cs have been issued for the procurement of centrally-funded oral contraceptives. The combined total of oral contraceptives included on these PIO/Cs is 1,496,000 monthly cycles scheduled for delivery during the period June 1979 through June 1981. These quantities have been ordered to enable the GOT to have minimally an end of year stock level equal to 100 percent of the previous year's usage. No condoms have been ordered due to the large reserve stock already on hand. It is possible that additional condoms will be ordered in 1981.

Also included in the 1979 ProAg is \$70,000 to help the ONPFP strengthen the current commercial system of distribution of oral contraceptives and condoms with Tunisian labels through detailing work with pharmacies and doctors. Between January 1 and October 4, 1979, an estimated 85,000 cycles of OP50, the overpackaged oral contraceptives, and 750,000 packages of Waha brand condoms were distributed through these outlets.

Because this is an important aspect of AID assistance, it should be the subject of an examination during Phase Two of the Evaluation. One of the team members will concentrate on the questions of general support, budget, commodities, equipment, vehicles and the logistics of the support system, particularly in relationship to programs in rural areas. The case of Oralyte is instructive, pointing up some of the problems of commodity procurement and logistics faced by the ONPFP. This area has not been addressed in previous evaluations and is critical to the future capacity of the ONPFP to maintain and expand service delivery.

d. IE&C

Of all the AID-assisted programs, this has shown the least development. As is summarized under the description of the Division of Communication's activities, there is considerable activity in organized contexts, in the mass media and among specialized groups and health and family planning staff. Of note is the UNFPA-sponsored project to develop education projects in organized contexts, and, more recently, among migrant workers in Europe (ONPFP, Rapport sur l'Etat d'Avancement du Projet d'Integration de l'Education en Matière de Planning Familial dans les Milieux Organisés). However, as has been noted recently, the ONPFP has a "dormant capacity" for meeting the goals established for AID assistance in the preparation of IE&C material for rural audiences, including the development of an active audiovisual component.

There have been repeated evaluations and criticisms of the IE&C component of the program (Fornos et al, Rothe and McMahon, and most recently, Bertrand). However, despite the identification of other needs, AID assistance has continued to focus on supplying new equipment and audiovisual aids rather than helping the ONPFP to identify essential personnel and technical skills needed for production and program development. Shortcomings identified in the Tunisian Family Planning Services Project Paper still exist. There has been little follow-up to recommendations in the form of pilot projects, special educational materials for non-literate populations, technical assistance or participant training. Unfortunately, one of the first such efforts, the recent participation of the ONPFP's Communication Division director in a recent workshop in the United States was not relevant to program development needs.

In addition, assistance programs funded by intermediary organizations such as FPIA and IPAVS have been introduced without adequate attention to monitoring to insure that the necessary and assumed educational component was developed, relying instead on the general programs of the ONPFP's Division of Communication to meet specific outputs. For example, the IPAVS program, Subgrant #294-000-1, assumes that "The program for each clinic will include group/home talks, audiovisual shows, mobile I and E teams and other motivational activities. IPAVS funds are not requested for this purpose, as the ONPFP is in the process of developing a national I and E program with the assistance of other donors; i.e., UNFPA, Government of Tunisia and AID/Tunisia." In the continuing support of the El Ariana Clinic, one of the two project objectives was to conduct I&E activities to publicize services. Yet, only \$1,440 of \$236,693 was budgeted for I&E in the form of newspaper advertising.

Considering the level of funding, \$281,000 for I, E & C categories in the 1979 USAID/GOT Project agreement, the lack of comprehensive, goal-oriented program planning is disturbing. An additional \$23,000 was budgeted for the U.S. purchase of audiovisual aids and production equipment. Ways to insure that this equipment is used effectively in support of special educational materials and programs for nonliterate rural target groups should be addressed in Phase Two.

e. Research and Evaluation

This area of assistance has seen a lot of activity, particularly with the surveys funded by the International Statistical Institute (WFS) and Westinghouse Health Systems (see Assessment of Intermediary Activities). As indicated in Part Two of the report, the Population Division has generated an enormous amount of data in the past two years. However, the challenge now facing the ONPFP is using this rich body of data efficiently and effectively for program management and planning.

f. Technical Assistance

It appears from the information available at this writing that this category of assistance has not been fully used (budgeted at \$40,000 for four person months in 1979). During 1978, Dr. Jane Bertrand evaluated the IE&C program and made several recommendations which the ONPFP is considering. Dr. Gilberte Vansintejin provided assistance in developing curriculum for paramedical training. In addition, Elizabeth Maguire's visits over the last two years have been essential elements in the success of CBD projects. A planned visit of a management consultant to review the overall ONPFP organization has been delayed until after Phase Two.

There are additional areas which would benefit from short-term technical assistance, including:

- cost-effectiveness analysis
- management information systems development
- production assistance in the development of audiovisual materials
- epidemiological interpretation and application of 1979 service statistics to 1980 program management

This is a flexible category of AID assistance and should be utilized fully in the coming years as part of a concerted effort by USAID to identify program needs as they arise and to facilitate the selection of experts to assist in meeting identified needs.

g. Short-Term Participant Training

As part of the participant training component, USAID has sponsored observational tours to the United States and participation in regional and international conferences and short training seminars for ONPFP staff members. In 1978, a group of four visited the United States and 12 participated in international conferences. As of October 1979, there were three U.S. trips for a total of 10 persons and four conference participants sponsored. The trip of Drs. Boukhris and Dali to C.D.C., I.F.R.P. and AID/Washington was particularly fruitful leading to an examination of possible new directions for research and cooperation. Future participant training should consider:

- the possibility of longer term training in such areas as data systems, epidemiology and demography
- the refocusing of the program to include more field visits to family planning programs in the developing world which face comparable challenges and problems (e.g., Indonesia's management information system, Mexico's IE&C and C.B.D. programs)
- increased participation in regional and international conferences

h. Budget

The following is a summary of expenditures to date under the current AID bilateral grant. During the first program year (CY 1978), expenditures totaled approximately \$1.3 million. This figure does not include funds used by AID/Washington for the central procurement of contraceptives. Of this \$1.3 million, about 30 percent was used for medical-surgical support services, 30 percent for medical and audiovisual equipment and supplies, 10 percent for training activities, 15 percent for IE&C activities and 15 percent for research and evaluation activities.

As of the end of August 1979, there have been expenditures of about \$332,000, not including centrally-funded contraceptives. These expenditures are distributed as follows: 35 percent medical-surgical support services; 30 percent medical and audiovisual equipment and supplies; 6 percent training; 18 percent IE&C activities; and 11 percent for research and evaluation. Because these figures represent only the first eight months of the year, there may be some changes in the percentages before the end of the year.

2. Assessment of Intermediary Activities

a. Family Planning International Assistance (FPIA)

A three-year centrally-funded FPIA project provides financial and material assistance to the ONPFP to expand family planning/MCH services in 12 delegations (total population of 400,000) in four Tunisian provinces -- Kasserine, Sidi Bouzid, Siliana and the health region of Menzel Bourguiba. As detailed in the March 1979 ONPFP report Projet Pilote: Le Planning Familial en Milieu Rural (P.F.M.R.), 1978-1981, the project design involves the use of mobile clinics (one per province) providing family planning and MCH services at designated locations in each delegation. In addition, social assistants (aides familiales -- eight per province) give family planning information, education and counseling at the household level and refer women to the mobile clinics for services.

The project has experienced, over the past year, a number of delays and administrative difficulties, as noted in trip reports by the FPIA Regional Director for the Near East and East Africa. Service delivery finally began in

January 1979, six months after the project's official starting date, and on a somewhat more limited basis than originally planned. Principal problems to date have involved vehicle and commodity procurement as well as insufficient monitoring of field activities by the ONPFP central office staff. The mobile clinics promised by the U.K. Overseas Development Ministry have recently been cancelled and replacement clinics provided by the ONPFP for three of the four project areas have been plagued with mechanical problems and are frequently not operating (as was the case when the evaluation team was in Kasserine). The mopeds assigned to the social assistants proved to be inappropriate and broke down shortly after arrival. Thus, the girls' ability to contact some of the more isolated households has been limited. Although none of the social assistants was available when the team visited Kasserine and Thala, we were told that these workers have not been well accepted when operating beyond clan lines. It was felt, moreover, that the acceptability and effectiveness of these girls would be higher if they provided family planning services rather than just information and referral to mobile clinics. A promising aspect of this project is the very active and effective work done by the regional delegate working, particularly with the men of the area through the political structure. In order for this project to meet the original objectives and provide necessary field support, much closer monitoring and more frequent site visits are needed by both ONPFP and FPIA personnel.

The ONPFP considers FPMR as an important pilot project, one that can serve as a model for a nationwide program. If this program is to be taken as the basis for a national strategy for rural areas, careful consideration should be given to the problems of administration and coordination that this project has faced. All of the problems of inter- and intra-ministerial coordination and cooperation come to bear on this regional level. Back-up services have not been adequately provided for FPMR because of shortages and ineffective deployment of personnel, transportation and materials.

b. International Statistical Institute (ISI)

The majority of local costs (\$171,000) for the ONPFP 1978 Tunisian Fertility Survey are being funded through an AID/Washington grant to the International Statistical Institute (World Fertility Survey). The survey, based on a representative sample of 5,841 households (4,113 women), is designed to provide national estimates of fertility, contraceptive knowledge, availability and use. Field work was carried out from mid-May to mid-October 1978. Following some delays in the coding and processing of the data, initial tabulations are now available. A final report is expected in early 1980.

c. IPAVS

IPAVS activities include: the establishment of El Ariana Clinic, opened in February 1978 for the provision of voluntary sterilization services; the RAM Center to service endoscopic equipment; and the National Training Center, opened in March 1979 and supported also by USAID and UNFPA. The Training Center serves as a national, regional and international center to train paramedical and medical personnel in both family planning and, in conjunction with El Ariana, in tubal ligation. In addition to establishing six

voluntary sterilization referral centers in Tunis, IPAVS is embarking on a project to upgrade and equip 12 ONPFP clinics nationwide to perform family planning services including tubal ligations.

The IPAVS grant agreements with the ONPFP have faced a number of delays and have resulted in additional administrative burdens on the USAID staff. Hopefully, the recent consolidation of the six separate sub-grants into two projects will alleviate some of the reporting requirements and problems of monitoring and administration. An outside evaluation of IPAVS activities in Tunisia was conducted in the beginning of October 1979. The usefulness of having a full-time IPAVS project administrator in Tunis was suggested as one of the report recommendations.

d. JHPIEGO

Under the JHPIEGO program, a total of 80 physicians have been trained in laparoscopy at El Ariana Clinic between June 1978 and October 1979. The training is reported to be of high quality and the program is developing a strong regional and international focus. In its first 15 months of operation, it attracted participants from 15 Francophone countries in North and sub-Saharan Africa. Because of the program's growing international role and because of difficulties in releasing potential Tunisian participants from their hospital duties to attend, only about one-half of the physicians trained to date are Tunisians. Furthermore, levels of Tunisian participation in the training programs have declined. In 1978, 29 Tunisians were trained in two sessions, whereas in 1979, in three sessions, only 13 Tunisian physicians have been trained. Ways need to be found to increase Tunisian participation to improve both the long- and short-term significance of the training to the national family planning effort.

Of additional concern are the monitoring and administration of the ONPFP/JHPIEGO program. In an international training session this summer, several of the thirteen participants were not certified at the end of the course because of a lack of screening of participants for surgical skills or coordination in obtaining a sufficient number of cases. Appropriate measures need to be taken to avoid similar occurrences in the future as well as to insure smooth handling of hotel and other accommodations for international participants. Recent efforts have been made to strengthen the administration of this program. Dr. King was in Tunis at the end of September 1979, and Dr. Young, another JHPIEGO gynecologist, is being sent in November to monitor and evaluate program activities as well as provide additional training and technical assistance where needed. Dr. Young will spend approximately two months in Tunisia, in the capital and visiting each of the provinces. The Phase Two Evaluation Team will be able to benefit from his findings.

Information available on JHPIEGO-supplied equipment indicates that as of September 1979, a total of 19 laparoscopes had been placed in Tunis and in 12 other provinces (an additional laparoscope has been placed in the RAM center in Tunis). Map 2 shows the location and dates when equipment was placed. It

is important to look more closely at the impact this new equipment is having. The rate of tubal ligation, by laparoscope and mini-lap, has shown a near-continuous decline since 1975 and has not improved in the first semester of 1979 (see Figures 5-9). Furthermore, the provinces with the lowest rates of acceptors have not received laparoscopes to date although the reservoir of high parity women who are potential acceptors must be very large in these areas. As can be seen from the map, the heaviest concentration of equipment is in Tunis, reflecting the concentration of population and trained medical personnel in the capital city. However, although Tunis has one-fifth of the country's population and one-third of the laparoscopes (six of the 19), the rate of ligation remains low. The rate of ligation per laparoscope is 1.13 per 1000 MWRA, lower than every province in the country with the exception of Gafsa/Sidi Bouzid and Medenine.

e. Syntex, Inc.

In July 1976, a three-year contract was signed with Syntex (under AID/pha-C-1143 Commercial Retail Sales Project) to assist the GOT, through the ONPFP, to increase availability of orals and condoms through the commercial sector. A full-time field project manager was hired by Syntex to develop, in cooperation with the ONPFP, a contraceptive marketing program, including package design, advertising, a promotional campaign, distribution and market research. The first year of activities included: preparation of a market plan; hiring a local detail man to visit doctors and pharmacists; selection of Tunisian brand names and packaging for orals (OP 50) and condoms (Waha); and a medical seminar attended by 200 physicians, pharmacists and family planning officials. Following an outside evaluation conducted in November 1977, AID/Washington decided to terminate the contract with Syntex in April 1978. It appeared that, for political reasons, the project's objectives -- removing oral contraceptives from the prescription list, mass advertising and distribution of contraceptives outside of pharmacies -- would not be achieved. However, as mentioned above, some contraceptive detailing and packaging work has continued under the ONPFP.

f. Westinghouse Health Systems

Under a six-month contract signed in June 1979, Westinghouse Health Systems is providing technical and financial (\$66,125) assistance to the ONPFP for the purpose of carrying out a contraceptive prevalence survey in Jendouba province. The survey, involving a representative sample of 3,000 women, is designed to provide information on contraceptive knowledge, availability and current levels of use. One of the principal objectives is to help evaluate the PFPC household contraceptive distribution project conducted during the period July 1977 to October 1979, in three out of the six delegations of Jendouba province.

Although there were initial difficulties in recruiting a project director with the necessary survey research skills, activities have been proceeding smoothly in the last several months. Field interviews were terminated in

September and data processing is now underway. The final report is expected in March 1980 and will include an evaluation of the impact of the PFPC household distribution project.

3. Issues for Phase Two Evaluation

- Define ways of assisting the ONPFP to strengthen its administrative structure to assure continued high levels of effective activity and a smooth transition during a period of decreasing bilateral assistance and increasing independence of the family planning program. Because of the potential future role of intermediary organizations, Phase Two should assess carefully administrative needs which will enable the ONPFP to plan, administer and monitor intermediary-funded programs. Specifically, what kind of presence is required on the part of the intermediary organizations? How will planning be accomplished when more assistance is directed through such intermediaries? Phase Two should also explore the ONPFP capacity to take an increasing role in the procurement and replacement of commodities, equipment and vehicles.
- Discuss the ways of maximizing the effectiveness and impact of AID assistance during the remaining years of the current bilateral grant and in any future agreements. Areas to be elaborated include:
 - a. Careful programming and detailing of assistance categories (especially the categories of I&E, research and evaluation and training).
 - b. Closer administration and monitoring of ongoing projects and an annual ONPFP/USAID/TUNIS review of AID-assisted activities.
 - c. Increased flexibility in use of funds, particularly through such categories as technical assistance and participant training, to be more responsive to changing needs.
 - d. More extensive and frequent communication between concerned officials in USAID/Washington, USAID/Tunis and the ONPFP including regular meetings on policy as well as implementation concerns and translation of key documents.
- Establish priorities for future AID assistance including a consideration of the following:
 - a. Greater focus on rural areas, especially those in the least-served areas of southern and central Tunisia.
 - b. Assist in strengthening the ONPFP management capability (including logistics, development of a management data system, role of computer technology, special projects, cost-effectiveness).

- c. Transition of community based distribution systems from pilot projects to a national strategy.
 - d. Develop programs in IE&C for use in rural areas which can justify the large expenditures in the past on audiovisual equipment (Phase Two should include an assessment of the current distribution and use of audiovisual equipment in rural areas).
 - e. The role of private and commercial distribution activities.
 - f. The role of family planning components in future integrated health projects.
- Review the log frame and implementation plans in light of the above.

4. Recommendations for Immediate Implementation

a. Bilateral Project Agreement

- Review plans for Project Amendment Number Two to insure that it reflects, in sufficient detail, the current status and needs in each assistance category as discussed in this report. Specific recommendations for inclusion are:
 1. In view of the pressing needs in Kairouan and the southern provinces of Medenine and Gabes, discuss with the ONPFP their plans for community-based distribution programs in these areas. If the approach proposed in 1978 by the ONPFP is feasible and is viewed as consistent with future national strategies, consider immediate implementation of this project.
 2. Take necessary first steps to plan and implement a pilot IE&C project in one province in 1980, including a synthesis of existing studies and surveys on attitudes, a content analysis of survey materials and any necessary additional studies and pre-testing.

Furthermore, there should be a special review of recent and proposed expenditures in the large category of systems support.

- To set the stage for Phase Two discussions of an effective nationwide integrated FP/MCH delivery system, a field trip for key ONPFP MOPH and USAID staff to observe successful Asian family planning programs is urged.

b. Intermediary Organizations

- Appoint a full-time ONPFP coordinator for the FPIA-funded CBD (PFMR) project to review progress and problems in meeting project objectives and to provide regular support to field activities.
- Provide a special budget, under the JHPIEGO/ONPFP agreement, to assure more effective handling of the logistical aspects of the participant training program.

III. CONCLUSION

As the Tunisian Family Planning Program enters the 1990s, it faces five major challenges:

- The recognition, both on the level of program policy and implementation, of the significance of population issues to national socio-economic development objectives and the essential role of family planning in integrated health care delivery.
- The improvement of overall program performance, as reflected in much higher contraceptive prevalence rates, and the reduction of regional imbalances in the availability and use of family planning services, through the development of a nationwide postpartum and community-based contraceptive distribution program with a strong IE&C component, increased availability of surgical contraceptive methods and the intensification of commercial and private sector activities.
- The consolidation and further development of rural programs, strengthening of existing outreach efforts and rural structures through increased decentralization and regional cooperation so that limited resources -- human, material and transport -- are deployed in the most effective way.
- The future development of the program as an international model and as a training ground for personnel from Francophone Africa and the Middle East.
- The transition to increasing independence from foreign donor support, with strengthened administrative capacity to direct program action and to plan for, administer and monitor support from intermediary organizations.

The function of this two-part, mid-project evaluation is to assist in developing strategy and programs to meet these challenges. The focus of Phase One was to identify the major issues affecting the family planning program and its performance, especially in rural Tunisia, to set an agenda for the Second Phase team and to open discussions of future program directions. In addition, because of the eventual phase-out of bilateral assistance and the fact that this evaluation coincides with the finalizing of the Second Amendment to the USAID/GOT Project Agreement for Family Planning Services, the team also proposed some recommendations to be reflected immediately in plans for 1980.

These five challenges should orient the second phase of the evaluation in discussing the issues raised in the body of this report, in determining ways in which USAID and intermediary assistance can contribute most effectively

to reinforce the structures which will meet those challenges after the phase-out of bilateral assistance, and in projecting future activities of the ONPFP and setting its goals for the period of the next Social and Economic Development Plan.

To accomplish this during the second phase, the team should be expanded to include even greater Tunisian participation, from the ONPFP as well as from the Ministry of Health, especially the Divisions of Planning and of Preventive and Social Medicine. Furthermore, it is hoped that from Phase Two will emerge a report which will include a series of joint recommendations and plans to open the 1980s with an increasingly vital, independent and effective program.

In closing, the significance of the Tunisian program needs to be underlined, for its importance extends beyond its national boundaries. Tunisia is the vanguard of family planning in the Middle East. In addition to serving as a leader and model for the Muslim world, it is having a direct impact in training personnel for family planning programs in Francophone Africa. In this entire region, Tunisia is most likely to be the first to achieve an annual growth rate of less than 2 percent and a crude birth rate under 30 per thousand, significant demographic milestones in developing countries.

Finally, Tunisia serves as a model for a broad population-based approach to family planning. As the P.D.G. of the ONPFP noted recently:

The success of a family planning program cannot be measured simply by a series of actions or statistics. More than just limiting births, the goal of family planning is the harmonious development of the population and the stability of the family. It is this humanistic approach that is the basis of our policy toward family planning.

It is this global approach that will orient the Tunisian family planning program as it faces and meets the challenges of the 1980s.

Figure 1

Government of Tunisia Family Planning Program : 1975 - 1978

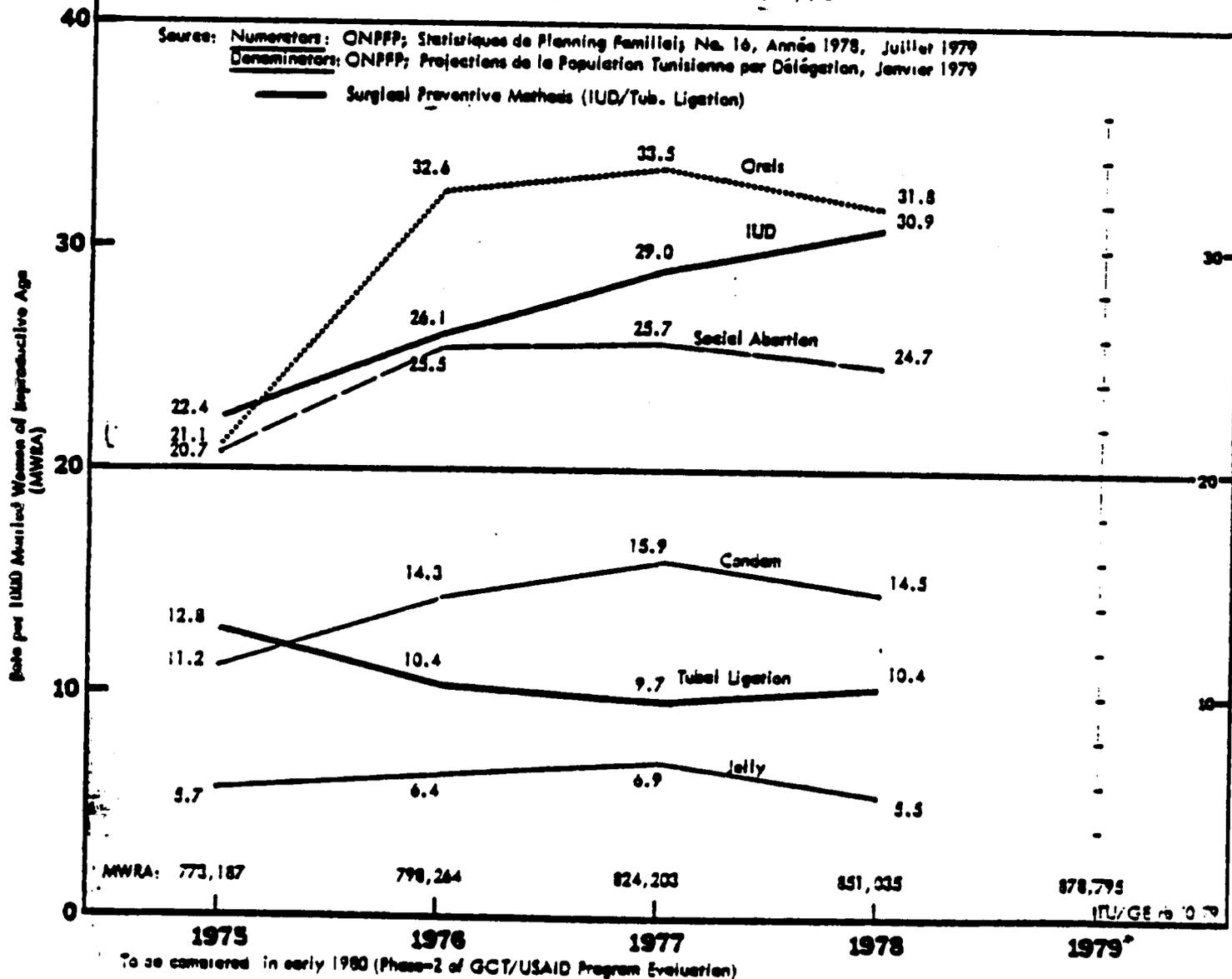
MOST RECENT THREE-YEAR TREND OF INCIDENCE OF
New Family Planning Acceptors, by Method

Unit: Rate per 1000 Married Women of Reproductive Age (MWRA)

GCT/USAID Program Evaluation, Phase 1, Sept/Oct 1979

Source: Numerators: ONPPP; Statistiques de Planning Familial; No. 16, Année 1978, Juillet 1979
Denominators: ONPPP; Projections de la Population Tunisienne par Délégation, Janvier 1979

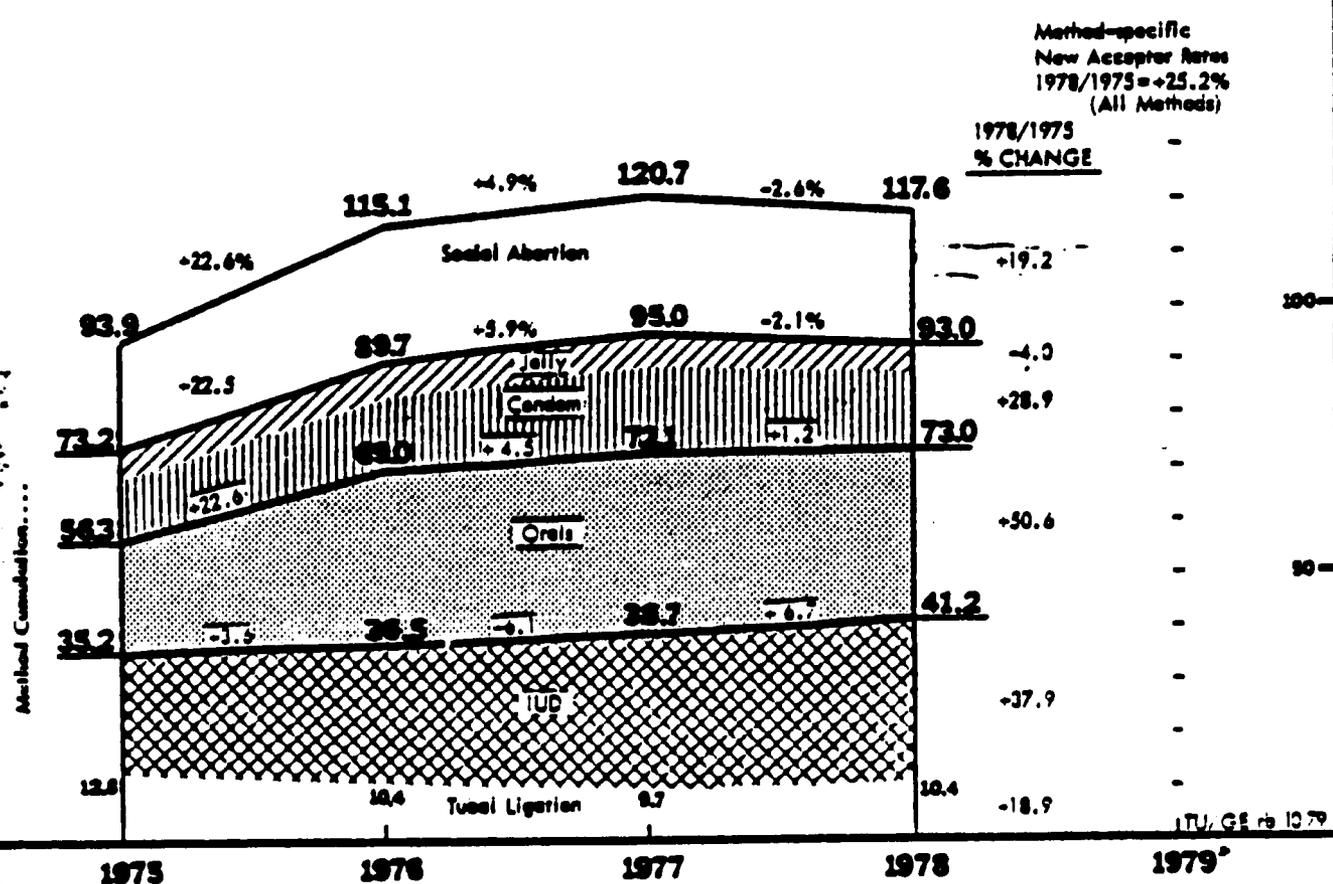
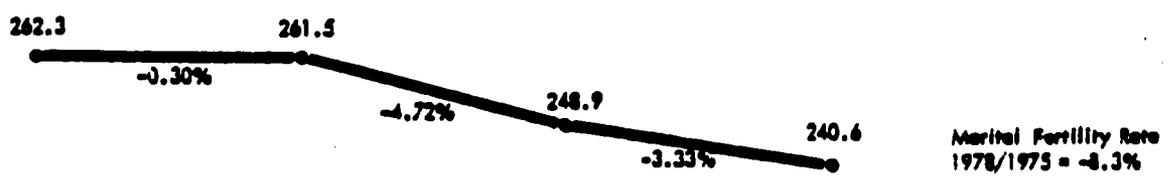
— Surgical Preventive Methods (IUD/Tub. Ligation)



GOT/USAID Program Evaluation, Phase 1, Sept/Oct 1979

Figure 2

Source: Numerators: ONPFP; Statistiques de Planning Familial; No. 16, Année 1978, Juillet 1979
 Denominators: ONPFP; Projections de la Population Tunisienne par Délégation, Janvier 1979



*To be completed in early 1980 (Phase-2 of GOT/USAID Program Evaluation)

Figure 3

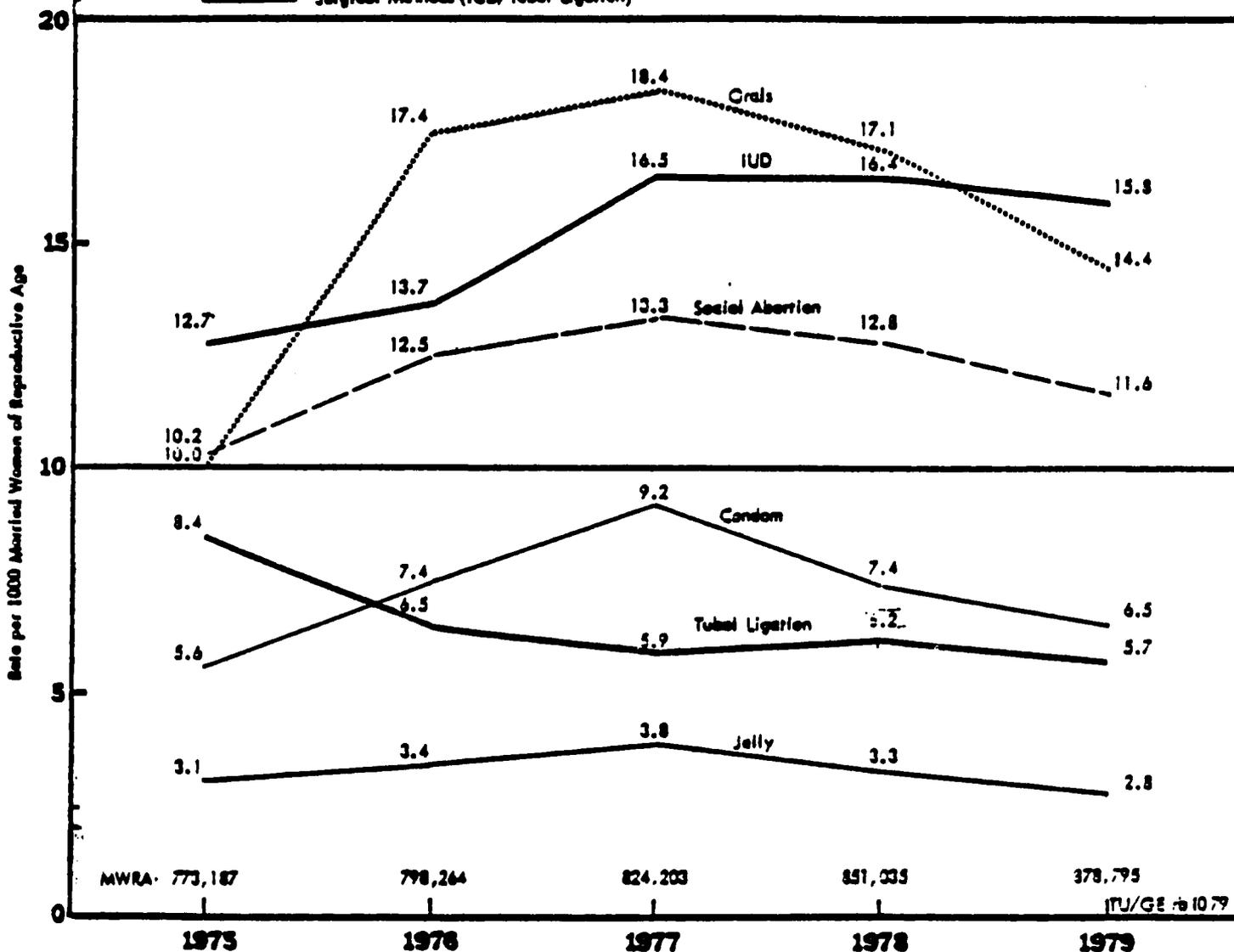
Government of Tunisia Family Planning Program: 1975 - 1979

MOST RECENT FOUR-YEAR TREND OF INCIDENCE OF
New Family Planning Acceptors, by Method
First Semester Only

Unit: Rate per 1000 Married Women of Reproductive Age (MWRA)

GOT/USAID Program Evaluation, Phase 1, Sep/Oct 1979

Source: Numerators: ONPFP; Statistiques de Planning Familial, received on request, September, 1979.
 Denominators: ONPFP; Projections de la Population Tunisienne par Delegation, Janvier 1979. Appendix Totals.
 ———— Surgical Methods (IUD/Tubal Ligation)

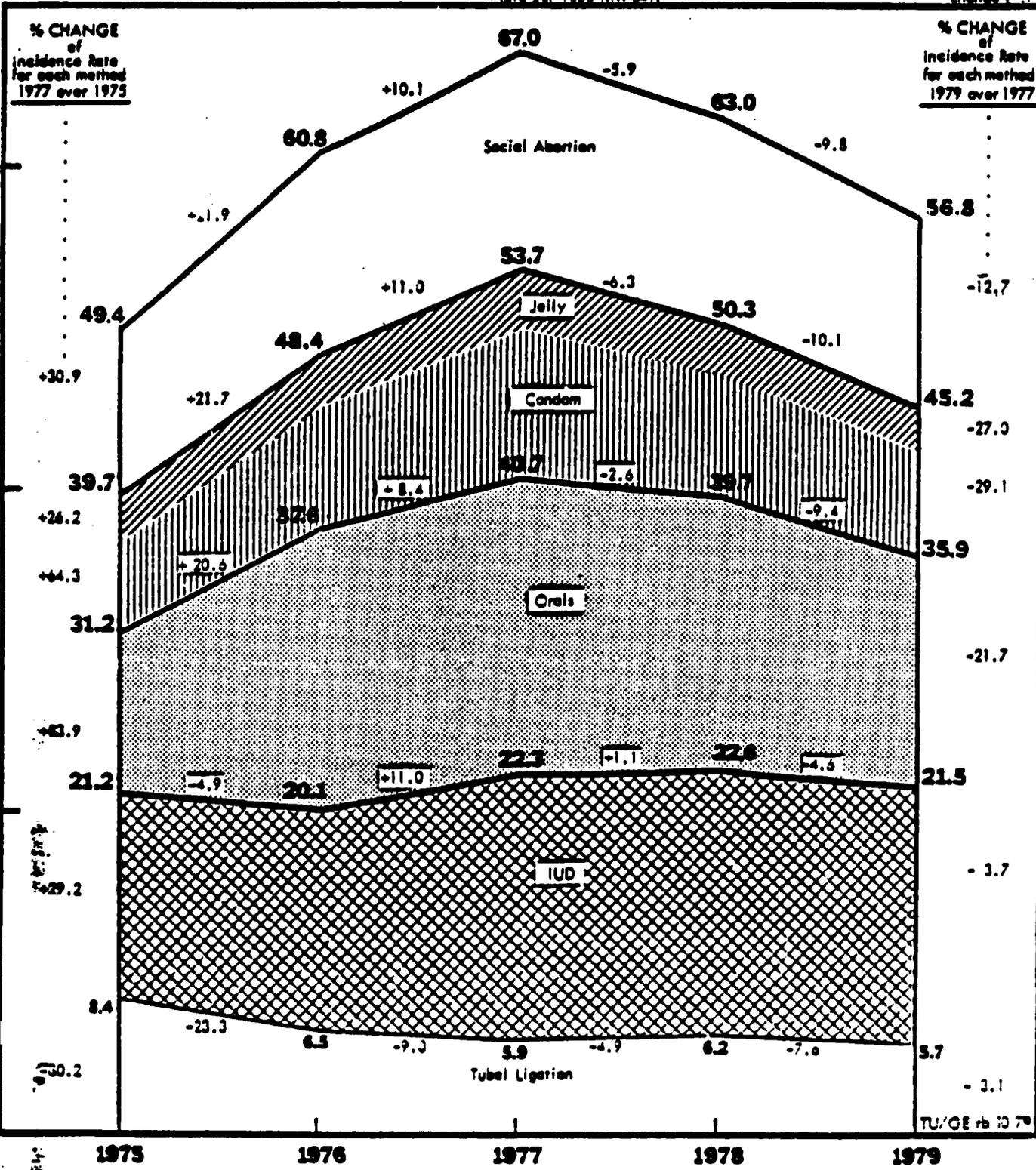


Government of Tunisia Family Planning Program: 1975 - 1979
MOST RECENT FOUR-YEAR TREND OF INCIDENCE OF
ACCEPTANCE OF FAMILY PLANNING BY METHOD
 First Semester Only

Unit: Rate per 1000 Married Women of Reproductive Age (MWRA)
 Incidence Cumulation from Bottom to Top (Bold Figures)
 Systematic analysis of change in trend (+/- % Light Figures)
 GOT/USAID Program Evaluation, Phase 1, Sept/Oct 1979

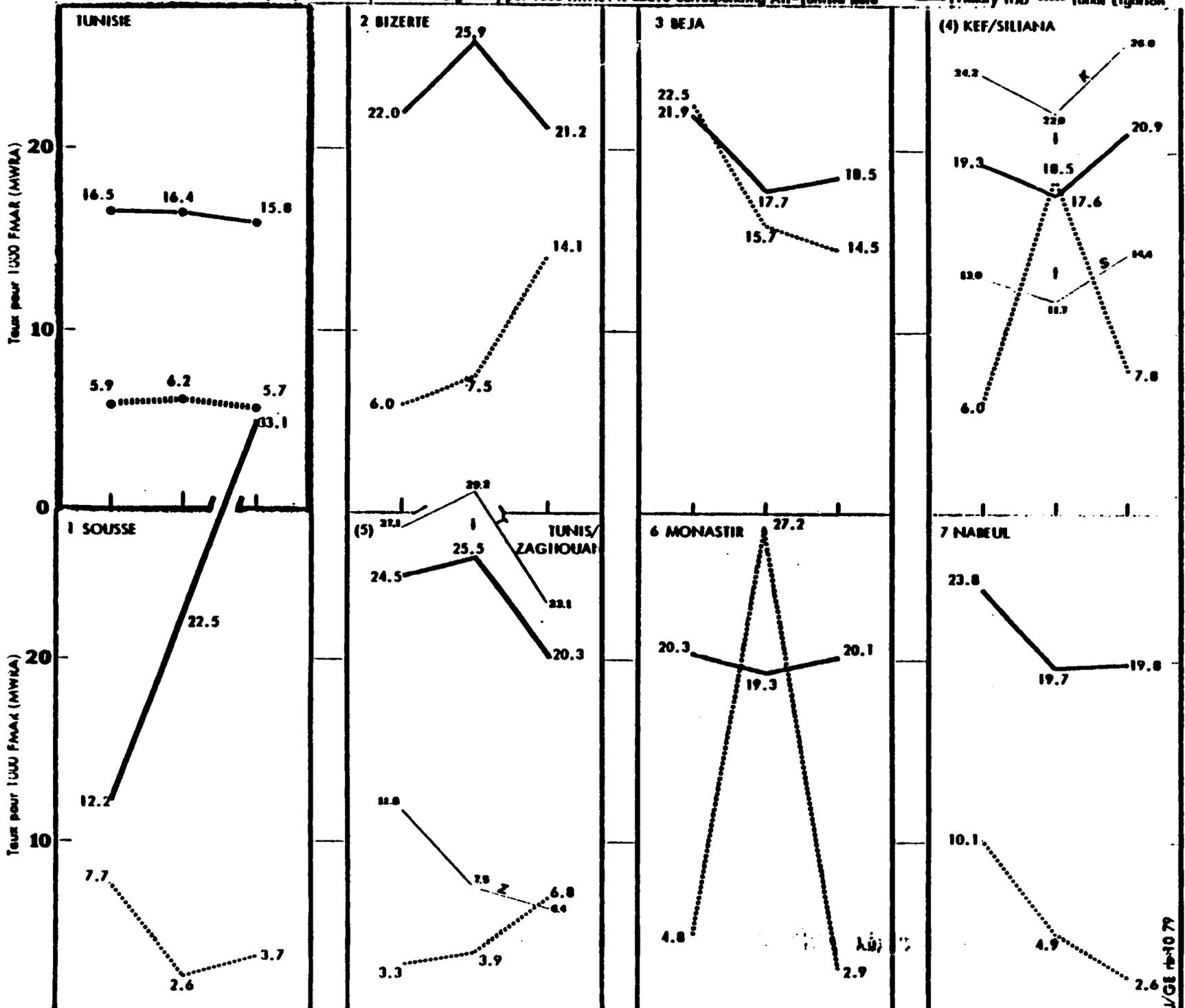
Figure 4

Source: Numerators: ONPFP; Statistiques de Planning Familial, received on request, September, 1979.
 Denominators: ONPFP; Projection de la Population Tunisienne par Delegation, Janvier 1979, Appendice; Totaux.
 Data Treatment: (1) Bold Figures: Method cumulation for half-year incidence 1975-1979; (2) Marginal Figures: Biennial incidence change (%)



"Regions 1-7" : First Semester (1-6) 1979 Rate(IUD)Tub. Ligation per 1000 MWRA is above corresponding All-Tunisia Rate

— Primary IUD Tubal Ligation



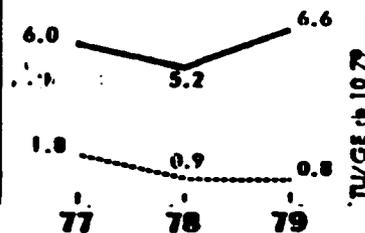
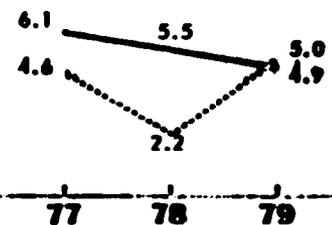
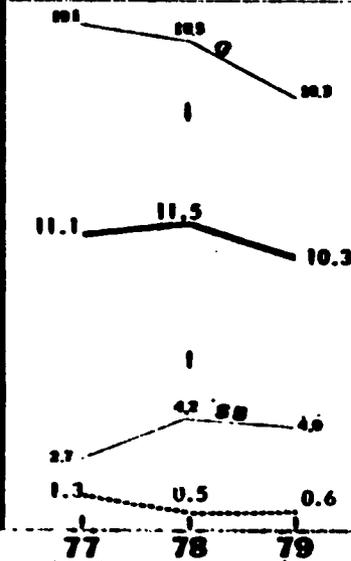
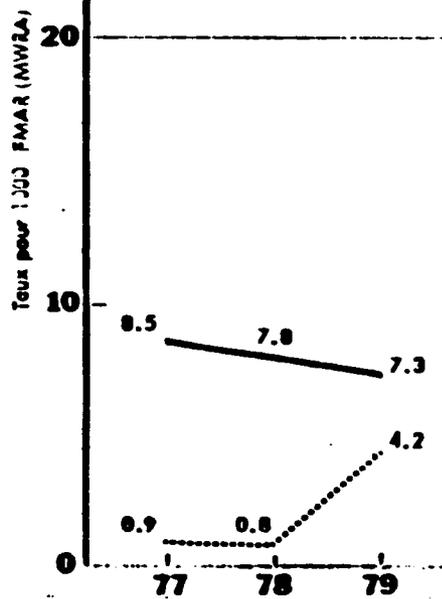
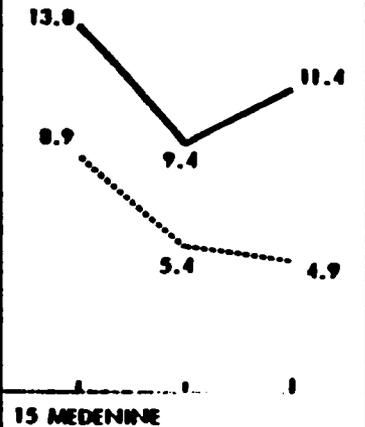
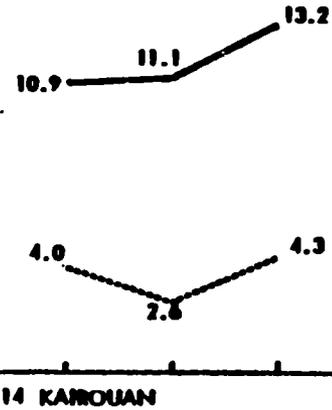
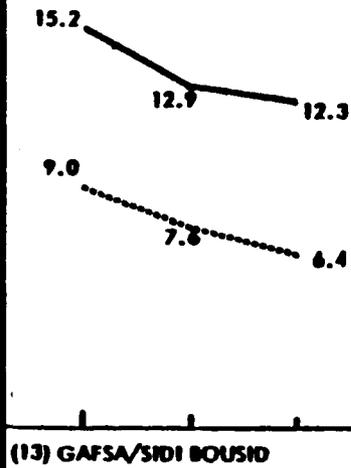
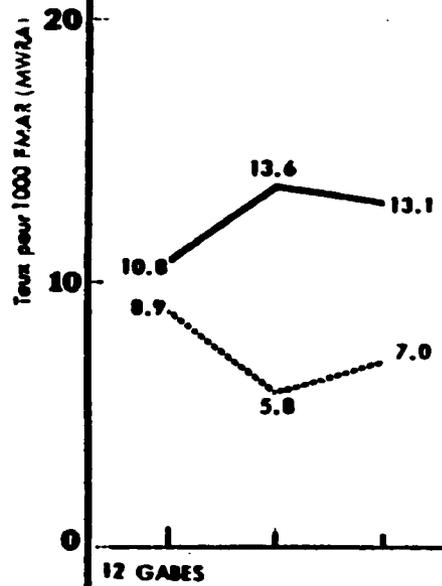


Figure 6

NEW ACCEPTORS of THREE METHODS of FAMILY PLANNING. 1st Semester 1979 (1-6)

Surgical Methods are ranked in descending order:

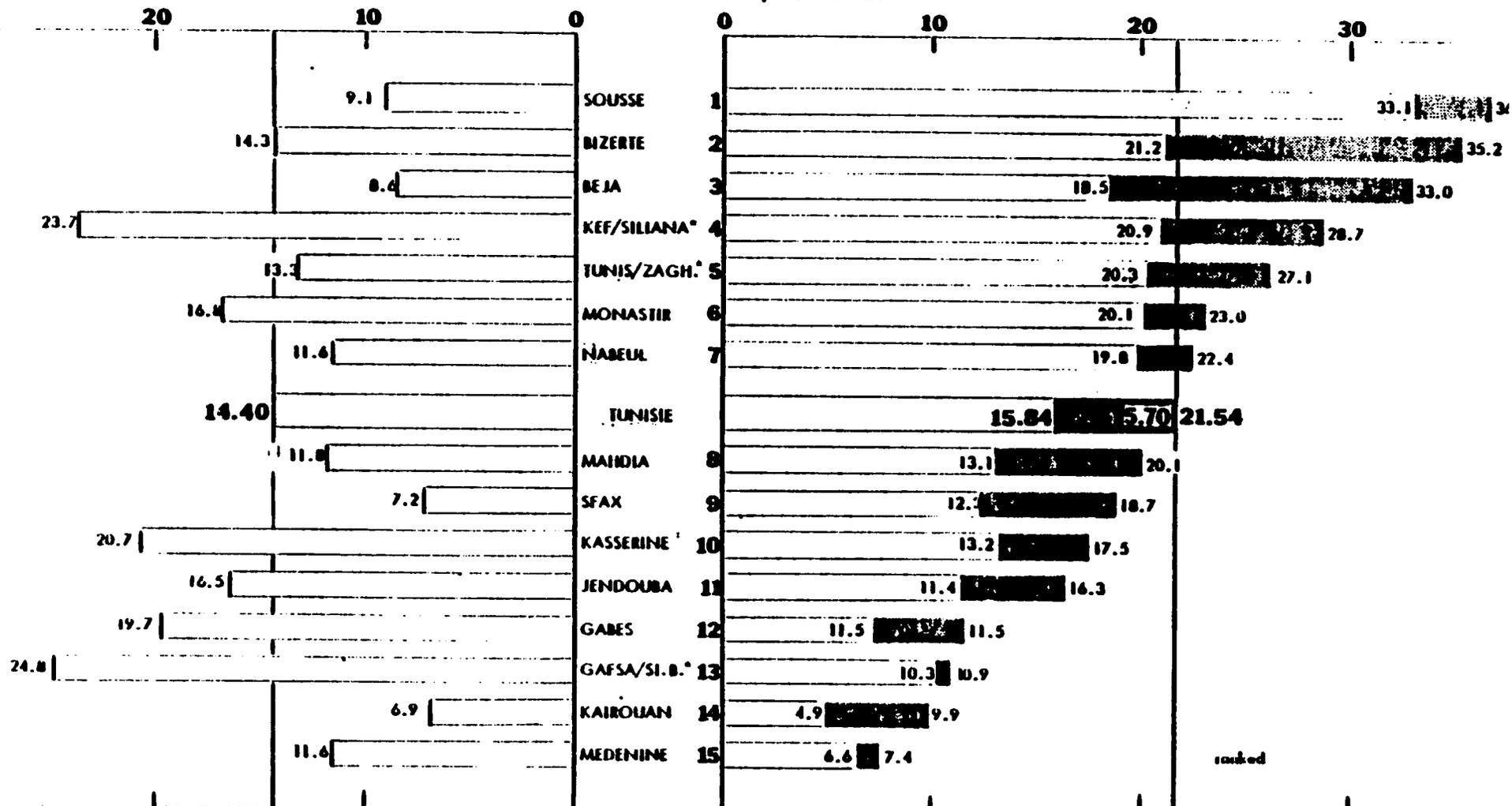
NEW PILL ACCEPTORS

PRIMARY IUD ACCEPTORS

TUBAL LIGATION

Rate per 1000 MWRA

Rate per 1000 MWRA



* These Governments do not yet have facilities and manpower to perform tubal ligations. As the "imported" ligations are tallied at the place of performance, numerators and denominators had to be fused in order to generate valid rates for the three "double regions". Of course, the ranking sequence does not imply "surgical attainment" beyond the 15 geographic entities.

Figure 7

Incidence of Tubal Ligation A) (1-6) 1979..... B) (1-6) 1975 % CHANGE
ranked 1979/1975

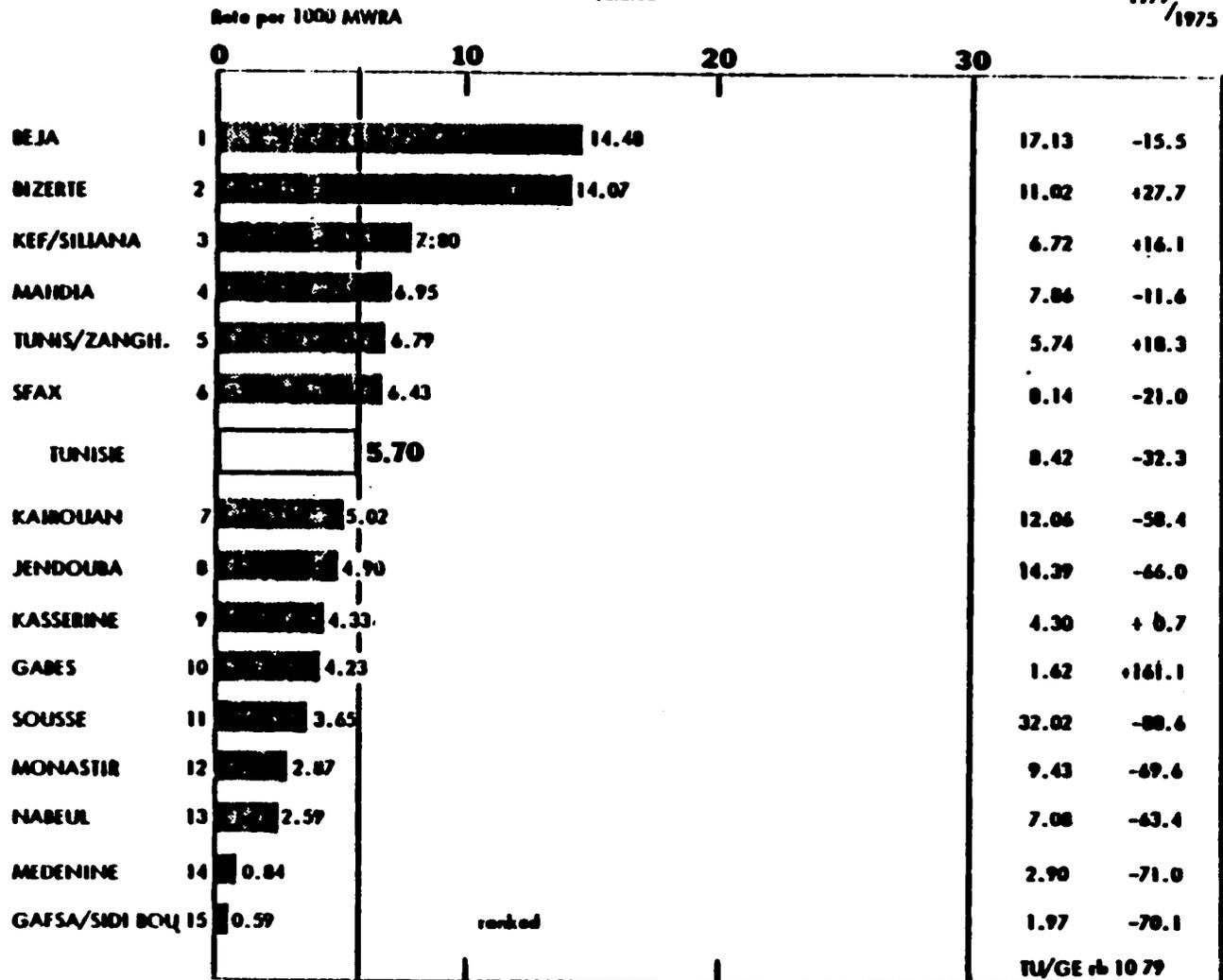
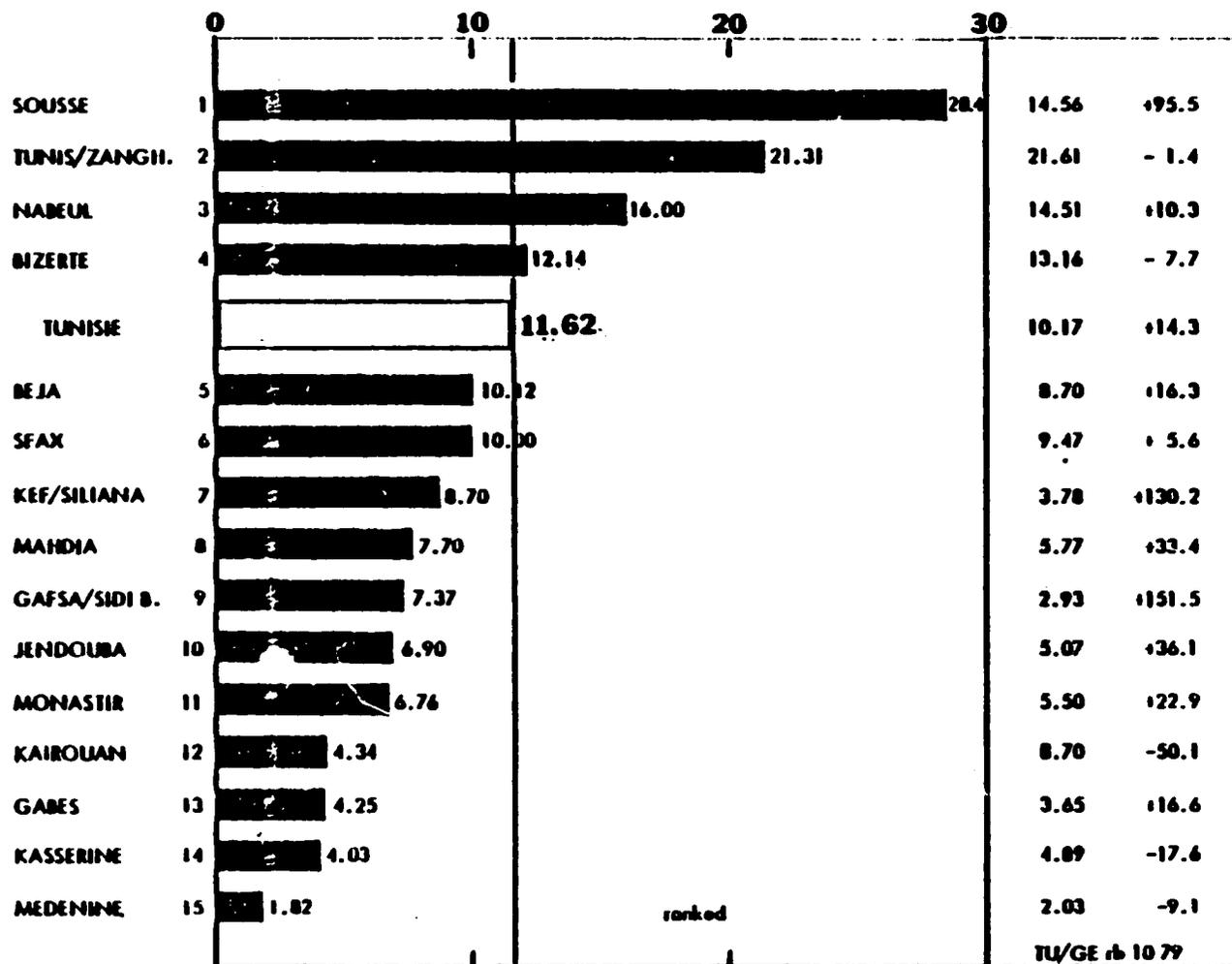


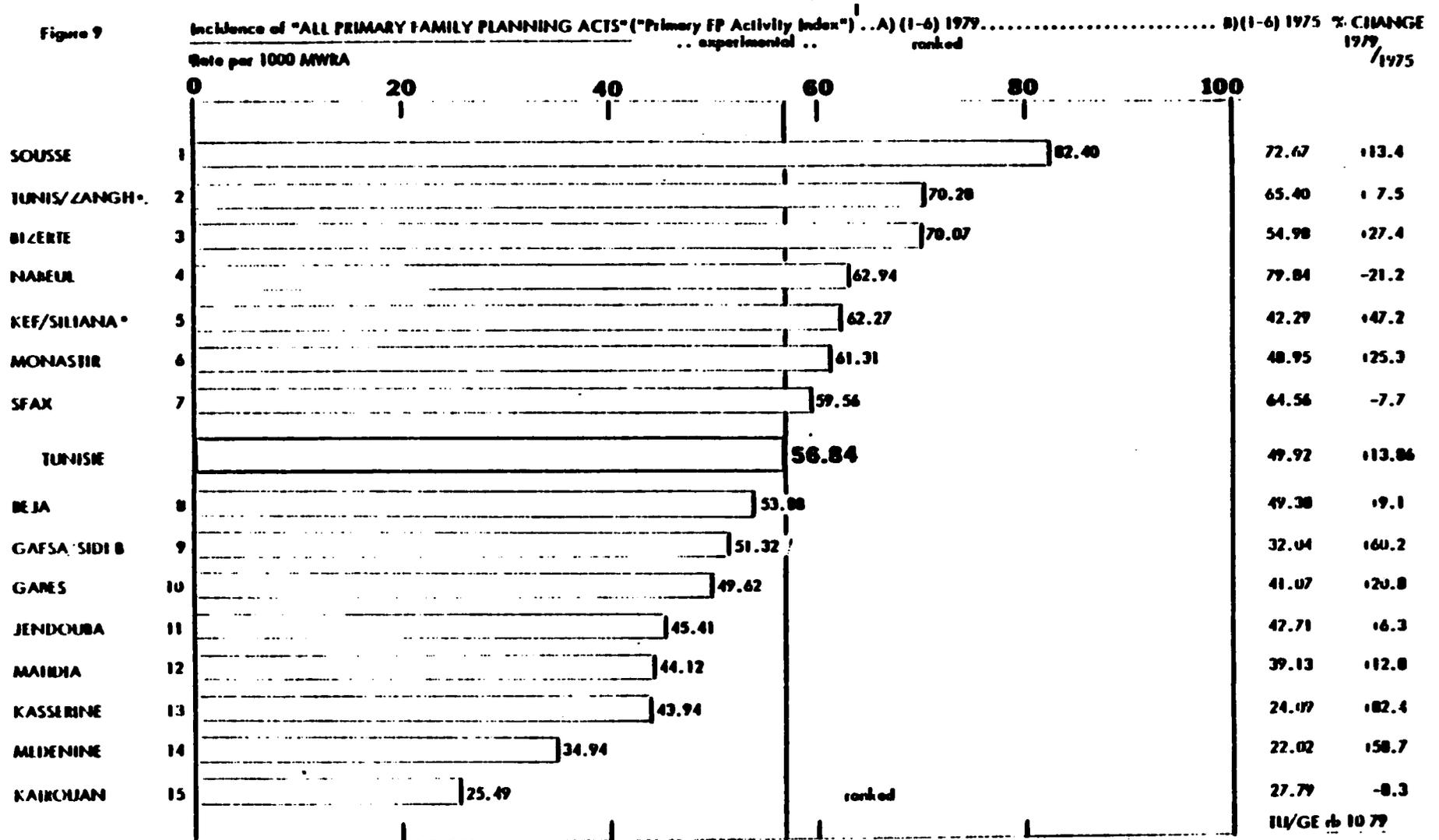
Figure 8

Incidence of Social Abortion A) (1-6) 1979 B) (1-6) 1975 % CHANGE
 Rate per 1000 MWRA ranked 1979/1975



TU/GE 10 79

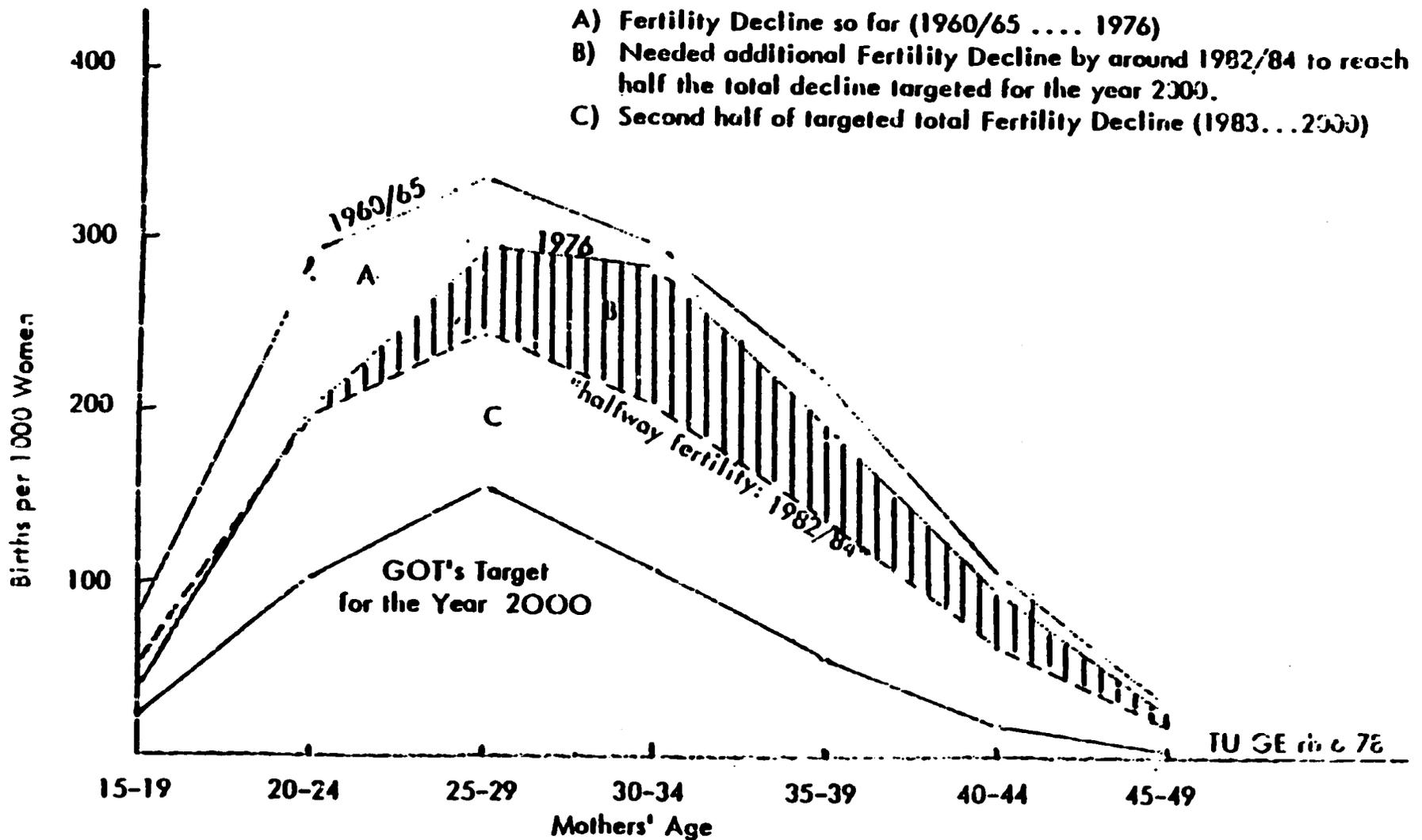
Figure 9



* Three pairs of regions (gouvernorats). They have been fused in this analysis because one region "exports" the (unknown number of) tubal ligations to the other region. The first of the two regions has a considerably higher performance than the second region.

† The "primary FPA Index" is defined as the rate per 1000 MWRA of the occurrence of "primary FP events" for a given time span. It includes "primary IUD insertions, primary pill acceptors, primary condoms and jelly acceptors, social abortions, and tubal ligation. This index is a robust summary index that gives a rough idea of the "prevalence input" into a system. Note, for instance, for the short time of 6 months in 1979, 8.2% of the MWRA were submitting to primary FP activities. In the Sousse region against only 2.5% in Kairouan Governorat. In addition, the latter value was actually regressing. Clearly, the Protection Prevalence for the two regions must be very different.

**Figure 10: Age-specific Past and Needed Future Fertility Decline (Right versus Left Decrease)
High Age vs Low Age**



BEST AVAILABLE DOCUMENT

TABLE 1.

INDICATEURS		1966	1973	1974	1975	1976	1977	1978
-Population tunisienne au milieu de l'année	(1)	4.717.500	5.444.200	5.616.300	5.608.000	5.737.000	5.591.500	5.937.200
-Sans masculin	(1)	2.323.700	2.652.600	2.758.900	2.843.000	2.908.400	2.985.300	2.939.400
-Sans 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 (15-34 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)	-	-	-	-	-	-	-
-Répartition par âges	(1)							
- 0 - 14 ans		46,5%	44,3%	43,7%	43,5%	43,3%	42,6%	42,0%
- 15 - 64 ans		49,9%	51,6%	52,1%	52,7%	53,2%	53,3%	54,4%
- 65 ans et plus		3,6%	4,1%	4,2%	3,5%	3,5%	3,6%	3,6%
-Décès enregistrés	(5)	206.730	194.764	194.500	202.324	208.730	205.128	201.300
-Morts enregistrés	(5)	48.307	43.716	40.238	40.241	36.912	34.310	34.020
-Mariages enregistrés	(5)	27.037	43.183	46.672	43.870	37.940	41.300	-
-Divorces enregistrés	(5)	4.616	5.099	6.060	-	-	-	-
-Taux de natalité	(5)	43,8‰	37,7‰	36,5‰	36,2‰	36,4‰	34,8‰	33,3‰
-Taux de mortalité corrigé	(5)	14,0‰	11,0‰	9,8‰	10,3‰	9,2‰	8,4‰	8,1‰
-Taux de fécon.géné.15-34ans	(5)	193‰	156‰	152‰	150‰	149‰	141‰	136,3‰
-Taux génés.de nuptialité	(5)	5,7‰	7,8‰	-	-	6,6‰	7,0‰	-
-Divorces pour 1000 habes	(5)	0,98‰	0,93‰	-	-	-	-	-
-Solde migratoire	(6)	-12.637	-12.768	+2.352	-2.135	-15.500	-24.300	-
-Estm.nais. moins décès		140.556	145.128	149.653	145.351	155.999	155.538	-
-Taux d'accroissement naturel		29,3‰	26,7‰	26,7‰	25,9‰	27,2‰	26,4‰	25,3‰
-Taux d'accroissement net	(7)	27,1‰	24,6‰	27,1‰	25,5‰	25,5‰	20,5‰	-

- (1) I.N.S. : Perspectives d'évolution de la population-fascicule II; Septemb. 1972. jusqu'en 1974. A partir de 1975, Projections de la population de la Tunisie 1975-2001; Mars 1977.
- (2) I.N.S. : Etudes et Enquêtes de l'I.N.S., série démographique N° 5-mai 1974. A partir de 1975, Projections de la population de la Tunisie, 1975-2001; mars
- (3) I.N.S. : Recensement général de la population et des logements de 1973
- (4) Ministère du Plan : Aménagement du territoire - l'Armature urbaine en Tunisie 1973.
- (5) I.N.S. : Statistiques de l'INS, série démographique N° 5 décembre 1974.
Les naissances et les décès enregistrés ont été majorés respectivement de 37 et de 27% jusqu'en 1974. L'INS estime cependant (à posteriori) que les naissances sont déclarées à 100% depuis 1972 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 37%).
- Ministère de l'Intérieur, cité par l'INS "Economie de la Tunisie en chiffre 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.
- Les taux d'accroissement nets ont été calculés en tenant compte du solde migratoire.

Source: ONPPP, Statistiques de Planning Familial 1976.

BEST AVAILABLE DOCUMENT

TABLE 2.

INDICATEURS DE PLANNING FAMILIAL

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	429.597	500.937	527.501
- Total des contraceptrices	41.517	246.675	241.335	256.984	299.351	346.357	397.634	397.682
- Nalles contraceptrices	16.176	43.665	43.840	50.90	58.052	75.323	86.021	81.149
- Nalles acceptrices de :								
D.I.U.	12.077	13.250	16.790	19.084	17.307	20.830	23.379	25.273
Pilules	350	12.026	11.194	10.795	16.310	25.987	27.567	27.017
Ligatures des trompes	766	2.453	4.964	10.757	9.856	3.259	7.987	8.232
Apparements sociaux	1.325	4.527	5.547	12.427	16.000	20.34	21.152	20.995
- Centres ayant eu une activité	-	330	309	392	420	462	517	N.D.
- Femmes mariées (15-49 ans) par centre	-	-	2.432	1.975	1.911	1.670	1.323	N.D.
- Médecins spécialisés	-	-	-	69	N.D.	N.D.	N.D.	N.D.
- Sages-femmes	-	-	-	92	N.D.	N.D.	N.D.	N.D.
- Auxiliaires médicaux	-	-	-	267	N.D.	N.D.	N.D.	N.D.
- Contraceptrices/médecin	-	-	-	3.721	-	-	-	-
- Contraceptrices/sage-femme	-	-	-	2.793	-	-	-	-
- Contraceptrices/aux.méd.	-	-	-	970	-	-	-	-

Impact du programme

Années	1975		1976		1977		1978		1979	
	Public	National	Public	National	Public	National	Public	National	Public	National
Nombre du programme Indicateurs x										
Femmes protégées au 1er janvier	77.959	88.325	94.294	107.163	117.006	140.976	131.165	152.960	137.427	160.375
Deux de protection pour 100 F.M.A.R. (15-49 ans) au 1er janv.	10.06%	11,5%	11,75%	13,5%	14,54%	17,5%	16,0%	19,4%	16,2%	21,3%
Naissances évitées	25.250	-	34.350	-	45.000	-	52.000	60.000	63.034	70.600
Naissances évitées	29.720	32.720	35.576	38.800	44.508	52.750	43.839	56.032	50.106	53.643
Indice de natalité	36,2 ‰		36,4 ‰		34,8 ‰		33,9 ‰			
Indice de fécondité (15-49 ans)	176 ‰		176 ‰		166 ‰		151 ‰			
Indice de fécondité (15-49 ans)	160 ‰		160 ‰		152 ‰		146 ‰			
Indice de fécondité (15-49 ans)	150 ‰		149 ‰		141 ‰		136 ‰			

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: ONPPP, Statistiques de Planning Familial, 1978.

- SUMMARY -

RESULTS OF PFAD HOUSEHOLD CONTRACEPTIVE DISTRIBUTION PROJECT

Table 3. Method-Specific Contraceptive Prevalence; Baseline Survey and Final Survey

Method	Baseline Survey		Final Survey		Percent Increase
	%	N	%	N	
Pill	1.0	(39)	3.1	(111)	215%
IUD	1.6	(62)	3.8	(137)	145%
Tubal ligation	3.5	(138)	9.7	(346)	178%
Other	0.5	(21)	1.0	(35)	86%
Total	6.6	(260)	17.7	(629)	168%
Number of Women	3944		3562		

Table 4. Contraceptive Prevalence by Sector; Baseline Survey and Final Survey

Sector	Baseline Survey		Final Survey		Percent Difference
	%	N	%	N	
Ouedrane	1.8	10	5.8	29	4.0
Oued Scheikh	11.4	62	20.4*	99	9.0
Gondoul	4.4	24	9.3	46	4.9
Bir Ali	4.6	25	19.7	103	15.1
Sdiret	7.5	45	20.5	114	13.0
Sidi Dhafer	10.6	44	33.9	118	23.3
El Abraj	6.5	14	19.5	37	13.0
Bouslim	13.5	21	30.1	46	16.6
Sidi Ali Belabed	4.3	15	11.9	37	7.6
Total	6.6	260	17.7	629	11.1

*34.4% in Bir Ali Ville; 12.3% in the rural remainder of the sector.

Table 5. Method-Specific Prevalence at the Final Survey, by Sector

Sector	Percent Using Each Method					Total	Number of Women
	None	Pill	IUD	Tubal Ligation	Other		
Bir Ali Ville	65.6	3.4	16.4	10.2	4.4	100.0	177
Ouedrane	94.2	1.0	0.6	3.6	0.6	100.0	501
Oued Echeikh	87.5	4.2	0.3	6.4	1.6	100.0	312
Gondoul	90.7	2.0	1.0	5.3	1.0	100.0	495
Bir Ali	80.3	5.2	7.1	7.3	0.1	100.0	523
Sdiret	79.5	2.7	4.7	12.9	0.2	100.0	552
Sidi Dhaher	66.1	1.1	2.6	29.6	0.6	100.0	348
El Abraj	80.5	6.8	5.8	6.3	0.6	100.0	190
Bouslim	69.9	2.0	5.9	19.6	2.6	100.0	153
Sidi Ali Belabed	88.1	4.8	2.3	3.2	1.6	100.0	311
Total	82.3	3.1	3.8	9.7	1.1	100.0	3562

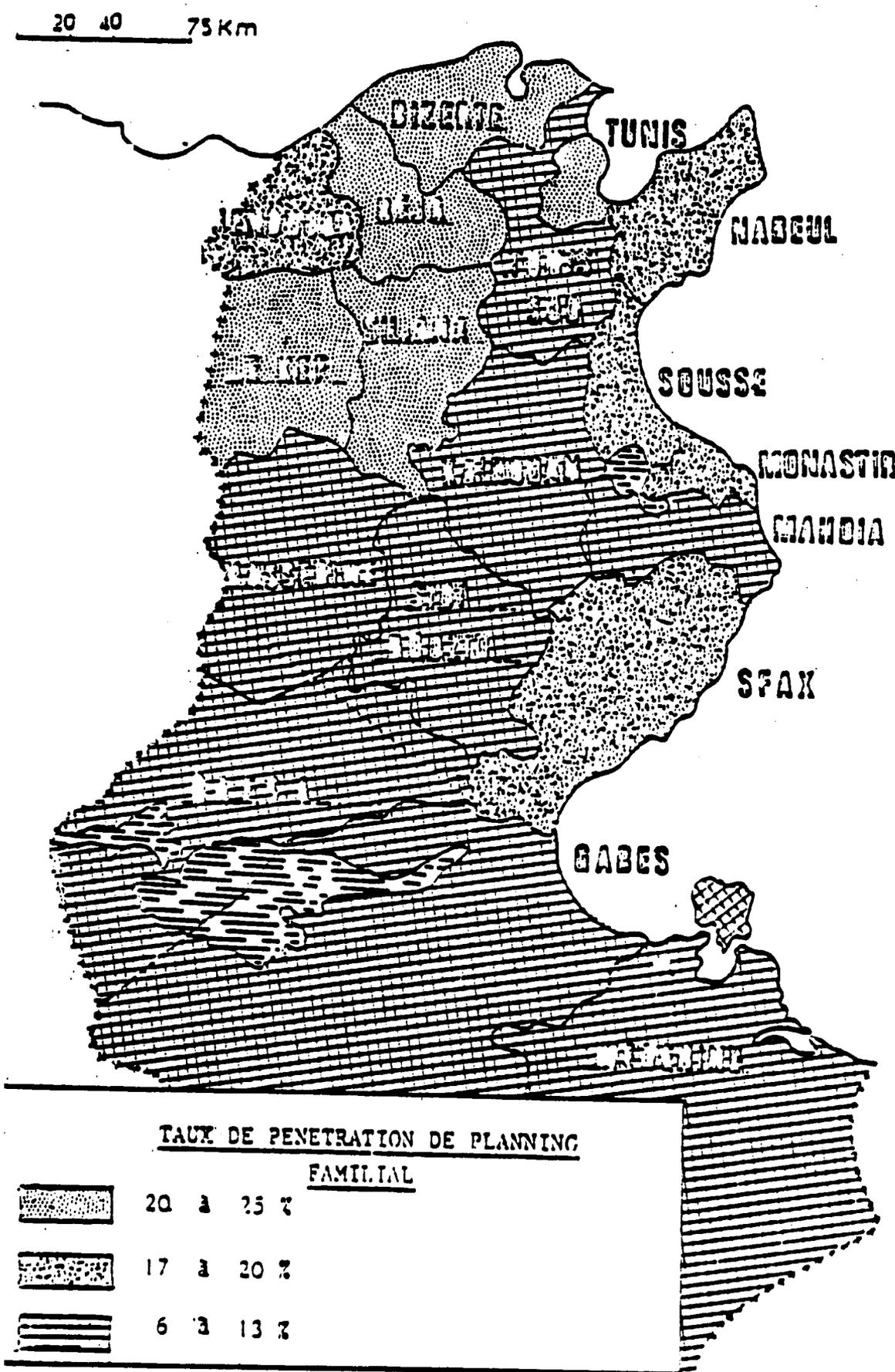
Table 6 Distribution According to Risk of Pregnancy; Baseline Survey and Final Survey

Risk Status	Baseline Survey		Final Survey		Percent Change
	%	N	%	N	
Not at risk	74.6	2929	82.4	2934	+ 10
Temporary	58.1	2282	57.1	2029	- 2
Contracepting	3.1	122	7.9	280	+ 155
Pregnant	20.3	798	17.0	603	- 16
Lactation amenorrhoea	34.7	1362	32.2	1148	- 7
Permanent	16.5	647	25.4	903	+ 54
Sterilized	3.5	138	9.8	349	+ 180
Subfecund	13.0	509	15.6	556	+ 20
At risk	25.4	995	17.6	625	- 31
Lactating	15.5	607	8.2	291	- 47
Not lactating	9.9	388	9.4	334	- 5
Total	100.0	3924	100.0	3559	

Source: PFAD Final Report

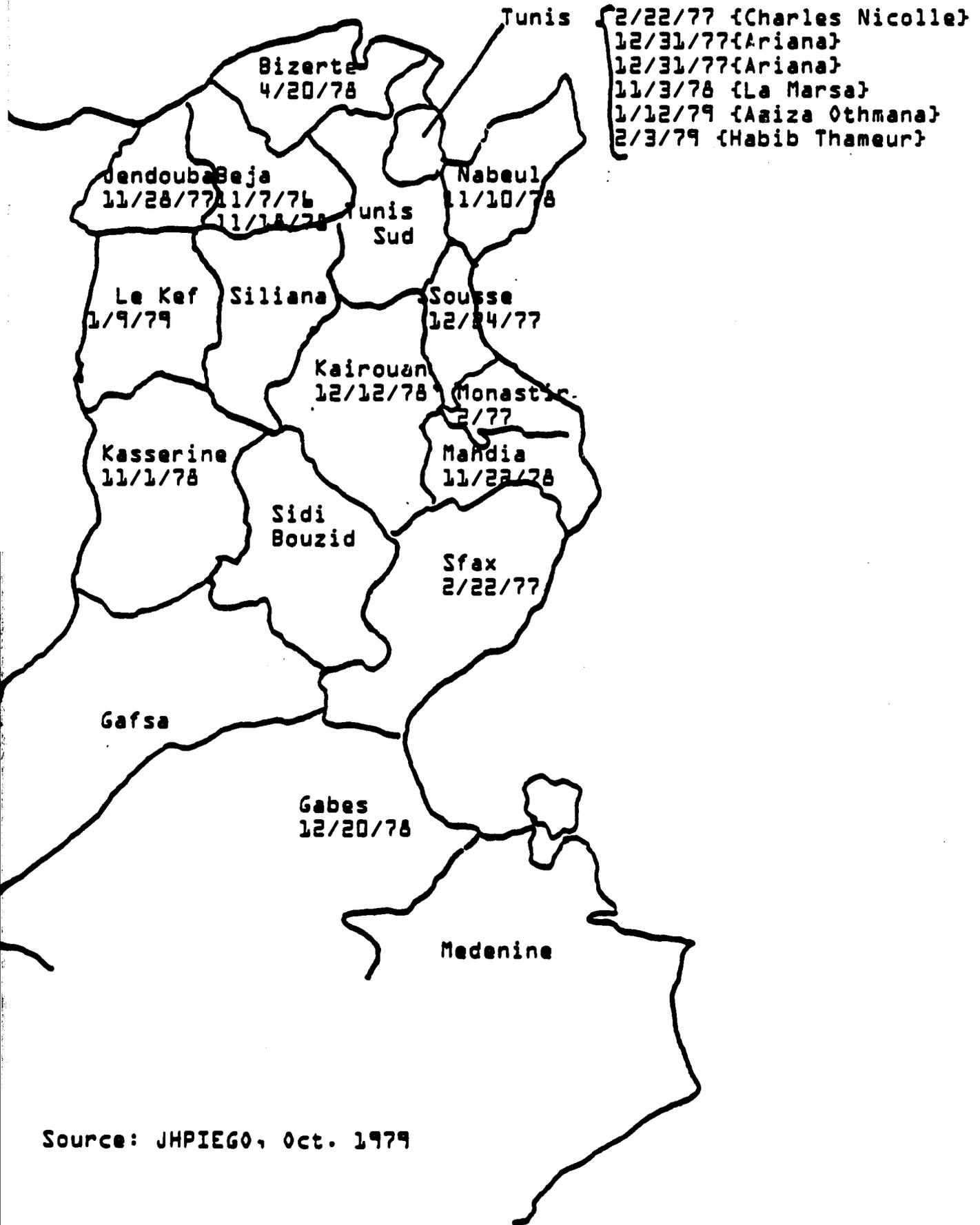
BEST AVAILABLE DOCUMENT

Map One: Estimated Contraceptive Prevalence by Region, 1978



Source: ONPFP Statistiques de Planning Familial, 1978

Map Two: Location and Date of Placement of Laparoscope Equipment



Source: JHPIEGO, Oct. 1979

Appendix A: Evaluation de Mi-Projet en Deux Phases

Projet 664-295, USAID/ONPFP

SERVICE DE PLANNING FAMILIAL
du
Gouvernement de Tunisie

Evaluation de Mi-Projet en Deux Phases

Phase I: Collecte d'Information et
Identification des Problèmes
Septembre 1979

Note d'Introduction:

Le présent document devrait constituer l'embryon du document de travail qui espérons nous constituera la base d'une commune approche bipartite pour l'exécution de la première phase de l'évaluation.

Nous sommes très reconnaissants à Mr. Mezri Chekir, Président Directeur Général de l'ONPFP, pour l'excellent exposé de synthèse qu'il a présenté lors de notre première réunion du 20 Septembre 1979 en présence des deux équipes.

Nous nous sommes permis d'en résumer les principaux points et d'y joindre nos idées et suggestions dans le but de développer le document de travail définitif.

L'esprit qui a animé le dialogue bi-partite durant les diverses sessions déjà tenues les 20 et 21 septembre, 1979 au siège central de l'ONPFP et au Centre de Recherche Futur (Clinique Ariana), nous a convaincu que la rédaction finale du document de travail préliminaire devrait maintenant être entrepris par les soins de l'ONPFP. Il serait souhaitable que ce document soit à la disposition de l'ONPFP et de la Mission USAID dès le retour des consultants de l'USAID de leur visite sur le terrain, le matin du Mercredi, 26 septembre 1979.

Tunis, le 22 septembre 1979

Résumé de l'exposé de Monsieur Henri Chelkir, Président Directeur
Général de l'Office National du Planning Familial et de la Population.

Après avoir souligné l'identité de vue entre l'Office National du Planning Familial et de la Population et l'AIU sur l'approche et la technique d'évaluation ainsi que l'importance de l'évaluation continue aussi bien qualitative que quantitative du programme de planification familiale - Monsieur Henri Chelkir nous fait part de l'étude d'évaluation et de synthèse actuellement menée par la Direction de la Population à l'ONPF en vue de doter, vers le début de l'Année 80, le programme de planification familiale des éléments susceptibles de permettre à l'ONPF de tracer la stratégie et les moyens d'intervention nécessaires à l'action de l'Office pour réaliser les objectifs démographiques dans le cadre du VI^e plan économique et social de la Tunisie pour les années 1978 - 1986.

Monsieur Henri Chelkir précise par la suite les grandes lignes de cette action qu'il définit selon le schéma qui suit:

Le Programme d'Education et d'Information

Amélioration et développement des services d'Education et d'Information introduire de nouvelles idées, de nouveaux projets pour élaborer les messages à diffuser vers toutes les couches de la Population cette action d'éducation d'information et de formation sera menée sur plusieurs fronts tels que les milieux organisés, les milieux scolaire et universitaires, les populations rurales, le personnel médical et para-médical etc...

Les Services Régionaux de Planning et de Santé Familiale

L'ONPF va encourager la synthèse et l'évaluation des projets entrepris en coopération avec d'autres pays donateurs ainsi que des projets de Santé communautaire de Hedjez El Bab'at de la Faculté de Médecine de Sousse. Un séminaire sera organisé par le doyen de la Faculté de Sousse pour tirer les conclusions et la stratégie à développer en matière de santé de base et proposer un plan d'action au Ministère de la Santé Publique pour la coordination du personnel et des moyens, pour une meilleure couverture de la santé y compris le Planning Familial.

Les Services/Cliniques Spécialisés

En dehors de l'infrastructure du Ministère de la Santé Publique des services et des cliniques spécialisés seront appelés à être créés, en effet les statistiques démontrent que ces centres ont beaucoup de succès auprès de la population qui montre une certaine réticence à s'adresser à l'hôpital ou au dispensaire pour le choix d'une méthode de contraception - Une étude de cette question devra être effectuée afin de donner les éléments nécessaires en vue du maintien, de l'évolution ou de la suppression de ces centres. Toutefois un effort sera entrepris auprès du secteur médical privé et des cliniques privées afin d'assurer l'information régulière de ce secteur sur

BEST AVAILABLE DOCUMENT

BEST AVAILABLE DOCUMENT

Les récentes techniques de contraception et de perfectionner la compétence des praticiens et autre personnel travaillant dans ce secteur et de les encourager soit par des moyens techniques soit par la formation à participer à l'action de l'Office.

Etude des Besoins du Programme de Planning Familial pour les Années 1981/1986

En coopération avec l'ONFEP le FNUAP a confié à des consultants Tunisiens des Ministères du Plan, des Affaires Etrangères, de la Santé Publique, et de l'ONFEP la préparation d'un document sur les besoins de l'Office pour l'exécution de son programme d'action dans les années 1981/1986.

Projection vers une nouvelle dimension du Programme

L'action de l'Office procède de la démarche générale de la politique Tunisienne et le récent X^e Congrès du Parti Socialiste Destourien a confirmé la poursuite de la politique démographique dans son contexte de développement économique et social. A l'heure actuelle il est constaté que 90% de la population a été en contact avec le planning familial mais l'objectif qui reste à atteindre est d'éliminer la confusion des citoyens, d'épisier leurs craintes, de leur apporter les informations nécessaires pour une meilleure connaissance des différentes méthodes de contraception et des services existants. Le citoyen doit être motivé pour l'équilibre de sa famille, de son environnement, et doit pouvoir maîtriser sa sexualité. A cette fin un travail en profondeur sera entrepris avec emphase sur les jeunes qu'ils soient dans les centres de formation professionnelle, Lycées, écoles, Maisons de Jeune et Maisons de la Culture. Une action sera aussi entreprise pour introduire des éléments de démographie, de planification familiale et de santé auprès des facultés de médecine afin de motiver le futur jeune médecin à aller au devant des besoins sanitaires de la population, là où elle se trouve. Pour assurer une plus grande couverture sanitaire dans le pays une action à long terme de santé de base intégrée se profile au niveau du Ministère de la Santé. Un médecin généraliste sera appelé à assurer la supervision des services de santé au niveau de la circonscription. Au niveau du Gouvernorat un médecin directeur sera responsable de la coordination de la stimulation et de la liaison entre les services de base et les hôpitaux régionaux. Le pays a été divisé en six régions sanitaires et les trois facultés de médecine se sont vues confier chacune une zone géographique d'activité. Nord, Centre et Sud respectivement pour les facultés de Tunis, Sousse et Sfax. Une action parallèle est menée pour la formation des paramédicaux, cette formation est dispensée selon le besoin. Elle peut être polyvalente pour l'exercice en milieu rural ou spécialisée pour l'exercice en milieu hospitalier. Monsieur Mezri Chekir fit part de sa confiance dans la réussite de la réorganisation sanitaire. La politique est tracée dit-il et l'action progresse sérieusement et à pas sûrs.

IDEES ET SUGGESTIONS

1. Il serait désirable de définir les objectifs en matière de fertilité par groupe d'âge et parité pour situer l'action programmatique à mettre en place en vue d'atteindre les objectifs démographiques.
2. Les objectifs du programme de service de planning familial devraient être redéfini par méthodes contraceptives, par région géographique, gouvernorat et délégation ainsi que par les caractéristiques socio-économiques de la population et la dimension de la famille. Les résultats du programme devraient être eux aussi évalué selon les mêmes critères sélectionnés pour la définition des objectifs.
3. Le programme de planning familial doit se placer dans une perspective globale qui prendrait en considération les facteurs tels que l'emploi, l'environnement, le logement, la Protection Maternelle et Infantile (PMI) y inclus la nutrition et qui ne négligerait pas les chefs de foyers.
4. Les activités d'Information et d'Education devraient être conçues et élaborées de façon à atteindre les différents groupes de population dont le plus important est le groupe de population rurale. Il est connue que la pénétration rurale est beaucoup plus difficile, ce qui nécessite des technique appropriées qui restent à développer par l'ONFPF.
5. La distribution des contraceptifs au niveau communautaire a été l'objet d'une coopération entre l'ONFPF et l'USAID, projets PFAD, PFPC, PFMR, projets qui devaient tester cette forme d'activité et en tirer les conclusions en vue de sa généralisation

dans le milieu rural Tunisien. Ou en est cette action? Quelles ~~sont~~ été les difficultés rencontrées et les enseignements à tirer? Il est prévu que ces questions seront incluses dans l'agenda du séminaire de synthèse de Sousse au début de l'année 1980.

6. Quels sont les efforts entrepris par l'Office auprès du Ministère de la Santé pour l'éventuelle institutionnalisation d'une nouvelle catégorie de personnel de santé familiale (aides familiales) pour une meilleure prestation de services de planning familial auprès de la population rurale dispersée. Dans la perspective de l'introduction de cette catégorie d'agents, quel est le calendrier élaboré avec le Ministère de la Santé pour l'exécution de ce programme.
7. Dans le cadre de l'accord bilatéral entre l'ONFPP et l'USAID pour les années 1978-1981 dont l'objectif principal est l'expansion et ^{l'}amélioration des services de planning familial en milieu rural, cinq principales actions doivent être réalisées:
 - a. un système de distribution communautaire de contraceptifs efficace et à coût réduit.
 - b. la formation du personnel médical et paramédical
 - c. l'installation d'un réseau de cliniques de PMI/PF bien équipées et opérationnelles.
 - d. un programme d'Education et d'Information bien élaboré avec emphase sur la population rurale.
 - e. une capacité d'évaluation et de recherches renforcé y compris la surveillance et la gestion.

Quel progrès a été réalisé pour chacune de ces actions. Pour la réalisation de ces actions, le programme commun s'était basé sur certaines hypothèses qui devaient faciliter l'exécution du programme. Au stade actuel du projet, est ce que ces hypothèses demeurent réalistes pour atteindre les objectifs fixés.

8. Etude des mécanismes mis en place par l'Office pour se servir de la retroalimentation (feed back) ainsi que des évaluations, dans le but d'une révision permanente des divers éléments du programme. Vu l'évolution vers une complexité inévitable du programme, la création d'une division de la planification et de synthèse semble-t-elle souhaitable?
9. En vue de promouvoir une meilleure coopération technique entre le Ministère de la Santé et l'ONPFP pour l'évaluation et la programmation, quels sont les efforts entrepris pour renforcer l'optique épidémiologique et l'interpénétration des recherches démographiques, épidémiologiques et sociales ainsi que leur liaison au programme de PF.
10. Etude du programme et des réalisations au niveau du post-partum. Etant donné que le thème Santé/Planning Familial a des liens inéluctable avec la Protection Maternelle et Infantile il nous paraît que la mesure quantitative et qualitative des soins de maternité en Tunisie menée conjointement par l'ONPFP, le Ministère de la Santé et les Facultés de Médecine fournirait les données de base nécessaires pour les années 80. Par l'organisation de la

Surveillance des Soins de Maternité (SSM), la mise en place d'un programme postpartum bien étudié et préparé sur une base scientifique ainsi que la fertilité des femmes qui entrent dans l'âge ^{de} procréer deviendraient ^{être} facilement réalisable.

11. Quels sont les plans prévus pour les études périodiques sur la prévalence des contraceptifs en vue de fournir les données complémentaires aux statistiques de service. Ces dernières devraient être vérifiées à intervalles réguliers, par rapport à une enquête nationale de prévalence (ENP) ^{dont la première} qui ~~pourrait~~ être réalisée en 1980-1981. A vrai dire, les deux sources de données (1) ENP et (2) SSM se complètent d'une manière harmonieuse et constitueraient une ressource fondamentale pour la planification des programmes de prestation des soins, de santé maternelle et de planification familiale. Aussi, l'analyse épidémiologique des données permettrait de fournir une preuve scientifique pour améliorer la santé de la nation.
12. En matière de formation continue, quel est le contenu de cette formation, sa fréquence et sa répartition géographique. Quels sont les changements prévus pour assurer un flux d'information entre l'Office et les centres régionaux dans le domaine des statistiques de service, de la motivation et de l'éducation, de la pratique clinique en ce qui concerne les nouvelles techniques ou les techniques améliorées de contraception.

13. Quelle est la politique de l'ONPFP en matière de recrutement de nouveaux talents pour étoffer le cadre technique et le cadre moyen actuel de l'Office (démographes, statisticiens, épidémiologistes, spécialistes de l'information, administrateurs de programme etc...) c'est à dire les spécialités qui sont aujourd'hui nécessaires pour développer et garantir une bonne exécution d'un programme devenant de plus en plus complexe et élargi vers le monde rural.
14. Etant donné les changements fondamentaux que l'on constate actuellement dans la gestion du programme national il est important de développer un nouvel organigramme qui définira clairement les fonctions, responsabilités et commandement. Il serait souhaitable que cet organigramme soit disponible lors de cette phase préliminaire de l'évaluation.

I. PURPOSE OF THE EVALUATION

The purpose of the visit as planned by AID/W was to evaluate the family planning program. The evaluation will be accomplished in two stages.

The first stage (end of September to beginning of October) consisted of preliminary data collection and synthesis designed to obtain background information needed for the evaluation.

The second stage, the more important phase of the evaluation, is tentatively scheduled for the month of January 1980. The focus of the evaluation will be the future course of the program inasmuch as about 25 percent of the time will be devoted to an examination of past activities and 75 percent to consideration of the future direction of the program.

The members of the first phase team were the following:

Dr. Roger Bernard: A Swiss medical epidemiologist who has made repeated visits to Tunisia as a consultant for IFRP (International Fertility Research Program, North Carolina, USA), USAID, and UNFPA.

Ms. Elizabeth Maguire: Population Advisor, Office of Population, AID/W. Ms. Maguire has a degree in demography and has also been to Tunisia on numerous occasions in connection with AID assignments and while supervising certain family planning projects in the provinces of Sfax and Jendouba.

Ms. Pamela Johnson: As a social scientist, Ms. Johnson's focus was on the social impact of family planning. This was her first AID assignment, although she previously spent 16 months conducting an anthropological study in Tunisia.

Other members of the USAID staff in Tunis who participated in the evaluation were as follows:

Dr. Harper: Chief, Health and Family Planning Office.

Mr. Alan Getson: Family Planning Officer.

Mr. Anwar Bach Baouab: Assistant, Family Planning and Health Office.

On the Tunisian side, the National Family Planning and Population Office (ONPFP) appointed Dr. Mrad Rafaat Dali to accompany the team and represent the ONPFP during the visit.

^{1/} Translation of a French document by Dr. Rafaat Mrad Dali

II. SCHEDULE OF MEETINGS

The team had numerous meetings both with field staff (regional offices of Kasserine, Jendouba, Sousse, Le Kef, Beja) and with officials of the Ministries of Public Health, National Education, and Social Affairs and of the National Union of Tunisian Women, the National Institute of Statistics, and the National Family Planning and Population Office.

The complete schedule of meetings since the team's arrival on Wednesday, September 19, 1979, was as follows:

Thursday, September 20

- 10:00 a.m. Visit to the National Family Planning and Population Office
10:30 a.m. Meeting with the President-Director General (PDG)

Friday, September 21

- Morning Meeting with the officials of the Family Planning Division (Mrs. Moussa)
11:00 a.m. Ariana Clinic: Meeting with the chiefs of OB/GYN and Dr. Guedri, Dr. Mohamed Boukhris, and Professor Rafik Boukhris

Saturday, September 22

- Morning Visit to the National Training Center

Sunday, September 23

- Afternoon Departure for Kasserine

Monday, September 24

- 8:30 a.m. Meeting with the regional delegate of Kasserine
10:00 a.m. Meeting with the resident physician of the subregional hospital of Thala
12:30 p.m. Meeting with the regional delegate of Kef

Tuesday, September 25

- 9:00 a.m. Meeting with the regional delegate of Jendouba
1:00 p.m. Meeting with the regional director of public health and officials in charge of the Medjez el Bab integrated health care project

Wednesday, September 26

- 10:00 a.m. Meeting with officials in charge of international cooperation at the Ministry of Public Health (Mrs. Daghfous)
11:30 a.m. Meeting with Mr. Mekki Chekir

Thursday, September 27

- 8:30 a.m. Meeting with Dr. Nacef, Director of Preventive and Social Medicine of the Ministry of Public Health
- 10:00 a.m. Meeting with Professor Hamza
- 11:30 a.m. Meeting with the Executive Assistant to the Minister of Public Health
- 4:00 p.m. Meeting with Mrs. Chatter, Director for Social Action of the Ministry of Social Affairs

Friday, September 28

Departure for Sousse

Family Planning/MCH Seminar, Monastir (September 28-29)

Saturday, September 29

- 8:30 a.m. Meeting with Mrs. Yacoubi, Dean of the School of Medicine of Sousse and tour of the campus

Monday, October 1

- 8:30 a.m. Meeting with Mr. Tarifa (INS--National Institute of Statistics)
- 11:00 a.m. Meeting with Mrs. Dordana Masmoudi (E.N.--Ministry of National Education)
- 1:00 p.m. Meeting with Mr. Cittoni, UNFPA Coordinator

Tuesday, October 2

- 11:00 a.m. Meeting with Mrs. Mzali, President of the National Union of Tunisian Women
- 5:30 p.m. Meeting with Professor Nacef

Wednesday, October 3

- 10:00 a.m. Final meeting between the representatives of the National Family Planning and Population Office and the members of the AID team, with a closing presentation by Mr. Mezri Chekir, PDG of the ONPFD.

III. MAJOR POINTS COVERED BY TEAM IN ITS DISCUSSIONS WITH THE NATIONAL FAMILY PLANNING AND POPULATION OFFICE

A. Evaluation

The evaluation is expected to be the fruit of the joint dialogue between the ONPFP and USAID and will result at the conclusion of the

second stage in a series of recommendations. The PDG reported on an evaluation and synthesis currently being conducted by the Population Division of the National Family Planning and Population Office which is intended by the beginning of 1980 to enable the ONPFP to establish the strategy and identify the steps needed to achieve the demographic objectives of the Sixth National Economic and Social Plan (1982-86).

The National Family Planning and Population Office also agreed in principle to acquire a computer to improve data collection and strengthen the program of epidemiological research.

B. Tubal Ligation

In the last two years there has been a decrease in the number of tubal ligations accompanied, paradoxically, by a continued rise in the number of pill and IUD acceptors. In this regard, the need to encourage gynecologists to practice in the rural areas was emphasized, in order to maximize the use of the laparoscopic equipment installed in the pilot clinics of the ONPFP.

C. Continuation and Strengthening of ONPFP Work

Continuation and strengthening of the work of the ONPFP in rural areas, in particular the PFMR rural family planning project.

The importance of the work done by family aides in rural areas with dispersed populations was stressed along with the excellent performance of the team in Bir Ali, where contraceptive prevalence has increased over the last two years.

D. Maternity Care Monitoring (MCM) Program and Maternity Record Forms

This project was suggested by Professor Roger Bernard to the ONPFP for study and approval. The project would establish a data collection system on maternal and infant health to include the following information: medical and obstetrical history, socioeconomic background, delivery and outcome, postpartum (condition of the mother and condition of the child).

1. Provide the physician with a collection of useful information on maternity occupancy rates, different methods of delivery and their complications, maternal and child mortality rates, etc. The information will serve to identify areas where the program should concentrate its efforts as well as to identify regional as well as national medical and sociomedical problems.
2. These same standardized record forms will provide the Ministry of Public Health with information on problems of maternal and child health and on the level and the quality of the services provided by the various maternity hospitals. They will also serve to identify problem areas and the type of measures that should be taken.

In summary, this project would permit a continuing evaluation of the health care provided by maternity hospitals, give reliable data on infant mortality, and thus influence women's attitudes toward family planning.

The PDG has stressed the importance of this project as a complement to the postpartum/postabortum program already begun by the ONPFP in certain regions of the country.

At the conclusion of the final meeting between the AID evaluation team and the officials of the National Family Planning and Population Office, the PDG gave a presentation which he cited figures showing the progress that Tunisia has achieved in five years of family planning efforts compared to other developing countries.

"The success of the family planning program cannot simply be measured by a series of actions or statistics. More than just linking births, the goal of family planning is the harmonious development of the population and the stability of the family. It is this humanistic approach that is the basis of our policy toward family planning.

The PDG then spoke to the members of the team concerning the progress that has been made in public health thanks to the development of integrated health care and increased emphasis on preventive medicine, resulting in better distribution and coordination of national health resources and services.

Appendix C: List of Persons Contacted

AID/W

K. MacManus - NE/TECH/HPN
B. Turner - NE/TECH/HPN
L. Kangas - NE/TECH/HPN
D. Piet - NE/TECH/HPN
M. Thorne - NE/TECH/HPN
Mary Huntington - Tunisia Desk Officer
P. Benedict - NE/TECH/SA
D. Gillespie - DS/POP
B. Johnson - DS/POP
Dallas Voran - DS/POP
A. Wiley - DS/POP

TUNISIA--September 20-October 4, 1979

AID/TUNIS

W. Gelabert - Mission Director
E. Auchter - Program Evaluation Officer
O. Harper - Officer of Health, Population and Nutrition
A. Getson - Population Officer
A. Bach Baouab - HPN

National Office of Family Planning and Population

Mr. Mezri Chekir - President
Mongi Bchir - Director, Population Division
Mme. R. Moussa - Director, Family Planning Division
Dr. R. Daly, Special Assistant to the PDG
Mr. Mohammed Ayad - Head of Research
Mr. Ahmed Beltaief - Head of Special Projects
Dr. Ridha Chadi - Head of the Medical Division
Mr. Chaffradine - Population Division
Mr. Mourad Ghachem - Head of the Communication Division
Mr. Hamadi Khouini - Head of Demographic Projects
Mr. Sadok Khouniali - Head of Regional F.P. Services
Mr. Taoufik Kilani - Demographer, Population Division
Mr. Fathi Ben Messaouadi - Sociologist, Population Division
Miss Najoua Safi - Project Head, Education in Organized Contexts

Mr. Abderrazak Thraya - Director, National Training Center

Dr. Mohammed Boukhris - Ariana Clinic, Medical Director

Dr. Rafik Boukris - Family Planning Research Center and Charles
Nicolle Hospital

Hamda Guedri - Family Planning Research Center

Ministry of Public Health

Mr. Rabah Dekhili - Chef du Cabinet
Mme. Jalila Daghfou - Director of International Cooperation
Mr. Mekki Chkir - Director of Planning and Research
Dr. Taoufik Nacef - Director of Preventive and Social Medicine
Mme. Glenza - Division of Planning and Research
M. Kabudi - Division of Planning and Research

National Children's Institute

Prof. Bechir Hamza

Ministry of National Education

Mrs. Dordana Masmoudi - Project Head, Education en milieu scolaire
Mr. Mejri - Member of project team

Ministry of Social Affairs

Mme. Chatter

UNFT (National Union of Tunisian Women)

Mme. M'zali - President

Medical Faculty

Dr. Lyacoubi - Dean of the Medical Faculty, Sousse

OB/GYN

Prof. Mohammed Chelli - Charles Nicolle Hospital
Prof. Ben Amor - Habib Thamur Hospital
Prof. Mohammed Haddad - Azziza Othmana Hospital

Other Agencies

Dr. Mario Cittone - United Nations

Dr. Don Kominsky - Project Hope

Ms. Kathy Jescenky - CARE

Mr. Patrick Dumont - Peace Corps

Outside of Tunis

Medjez el Bab

Dr. Belgacem Sabri - Public Health M.D., Coordinator of Project in
Integrated Medicine
Dr. Brigitte Chehed - Project in Integrated Medicine.
Dr. Belgacem Znaidi - Medical Director of the Northwestern Health Region

Kasserine

Mr. Abdi - F.P. Regional Delegate
Mr. Guermi, F.P. Regional Secretary
Dr. Iliev Nentcho - OB/GYN, Regional Hospital

Thala

Dr. Hedi Sawhari - Auxiliary Hospital
Mme. Nissaf Abdelhedi - Midwife

El Kef

Mlle. A. Gayles - Regional Delegate, F.P.
Dr. Paul De Vos - Chief of the Dutch Medical Team

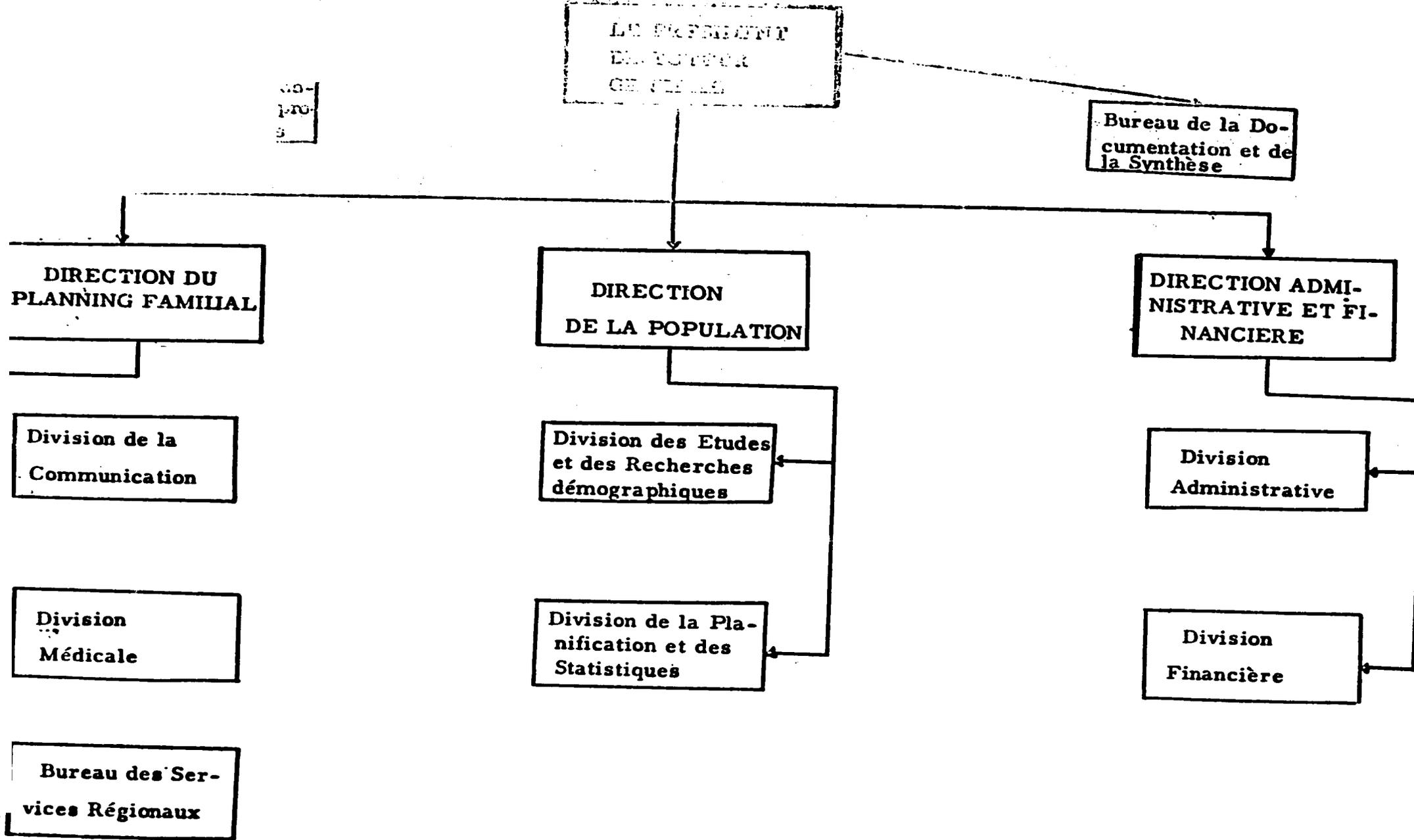
Jendouba

Mezri Ahmed - Regional Delegate, F.P.
Hamadi Bechir - Secretary

Béja

Mr. M. Ben Achour - Regional Delegate, F.P.

Appendix D: ONPEP Organization Chart

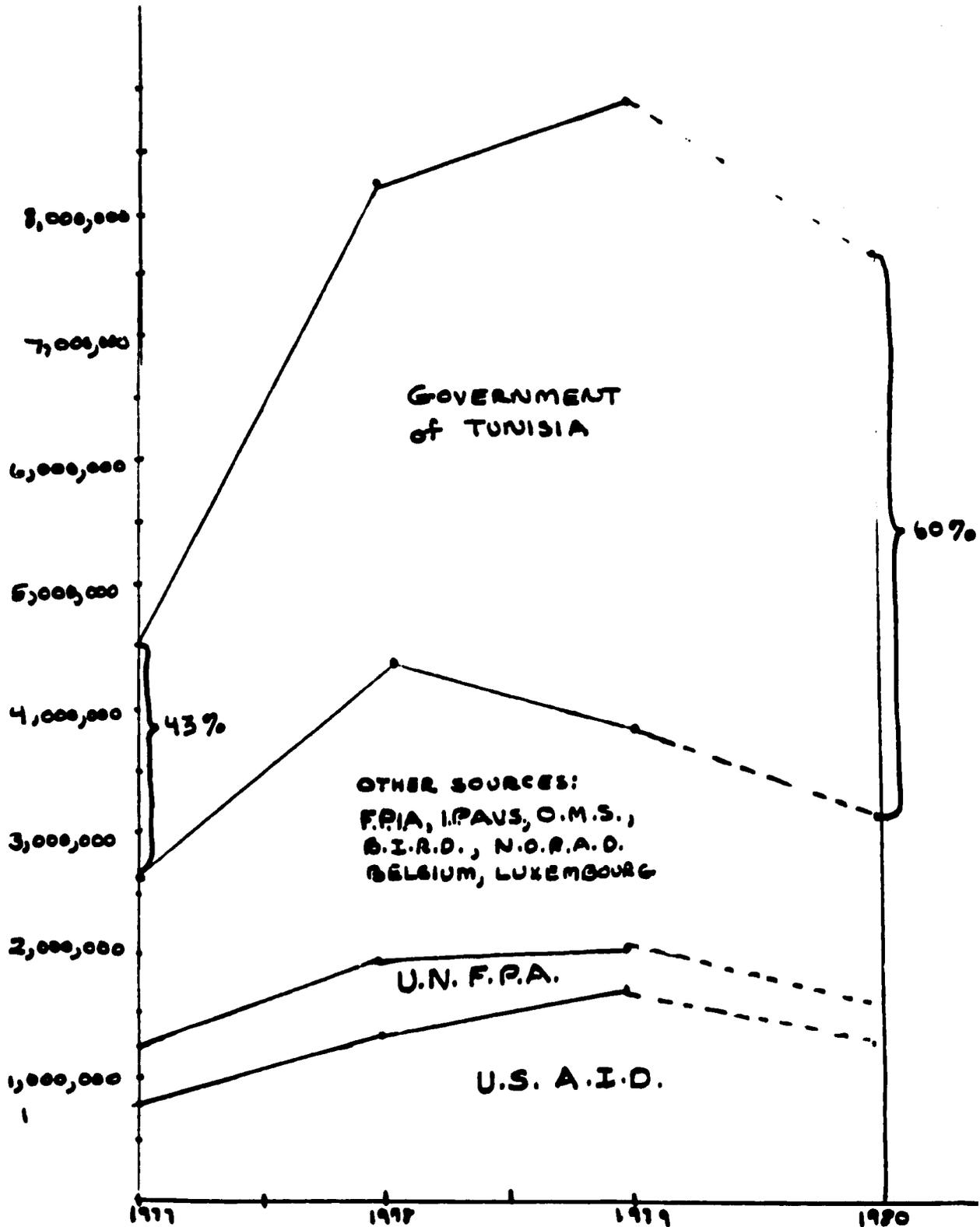


Appendix E: Bibliography

The Mission recommended and the team reviewed the following key documents:

- Project Paper, Project 664-0295, Family Planning Services
- Demographic Brief for Tunisia, World Bank, Feb., 1978
- Population/Family Planning Project: Tunisian, AID Field Evaluations, July 1975
- Programme d'Activités, 1977/1981, ONPFP, Sept. 1977
- L'action de l'Office National du Planning Familial et de la Population, 1974-1978: Objectifs, Réalisations, Résultats, ONPFP, March 1979
- Résultats, 1978 - Programme, 1979 ONPFP, March 1979
- Consultation on Research and Evaluation Strategy, UNFPA; June 1978 (Bernard/Omran Report)
- I, E, & C, for Family Planning; The ONPFP Program, June 1978 (Bertrand Report)
- Assessment and Some Recommendations, Dec. 1976 (Rothe/MacMahon Report)
- Statistiques du Planning Familial, 1978, ONPFP
- Le Planning Familial en Milieu Rural, (1978-1981, ONPFP, Mars, 1979)
- Requête d'assistance du Fonds des Nations Unies, pour les Activités en Matière de Population au Programme National de Planning Familial pour les années 1978-1982, ONPFP, June 1977
- Imp. Report, E, Maguire, DS/POP/RES, September - 1978, April - 1979

Appendix F: Estimated Support of O.N.P.F.P. by Source (1977-1980, in Tunisian dinars)



Source: ONPPP, Programme d'Activités 1977-81, Sept