

PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol U-447

1. PROJECT TITLE Population Programs  Intermediaries: IPAVS, JHPIFGO, IFRP, Westinghouse, Population Council and INTRAH			2. PROJECT NUMBER 664-0795	3. MISSION/AID/W OFFICE USAID/Tunis <i>ISN=37038</i>
5. KEY PROJECT IMPLEMENTATION DATES			4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each F864-84-5)	
A. First PRO-AG or Equivalent FY <u>81</u>	B. Final Obligation Expected FY <u>86</u>	C. Final Input Delivery FY <u>86</u>	<input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION 7. PERIOD COVERED BY EVALUATION From (month/yr.) <u>10/81</u> To (month/yr.) <u>9/84</u> Date of Evaluation Review _____	
6. ESTIMATED PROJECT FUNDING			8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR	
A. Total \$ _____				
B. U.S. \$ <u>9.0</u> million				

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., program, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. Technical and financial aid provided by the intermediaries has been fruitful and has contributed appreciably to the program's progress. Technical and financial assistance from A.I.D. should continue beyond 1986.	MFPFP, ONFP/ USAID	New bilateral agreement
2. Questions related to future assistance modalities should be discussed and acted upon by ONFP, AID/W, USAID/Tunis and the intermediaries with consideration to administrative and financial constraints and possibilities, human resources, and different interested agencies and organizations.	MFPF/ ONFP, intermediaries/ USAID	Sept. - Dec., 1984
3. Future assistance should be provided under a bilateral agreement between USAID and the GOT defining technical and financial assistance framework after 1986.	MFPF, ONFP/ USAID	New bilateral agreement
4. The ONFP should begin to develop perspectives of activities required under the VIIth Plan and should estimate its needs in terms of external aid.	ONFP	Ongoing
5. The cooperative agencies should design plans of actions to address specific evaluation recommendations	ONFP/intermediaries/ USAID	Ongoing

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS			10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT		
<input type="checkbox"/> Project Paper	<input type="checkbox"/> Implementation Plan e.g., CPI Network	<input type="checkbox"/> Other (Specify) _____	A. <input type="checkbox"/> Continue Project Without Change		
<input type="checkbox"/> Financial Plan	<input type="checkbox"/> PIO/T	_____	B. <input type="checkbox"/> Change Project Design and/or		
<input type="checkbox"/> Logical Framework	<input type="checkbox"/> PIO/C	<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Change Implementation Plan		
<input type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P	_____	C. <input type="checkbox"/> Discontinue Project		

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANT'S AS APPROPRIATE (Names and Titles)		12. Mission/AID/W Office Director Approval	
James E. Vermillion <i>James E. Vermillion</i> Health, Nutr. and Family Planning Dvlp. Officer		Signature <i>Ernest E. Hardy</i>	
Frank Kerber <i>Frank J. Kerber</i> Program Officer		Typed Name Ernest E. Hardy A/Director	
		Date 10/02/84	

NEAR EAST EVALUATION ABSTRACT

PROJECT TITLE(S) AND NUMBER(S) Population Programs Intermediaries: IPAUS, JHPIEGO, IFRP, Westinghouse, Population Council and INTRAH	MISSION/AID/OF OFFICE USAID/Tunis
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PROJECT DESCRIPTION  
Following completion of a four year (78-81) AID bilateral program of \$6.6 million to "assist the GOT to strengthen and expand family planning (FP) services, primarily in rural areas", an \$9.0 million program has been funded for 81-86 to assist in providing clinical services, training, rural outreach and peri-urban efforts, voluntary sterilization,

AUTHORIZATION DATE AND U.S. LOP FUNDING AMOUNT —	PES NUMBER 84-5	PES DATE 10/02/84	PES TYPE <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Other (Specify)
ABSTRACT PREPARED BY, DATE — James Vermillion — Health and FP Devel. Off.	ABSTRACT CLEARED BY, DATE Frank Kerber <i>Frank J. Kerber</i> Mission Evaluation Officer		<input type="checkbox"/> Special <input type="checkbox"/> Terminal

IEC, program monitoring, and research and evaluation. This program is being carried out by AID funded intermediary organizations, namely the Population Council, INTRAH, IPVAS, JHPIEGO, Westinghouse Health Systems, and to a lesser extent, IFRP. The general objective of this mid-term evaluation was to determine the progress of the project and its various component activities and to suggest future directions for FP and population activities necessary to the achievement of medium and long range population goals of the GOT.

During the past three years, sustained progress has been made toward the achievement of the demographic objectives of the GOT's Vith Plan. Prevalence of modern contraceptive use has increased from 28% in 1980 to 35% in 1983. The crude birth rate has dropped from 35% in 1980 to around 31% in 1983; the natural growth rate has likewise declined from 2.7% in 1980 to between 2.3 and 2.4% in 1983. Numbers of new acceptors for all contraceptive methods (except pills) have increased between 1979 and 1983: 14% for tubal ligation, 68% for IUDs, and 6% for secondary methods. The drop in the number of pill acceptors in the public sector has been largely compensated for by increased distribution in the private sector.

With respect to norms and standards, supervision, training and follow-up, quality of FP services in Tunisia is good. The system is still strongly adherent to a medical model, but limited progress has been made toward liberalization of pill distribution. ONPFP participation in training has been active, but progress in basic training for medical and midwifery students has been slow. Only recently has an optional 10 day course in FP been added to the existing 5 hours presently required of these students. The rural program is too new to enable sound examination, but service delivery appears good; management tools have been produced for this program. The peri-urban program is uneven in delivery, depending on the support and cooperation from other departments (MOPH and MSA). IEC activities need reinforcement, especially in production of audiovisual aids for group education and improvement in the use of television as a medium.

The ONPFP has initiated steps to expand participation of the private sector but more efforts are needed to reinforce the present level of activities and meet the expressed needs of this sector, especially in the area of FP information and education.

Additional scientific research on population in Tunisia is needed, and the ONPFP should either carry out or participate in such studies.

In summary, important progress has been made in areas such as program planning, monitoring and evaluation; strengthening and expanding FP services in rural and peri-urban areas; focusing continuing education toward problem solving; and improving service delivery statistics to provide the PDG and staff with more reliable information relevant to program management. In all of these accomplishments, the assistance of the intermediaries has been important, both in stimulating growth and in strengthening on-going activities. Future assistance should aim toward innovative approaches and training activities.

EXECUTIVE SUMMARY

GOT/USAID EVALUATION  
OF THE  
TUNISIAN FAMILY PLANNING PROGRAM

A Report Prepared By:

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During the Period:  
MAY 9 - JUNE 1, 1984

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## SUMMARY OF MAJOR FINDINGS AND RECOMMENDATIONS

### 1. Introduction

Since 1965, A.I.D. has contributed nearly \$38 million in assistance to the Tunisian population and family planning program. Initially provided under a bilateral agreement, the assistance was centered on the development of infrastructure and the training of personnel to provide the population with family planning information and services. Between 1978 and 1981, \$6.6 million in bilateral assistance was provided to help the Government of Tunisia (G.O.T.) reinforce family planning services, especially in rural areas. A joint G.O.T./A.I.D. evaluation of the program carried out in 1980 recommended a continuation of assistance designed especially to increase the impact of the program in rural areas. To that end, A.I.D. agreed to provide continuing assistance to the program over a five year period (1982-1986) to coincide with the G.O.T.'s Vith Development Plan. As a means of increasing Tunisian responsibility for management of program resources, A.I.D. decided to provide this additional assistance through A.I.D. centrally funded population intermediaries who would work directly under the G.O.T.'s National Office of Population and Family Planning (ONPFP) to design and implement the program. The six organizations selected to participate were The Population Council, IFRP, INTRAH, IPAVS, JHPIEGO, and Westinghouse Health Systems. Midway through implementation of this program, a joint evaluation team, including three external experts and three Tunisian nationals, assessed progress of activities against the Government's mid- and long-term population objectives.

The evaluation team was in Tunisia from May 9 to June 1, 1984 to examine achievements in fields including service availability and delivery; training; information, education and communication; and research and evaluation. Given the growing role played by the private sector in the national family planning program, the team devoted particular attention to this sector. The team also gave special attention to the role of the ONPFP in research on population and development.

### 2. Major Achievements of the 1980-84 Program

During the last four years, important achievements were made in areas covered by the program. These were the result of increased cost effectiveness in the use of human and material resources at both central and regional levels through the improvement and rationalization of management methods; improved planning and followup; bringing services closer to the poorest

rural and urban populations; continued training of staff and field personnel; and the development of a statistical service unit providing more accurate and valid information necessary to program management and decision making.

The intermediaries, through their support of new activities and the reinforcement of existing programs, contributed greatly to continued program development. The President Director General of the ONPFP has warmly acknowledged this contribution.

### 2.1 Demographic Accomplishments

During the last few years, and despite population growth effects due to the population age structure, the growing acceptance and utilization of modern contraceptive methods, along with a rise in the age of women at marriage, have had considerable impact towards the achievement of Vith Plan goals. The prevalence of the use of modern contraceptive methods increased from 29% in 1980 to 35% in 1983; the crude birth rate, at 35% in 1980, decreased considerably in 3 years, falling to 31% in 1983; the natural growth rate fell from 2.7% in 1979 to between 2.3 and 2.4% in 1983. These results are extremely encouraging and confirm the degree of program accomplishments.

Furthermore, during the 1981-83 period, the ONPFP continued development of its regional administrative and technical infrastructure. At present family planning service delivery is carried out in 800 centers of which 762 are serviced by 61 mobile teams and clinics; the remainder consist of 38 Regional Centers of Education and Family Planning (CREPF) and clinics.

Whereas the previous evaluation was concerned with the declining number of new acceptors between 1977 and 1980, it should be noted that, in comparison with 1979, a 68% increase in initial IUD insertions has taken place; also a 14.5% increase has taken place in the number of tubal ligations and a 6% increase in the number of secondary method acceptors. The increasing number of new IUD insertions was paralleled by a decrease in IUD removals and an increase in reinsertions (32% more in 1983 than in 1982). With respect to oral contraception, the decrease in new public sector acceptors (down 34% in comparison to 1979) was largely compensated by an increased private sector participation representing an important source of contraceptive supply and services (mainly pills and secondary methods) for nearly one-fourth of the total number of users. Between 1980 and 1983, the number of pill cycles distributed by the private sector has more than doubled while condom distribution has increased by 40%. The availability of family planning services is practically universal in urban areas and is estimated to be between 50 and 70 percent in rural areas.

## 2.2 Service Delivery

Under the guidance of the ONPFP's Rural Coordination Unit, 6 mobile clinics and 2 mobile teams deliver family planning services to the population of 22 rural delegations in 9 governorates. In addition to the personnel in these units, 40 animatrices were recruited and trained for the program. The main difficulties experienced in this program are: lack of personnel stability (animatrices and midwives); the need for adequate transport for animatrices; and, a certain hesitation of the population to use publicly the services offered by mobile clinics. Although very recent, the program has already achieved positive results both in service delivery and in the development of methodologies and mechanisms to improve identification of the target population, reinforce information and insure improved followup. Use of these management tools has already been expanded to other rural areas outside the geographic limits of the program.

An effort was also undertaken to improve information and access to family planning services in the periphery of Tunis, Sousse, and Sfax. The program aims at opening, within Ministry of Public Health (MOPH) structures, new family planning clinics (25 in Tunis, 2 in Sousse, and 2 in Sfax), as well as at reinforcing information and education activities of animatrices from the ONPFP and Ministry of Social Affairs (MSA). A system of liaison forms has been developed to measure animatrice performance and to identify resistance to contraception. The results of this program vary and are directly related to problems encountered including transportation difficulties and insufficient cooperation with MOPH and MSA personnel who are not always sufficiently motivated. A supervisor was recently appointed specifically to oversee this program in the Greater Tunis area.

In terms of norms and standards of supervision, training, and followup, the team found the quality of family planning services to be very good. There is no major problem from a medical viewpoint. Tubal ligation complications are about 0.25% (including pregnancies) and no criticisms have been expressed by the majority of the medical community regarding the quality of services offered by the program. A certain liberalization of services, particularly pill and secondary method resupply, is already found in certain regions; measures are anticipated at the central level to generalize this policy.

### 2.3 Training

Previously, ongoing training was oriented to the acquisition of new knowledge, and did not address specifically identified program needs. In 1982, the ONPFP reviewed its policy in this field, and ongoing training now aims at problem solving by addressing specific regional characteristics and problems expressed by field personnel. During the last 3 years, central and regional office personnel participated in several workshops which promoted increased management efficiency (problem identification, scheduling of personnel, implementation, evaluation) and improved program performance. Training curricula, along with methodological and pedagogical forms, were developed for various health and special personnel. Recently a set of evaluation forms designed to measure the impact of training on program performance was developed.

For the first time since the program was started, a 10-day optional family planning course will be incorporated in the curriculum of the medical schools for the 84-85 academic year, in addition to the existing 5-hour family planning course for all medical students. This optional program provides an excellent opportunity to reinforce existing relationships with academic authorities, consolidate family planning teaching, and generalize it to all medical students.

### 2.4 Information, Education and Communication

During the 1970's, information activities were mainly aimed at sensitizing and informing the population about family planning questions. During that time, they were based on a strategy of mass information campaigns. Results were rewarding since, by 1983, 90% of Tunisian women knew about the existence of modern contraceptive methods. In 1980, the ONPFP reviewed its strategy and gave an increasingly larger place to individual and group education without, however, abandoning the mass media. Individual education is conducted by ONPFP animatrices as well as by personnel of the MSA, the IPPF affiliate, the Tunisian Family Planning Association (ATPF) and the National Union of Tunisian Women (UNFT). The number of individual contacts went up from 28,000 in 1981 to 97,000 in 1983. Group education is aimed at various audiences -- political, professional, and cultural. Although radio is well used, a certain weakness can be observed regarding the use of television where programming is neither regular nor varied. Newspapers also need to be used to a greater extent. Message content and form should be varied to reach a maximum number of audiences. With respect to audio-visual support material, a particular effort was made in connection with individual

education programs; all animatrices are given demonstration kits as well as folders on IUDs, pills, tubal ligation and secondary methods. The design and production of audio-visual support for group education for each specific target population need, however, to be reinforced.

## 2.5 Private Sector

Private sector participation in the national family planning program has increased considerably during the last few years. At present, it is estimated that nearly one-fourth of contracepting couples go to the private sector, especially for oral contraception and particularly in urban areas where most private physicians and pharmacists have their practices. There is, moreover, a clear tendency, particularly among pharmacists, to settle in smaller cities. The ONPFP has already undertaken a number of steps to insure improved pharmacist and physician participation in family planning activities. Thus, it established within the Medical Division a unit specifically responsible for a decentralized distribution of contraceptives; it organized workshop and information events for private physicians and pharmacists; and it collaborates with medical services in private companies within the framework of their occupational health programs. Although considerable, these efforts need to be sustained and expanded to strengthen private sector family planning activities, particularly in the field of information and education. Another important question related to an increased private sector participation in family planning is the legal framework in which such an expansion is likely to take place (codification, standards, reimbursement for family planning activities, etc.).

## 2.6 Research and Statistics

During the last two years, the Population Division developed its data collection and data processing capabilities, particularly through the efficient use of its microcomputer; this has yielded better data analysis and feedback directly related to program management. Progress achieved in this field is noteworthy and has contributed greatly to the improvement of program performance. Also to be mentioned is the enhanced operations research capacity developed by this Division (field visits, mini-surveys, compilation of activity records, utilization of animatrice followup forms) which constitutes an integral part of the evaluation system. In addition, the Division has undertaken larger surveys. Some, such as the urban survey on fertility and contraception, are excellent; others are less so. The Rural Survey on Family Planning, for example, suffers from methodological errors which restrict its

scope. Preliminary findings of the CPS survey show certain inconsistencies with prevalence estimates based on service statistics. These need to be clarified during the final analysis.

Those interrelations which exist between demographic parameters (mortality - fertility - migration) and social, cultural and economic factors contribute dynamically to the development process. In addition to the usefulness of an improved understanding of these interactions for the elaboration of a long-term development policy, research in population can influence more directly the ONPFP's strategy concerning family planning activities as such. It is, therefore, appropriate that the Population Division encourage and participate in the implementation of research activities on population and development. However, personnel constraints and the numerous and important tasks related to service statistics, special projects, operations research and surveys, limit for the time being the Division's capacities in this field. As the implementation of certain tasks becomes more familiar and "routine" (preparation and processing of statistical tables, prevalence estimation, etc.), the Division's work program will be lighter, and it will probably be possible to devote more time and personnel to research on population.

## 2.7 Program Budget/Management

With respect to management, two aspects need to be mentioned. When the five year intermediary effort was begun, the need to assume a progressive increase in the G.O.T.'s share of the financial support for the program was stressed. Whereas in 1982 the G.O.T.'s share of funding was 56% for the ONPFP, it rose to 63% in 1983, 73% in 1984 and the VIth Plan anticipates an 85% government participation in 1985. It is true that the size of external organization phase-down has been partially compensated by the strengthened dollar. Nonetheless, considering the overall ONPFP budget which only increased by 20% in 4 years -- with 10% inflation a year and 16% salary increases in 1983 -- the team can see that during the same period, because of improved financial and human management a considerable number of activities, listed in this report, were carried out.

Finally, the team notes progress that has been made in decentralization of the management of the ONPFP. Based on ONPFP general policy and in conformity with implementation guidelines issued by the Direction Générale in collaboration with regional officials, regional delegates have been given more flexibility in choosing their priorities and establishing

their work programs which are therefore more adapted to the specific needs of each region. Furthermore, each region has its own bank account, which facilitates its financial management, and is reimbursed, within the limits of its annual budget, in relation to activities performed.

### 3. Transfer of ONPFP Tutelage to the Ministry of the Family and Promotion of Women

During this evaluation the transfer of ONPFP tutelage to the Ministry of the Family and Promotion of Women was officially announced. The law pertaining to this change in the status of ONPFP must yet pass the National Assembly and be signed by the President. Presently a commission has been established to review the practical modalities of this transfer.

One of the principal factors which has permitted sustained growth of the family planning program has been the institutional framework of the ONPFP which has facilitated the development of permanent and mobile infrastructures and the necessary human resources for the operation and management of family planning activities. To reinforce existing activities and to continue expansion of the program, on the basis of its assessment the evaluation team believes that it is essential to maintain the integrity and specificity of ONPFP services in the cadre of a specific institutional framework. The evaluation team was encouraged by assurances to this effect given by the Chef de Cabinet of the MFPF, noting their importance to continued program momentum, especially in the short and medium term.

Also, the evaluation team notes that a certain caution is needed in the introduction of family planning in social programs so as not to create an image of implied linkage between the two types of services.

### 4. Integration of Family Planning Services into the Primary Health Care Structure

With the development of the Primary Health Care (Santé de Base) infrastructure, a question of integration of family planning services arises. If the principle of such integration, to bring service into these new facilities, is not contested, then the evaluation team suggests that all parties concerned (MOPH, ONPFP, MFPF) study all questions related to the long term and progressive transfer of family planning service delivery to these MOPH structures, and specifically to Basic Health Centers, as infrastructure and personnel are available. This could lead to the formulation of an upgrading plan which would normally consider the following four priorities:

- continued quantitative improvement of family planning services;
- continued qualitative improvement of family planning services;
- continued improvement in availability and accessibility of each contraceptive method; and,
- that the responsibility for establishing quantitative and qualitative family planning norms and standards will be with the ONPFP and the MOPH working in close collaboration.

While establishing this process, it is also important to take into consideration the objectives of the VIIth and following plans.

#### 5. Future A.I.D. Assistance

The evaluation team believes that technical and financial aid provided by the intermediaries has been fruitful and has contributed appreciably to the progress of the program over the past years and, similarly, to the constant rise in contraceptive prevalence and the realization of the VIth Plan's demographic objectives. To aid the G.O.T. in realizing its long-term demographic objectives, the evaluation team believes that:

- a) Technical and financial assistance from A.I.D. should continue beyond 1986. Assistance through intermediaries seems a good mechanism for this aid since it is adaptable to specific needs.
- b) Questions related to future assistance modalities should be discussed and acted upon by those involved (ONPFP, A.I.D. Washington, USAID/Tunis and the intermediaries) with consideration given to administrative and financial constraints and possibilities, human resources, and different interested agencies and organizations.
- c) Future assistance should be provided under an agreement protocol between A.I.D. and the G.O.T. which would define the technical and financial framework of assistance after 1986.
- d) The ONPFP should begin to develop perspectives of activities required under the VIIth Plan and should estimate its needs in terms of external aid.

## 6. Recommendations

The recommendations which follow have been identified in order of priority A, B, and C corresponding respectively to performance over the short, medium and long term.

### 6.1 Population and Development

-A workshop should be developed in 1985 by the ONPFP to examine in depth the ways in which population phenomena interact with development processes in Tunisia. This workshop would have as an objective informing those responsible for the preparation of the VIIth Plan of the implications of population parameters in various sectors. Departments including the Ministry of Plan, MOPH, MFPP, Ministry of the Interior, MSA, and the Ministry of Education should participate in this workshop (see annex to the report). (Priority A)

-Population research studies should be continued following priorities of the program as well as human and material resources. (Priority A)

-Relations with INS and other research institutions should be enhanced to develop better capacities in demography, population and development. (Priority A)

-The ONPFP's participation should be insured in sectoral and synthesis commissions engaged in preparation of the VIIth Plan. (Priority A)

### 6.2 The Private Sector

-The development of the ONPFP contraceptive distribution system to the private sector should be continued with an evaluation of the system -- after a special program of education, information and family planning service delivery activities in that sector is carried out, addressed to pharmacists and private practice physicians. (Priority A)

-The dialogue initiated with medical organizations and associations should be reinforced to develop the practical aspects of an effective collaboration. (Priority A)

-The needs of private physicians and pharmacists in continuing education should be reviewed. (Priority A)

-One or more workshops should be organized under the auspices of the ONPFP to discuss questions related to a broadened role for citizens in bearing contraception costs, (politics of contraceptive pricing, legislation, insurance

reimbursement, etc.). A similar workshop could be held for representatives from organizations representing pharmacists, private practice physicians, representatives from the MOPH and other interested groups. It is desirable that the ONPFP develop a document treating in depth family planning and the private sector and prepare statistical information and other data for use in these workshops. (Priority B)

### 6.3 Family Planning Services

#### Norms and Standards

-The Medical Division should continue the development of norms and standards for each contraceptive method and insure wide distribution to all medical and socio-health personnel concerned. (Priority A)

-The distribution of secondary methods should be generalized to all socio-health personnel, animatrices, nurses, hygienists, social assistants and chief nurses in the dispensaries to facilitate, as fully as possible, their accessibility. (Priority A)

-A system of resupply by animatrices and chief dispensary nurses should be generalized for pill users who present no problems and whose follow-up indicates no contraindications. (Priority A)

#### Supervision

-Supervision visits should be more systematically planned and scheduled. (Priority A)

-Supervision documents should be developed to increase the productivity of on-site visits and to systematize their follow-up. (Priority A)

-The tasks and responsibilities of the physicians in the Medical Division should be more accurately defined. (Priority A)

-Quarterly meetings should be held at the ONPFP level between supervising midwives and the Medical Division. (Priority A)

-A review of options, means, and needs to reinforce interregional supervision should be undertaken. (Priority B)

#### Follow-up

-A simple procedure allowing for a permanent and systematic identification of women to be contacted for follow-up should be encouraged. (Priority A)

-Basic health center personnel should be encouraged to participate in acceptor follow-up activities. (Priority B)

#### Service Availability

-A survey should be undertaken to determine accurately the size and location of and the reasons for unmet demand and obstacles to contraception. (Priority A)

-Secondary methods should be promoted for temporarily separated couples. (Priority B)

-Information and educational materials should be adapted to address misbeliefs. (Priority B)

-Training of animatrices should be reinforced to better prepare them to confront rumors and misbeliefs. (Priority B)

-Information activities for men should be increased. (Priority A)

-Additional efforts should be made to recruit male educators. (Priority A)

-Increased emphasis in IEC should be placed on topics related to mother and child care, particularly concerning birth spacing to encourage younger women with fewer children to use contraception. (Priority A)

#### 6.4 The Rural Program

-The quantitative, qualitative and cost/efficiency aspects of the mobile clinic program in the 22 target delegations should be assessed as a basis for deciding on the best strategy related to the expansion of mobile clinics to other governorates. Activities, including gynaecology activities, undertaken by the mobile clinics and teams should be compared to those performed by other means. (Priority A)

-Animatrice transport needs to be facilitated by an improved coordination of the education team, mobile clinic, and animatrice schedules. (Priority A)

-Vehicle service should be provided with a well-equipped mobile maintenance unit for emergency repair on the spot. This would probably assure the repair of a great majority of the vehicles which break down. (Priority A)

-The MWRA census should be continued using the individual follow-up form. (Priority A)

- Family planning information and promotion for local officials should be reinforced to further benefit from their collaboration. (Priority A)
- Animatrices should be provided with pills and secondary methods for re-supply purposes. (Priority A)
- The ONPFP should envision means of better responding to expressed needs of the population, such as, for example, treating in the clinics minor gynaecological problems diagnosed but presently referred elsewhere for treatment. (Priority B)
- Collaboration with Social Education teachers should be increased to inform and sensitize men to family planning. (Priority A)
- Groups of women volunteers (such as satisfied acceptors or natural leaders) should be identified who, after adequate training and provided with simple educational support, could sensitize and motivate women in their surroundings, help the animatrices during their visits, and encourage users to obtain followup. (Priority B)

There is no easy solution to turnover of animatrices; one possibility is to consider using social assistants from the Ministry of Social Affairs, similar to the way MOPH medical and paramedical personnel are being used. (Priority B)

#### 6.5 The Peri-Urban Program

- More systematic use needs to be made of data in the liaison forms. (Priority A)
- To improve understanding of resistance factors, mini-surveys should be conducted on women who were interested but who did not return for family planning services. (Priority A)
- Social animatrices should be selected from those who already live in the target districts. (Priority B)
- Private sector collaboration should be increased by establishing liaison between the family planning center and private physicians and pharmacists. (Priority A)
- Workshops involving both social personnel and ONPFP Delegation personnel should be organized to discuss problems and design strategies adapted to the needs of each region. (Priority A)

-The recruitment of full-time physicians who would implement activities in 2 to 3 centers at a time should be considered. (Priority B)

-Socio-demographic mini-surveys in large cities such as Bizerte, Kairouan, Gabès should be undertaken for an improved understanding of suburban district characteristics, and for an intervention adapted to the specific needs and topography of each city. (Priority C)

#### 6.6 Postpartum Program

-The results achieved by various approaches should be examined to determine advantages and drawbacks of each and to develop the most appropriate strategy for the post-partum program. (Priority A)

-The introduction of audio-visual material should be considered for family planning education of mothers during their stay in the maternity clinics. (Priority B)

-The role of supervising midwives for this program needs to be reviewed; their employment, even part-time, in promoting family planning with new mothers may be a poor use of their time. (Priority B)

-The staff of all maternity clinics needs to be motivated to participate actively in family planning work during their daily activities. (Priority A)

#### 6.7 Voluntary Sterilization Program

-Tubal ligation medical files now in abeyance at the ONPFP should be completed by sending them back to delegations which have a correctly completed copy. Medical files need to be analyzed, as described, in late 1984. (Priority A)

-Given the current status, an evaluation of questions of program quality and safety, from a medical point of view, is not needed at this time. (Priority A)

#### 6.8 Contraceptive Prevalence

-All prevalence estimates need to be standardized for correct comparisons and estimates of tendencies. (Priority A)

-Reasons for the inconsistencies between 1983 CPS and other estimates of prevalence need to be determined. (Priority A)

-The ONPFP should continue to compare prevalence performance with VIth Plan objectives. (Priority A)

## 6.9 Management Information

- Activities should be continued in the collection, processing, and analysis of data necessary to the management of current activities and to decision-making. (Priority A)
- The ONPFP Population Division should collaborate closely with other Divisions as well as with the Ariana Clinic to develop new instruments for data collection, processing and analysis to improve their respective activities. (Priority B)
- The ONPFP should continue to expand and improve the information feedback mechanisms already established for the regions and expand these mechanisms to delegations, service outlets and mobile units. (Priority A)
- Standard terminology needs to be developed. Use of different phrases for the same concept or measure leads to erroneous interpretation. The Population Division could prepare a one-page list of the 10 or 12 concepts most often used and could identify the preferred term for each concept. (Priority A)
- The tabulation and analysis of acceptor characteristic data should be completed as soon as possible. This information is important, especially at the governorate level. (Priority A)
- The Population Division training program, begun by a seminar in 1983 and a 3-day program in January 1984, should be continued. (Priority A)
- The number of Population Division staff who can use microcomputers should be expanded. (Priority B)
- Computer capacity should be reinforced and adequate training should be provided to staff. (Priority B)
- Particular attention should be given to the application of scientific research principles (such as identified in the annex to the report) in all surveys and studies. (Priority A)

## 6.10 Basic Training

- The ONPFP should continue its action undertaken with academic authorities. Physician participation in family planning is now voluntary; it is necessary to explore means to reinforce theoretical and applied family planning training in the required curriculum of doctors, pharmacists and midwives. A certificate in family planning might be instituted for particularly interested doctors and

pharmacists. A commission of academic authorities and representatives from the ONPFP, the MOPH and the Ministry of Higher Education and Scientific Research could study aspects of this issue. (Priority C)

-To enhance dialogue with academic authorities, the ONPFP should examine certain needs which have been expressed by academic deans and associate deans. These include providing scholarships for family planning education, financing participation at international family planning conferences, reinforcing bibliographic family planning materials, audio-visual support in family planning and providing visiting professors from abroad. (Priority B)

-In terms of training of obstetrical nurses, the ONPFP could assist in curriculum development and could provide practical training in the CREPF's and in the mobile clinics. (Priority B)

#### 6.11 Continuing Education

-Planned decentralized training activities for the various categories of the socio-medical personnel should be continued. (Priority A)

-The human resources of the Training Center should be reinforced to provide it with the means to improve its preparation, management, and evaluation of training activities, especially given its planned expansion. The Training Center should be headed by a full-time Director seconded by a technical assistant specializing in training. (Priority A)

-The production of audio-visual support materials should be reinforced. (Priority A)

-Emphasis should be placed on training medical and paramedical personnel in basic health facilities, including regional primary health care (Santé de Base) chefs de service. (Priority A)

-Ways of collaborating with MOPH Regional Committees for ongoing training need to be considered. (Priority B)

-About 300 to 350 social education teachers responsible for educational programs in the localities should be trained. (Priority A)

-Training and continuing education activities need to be extended to private physicians and pharmacists. (Priority A)

-Refresher workshops for regional delegates need to be scheduled in the areas of evaluation, communication, personnel management, and methodology for training trainers. (Priority A)

-The new evaluation instruments recently developed by the Training Center need to be applied. (Priority B)

#### 6.12 Information, Education and Communication

-Specific plans of action for each target group should be developed. An ongoing evaluation methodology for the various IEC activities needs to be developed and applied on a continuing basis. (Priority A)

-Audio-visual material adapted to each target group should be designed and tested. (Priority B)

-The possibility of a wider use of mass media should be studied and a review be made of family planning programming and message formulation for television. (Priority B)

-Cooperation with the private sector should be reinforced to benefit from expertise in audio-visual production. (Priority A)

-The main ONPFP library should be expanded in the areas of human reproduction, contraception, family health, demography, sexually transmitted diseases, sexuality, communication and ecology. French and Arabic bulletins should be available such as those easily obtained from IPPF, The Population Reference Bureau, the UN, WHO, etc. (Priority A)

The IEC Division should review, edit and distribute documents produced by Action Familiale de la Prélature de Tunis (Priority A)

Consideration should be given to initiation of a newsletter to cover regional delegation initiatives, program evolution, and technical progress as well as to reinstating the Revue Tunisienne de Population. (Priority B)

#### 6.13 Management

-In accord with the progressive G.O.T. assumption of program costs (including salaries), future external aid should focus on the financing of new and innovative projects--such as private sector participation in the national family planning program, research in population and development--and in assistance to programs which need reinforcement (training, IEC, evaluation, extension of services into interior areas). In this regard, the ONPFP should undertake a study to determine financial and human resource needs and resources relevant to activities programmed in the VIIth Plan. Technical and financial support for such a study is desirable. (Priority B)

-Continuing effort should be devoted to defining the tasks, roles and responsibilities of personnel in each Division in the central office. (Priority A)

-Personnel evaluation mechanisms should be introduced, with priority for technical personnel. These evaluations should be considered for promotions, filling posts, etc. (Priority A)

-The information processing capacity of the ONPFP should be reinforced and the analytic capability enhanced. (Priority B)

-Decentralized management procedures capable of improving the program should be put in place, for example, regional or delegation responsibility for identification of FMAR's and distribution of services. (Priority A)

## PES

### 1. Summary

(see first part, Evaluation Executive Summary)

### II. Project Background

During the fall of 1979 and the spring of 1980 a joint GOT/A.I.D. evaluation of the Tunisian family planning program was conducted. This evaluation was developed in two phases: Phase One, which assessed the impact and current status of the program; and Phase Two, which provided recommendations for improving and expanding the national program. Essentially, the evaluation teams recognized that the Tunisian program had become one of the most successful family planning programs in Africa and the Middle East. Several weaknesses were noted, however, that inhibited attainment of full program potential: program services were not as readily available in rural areas as they were in urban areas; and information and education activities were weak, particularly regarding the development and production of educational materials for rural, non-literate populations. It was also evident that program performance in terms of numbers of new family planning acceptors and continuing users had levelled off and in some geographic areas had shown a decline over the past few years. In view of the obstacles remaining in order for the GOT to provide family planning services effectively to all eligible groups on a nationwide basis, the evaluation team recommended that A.I.D. assistance be continued beyond the planned 1981 phase-out period.

Future assistance requirements were estimated by the GOT during the second phase of the mid-project evaluation. The National Family Planning Office (ONPFP) estimated that its family planning program for the 1982-1986 period would cost approximately \$50 million. Of that total, \$15 million would be solicited from A.I.D. USAID/Tunis reviewed the ONPFP \$15 million budget requests and identified approximately \$9.0 million in program activities that could be supported if future A.I.D. assistance were to be made available. USAID/Tunis forwarded to AID/W a request for continued population assistance to Tunisia.

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Ensuing discussions resulted, in principle, to provide continuing support for Tunisia's family planning program at a level of \$3.0 million per year. This money would be obligated over a three-year period (FY 82-84) and disbursed over a five-year period (FY 82-86). Funding for the future program would be through AID/W-funded intermediaries organizations and be included in the DSB budget.

As this was to be the final tranche of A.I.D. population assistance, the future program included plans for a transition from the bilateral project to an intermediary-supported effort and ultimately to a program financed entirely by the Government of Tunisia.

After solicitation of interest from several population intermediaries, AID/W determined that the Population Council was the best suited to provide future assistance in the major area of rural program services and support, with other intermediaries assisting in complementary areas. On September 8, 1980 a meeting of all interested intermediaries was held to discuss participation in the future assistance program to Tunisia. As a result of this and several follow-up meetings and discussions, five organizations were selected for this task: The Population Council, International Project; Association for Voluntary Sterilization (IPAVS); Johns Hopkins University - Program for International Education in Gynecology and Obstetrics (JHPIEGO); International Fertility Research Program (IFRP); and Program for International Training in Health (INTRAH).

Subsequently the program areas of responsibility for each intermediary were defined except for the Population Council and a consensus was reached in principle that each would continue activities within the framework of its current field of responsibility. For the Population Council, however, it was necessary to establish a new program with the ONPFP. A series of meetings resulted in the following "mix" of program areas and intermediaries:

- Population Council - rural program services, information, education and communications program, research and evaluation
- IPAVS - national sterilization program
- JHPIEGO - medical/clinical training
- INTRAH - ONPFP staff training, para-medical, and social service training
- IFRP - bio-medical research.

### III. Evaluation Methodology

The general objective of the evaluation was to determine the progress of activities programmed under the agreement established between the National Office for Family Planning and Population (ONPFP), AID and the intermediary organizations. This objective implies an evaluation of the five year program with particular attention to recommendations made during the evaluation conducted in 1980, and to activities planned for the period 1984-1986; this is particularly important for rural and peri-urban areas and private sector activities.

Prior to the evaluation a preparatory meeting was held on April 30, 1984 in Washington D.C. This meeting was attended by AID/W Near East bureau staff, the Research and Population division chief, representatives from the intermediary organizations and three members of the evaluation team (1). Following a general overview of the Tunisian family planning program, representatives from each of the intermediaries made a presentation of its program summarizing objectives, accomplishments and specific problems. Part of the meeting was also devoted to review and comment on the terms of reference of the evaluation.

The evaluation was carried out from May 9th to June 1st, 1984 in Tunisia, following a classical methodology of document review, discussions and work sessions with representatives of

the ONPFP and other ministries and organizations involved in family planning activities (see list in Annex 4), site visits (Sousse, Sfax, Sidi Bou Zid, Gafsa and Tozeur), meeting with USAID representatives and Health and Population division staff, debriefings and discussion of major findings and recommendations with the ONFP and USAID director.

#### IV External Factors

##### A. Value of the Dollar

The continuing rise in the value of the dollar has contributed to the significance of AID/USG contribution to this activity. While the development and actual implementation of a gradual local takeover plan for program funding has remained on schedule, it is questionable whether this could have been done were the dollar less strong. By extension, this factor may impose an exceptionally heavy burden on the GOT/ONPFP when the full weight of program funding is to be assumed by the GOT/ONPFP at the end of FY 86.

##### B. Population Policy

With support from President Bourguiba, the Tunisian Family Planning program began on a pilot basis in 1964, and it quickly developed into a national program. In 1973, the ONPFP was created as a semi-autonomous agency within the Ministry of Public Health (MOPH), with the responsibility for planning coordinating, implementing, and evaluating family planning activities in Tunisia. The ONPFP has worked to develop appropriate policies, a nationwide administrative and service-delivery infrastructure, and a range of programs including services, training, information and education, and research and evaluation capacity. In addition to direct government service-delivery approaches, the ONPFP encourages the private sector to participate in the provision of supplies and services. For example, commodities (pills and condoms) are channeled through pharmacies and physicians for subsidized low-cost distribution (in effect, a social marketing program, although this term is not used in Tunisia).

C. Demographic Objectives: VIth Plan Goals

Recent development plans in Tunisia have given attention to the relationship between demographic trends and social and economic development. In the early 1970's, Tunisia established demographic goals for the end of this century that called for reaching a net reproduction rate of 1.2 by the year 2001. (This means childbearing at a rate of about 2.5 per family, somewhat above replacement-level fertility.) Furthermore, the VI Plan states that in order to reach the 1986 objective, contraceptive prevalence must increase from its 1980 level of 27 percent (MWRA currently practicing effective means of fertility control) to 40 percent in 1986, with separate targets for urban and rural areas, and for the private and public sectors, as shown in the following table:

VIth Plan average contraceptive prevalence rates

	1980			1986		
	<u>Public Sector</u>	<u>Private Sector</u>	<u>Total</u>	<u>Public Sector</u>	<u>Private Sector</u>	<u>Total</u>
Urban areas	23.2	11.7	35	35	10	45
Rural areas	13.8	4.2	18	27	9	36
Country Total	18.8	8.2	27	31	9	40

V. Key Project Assumptions

On-going population/family planning activities in Tunisia were designed to assist in the transition from the previous bilateral project to a program financed (entirely) by the Government of Tunisia. The planning for the intermediary/cooperating agency mode of assistance did not follow the standard AID-bilateral documentation procedures, including listing of key project assumptions. It could be stated, however, that the major assumption guiding project implementation was that project and GOT activities, inputs, duration, etc. were sufficient and were an appropriate means of establishing a family planning effort suitable to Tunisian needs and resources. This "assumption" was based on a project design which depended on a continuing ability for the GOT to assume operating costs of the family planning program. Since the project design, however, the Tunisian economy and demands on the resources of the GOT have increased considerably.

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VI. Progress since last evaluation

(1) Activity Status

A. Population Council Program

<u>Activity</u>	<u>Expected Status</u>	<u>Actual Status</u>	<u>Remarks</u>
1. Family Planning Services Development Rural Areas	1. accelerated family planning outreach effort in 14 delegations/8 governorates - 8 mobile teams (40 animatrices and 5 educators) - IEC and contraceptive services - motorbicycles purchased and tested - new IEC materials designed and tested - new IEC materials designed and tested	- 5 mobile teams covering 7 governorates; 3-4 animatrices per governorate  - socio-demographic and contraceptive survey under-taken - activity form; monthly statistics; and individual education and follow-up forms developed - information brochures for illiterate women - recruitment and referrals being done	- personnel shortages result from unstable employment potential; and difficulties in placing in rural areas/mobile units  - acceptability of mobile clinic concept not clear - IEC evaluation not sufficient - follow-up activities need strengthening
2. Family Planning Services Development All Governorates	2 a. improved and expanded family planning rural outreach - increased male participation in family planning activities - improved mobile unit cost-effectiveness - increased linkages with Rural Health Project  2 b. increased person-to-person IEC services - train MOH infermiers itinerants, and MSA-social workers - enhance effectiveness of rural health workers (animatrices)	2 a. insufficient attention to informing and sensitizing men to family planning (MSA) - 5 male assistant delegates hired and trained - no data available or analyzed on mobile unit costs; no progress made - little coordination achieved  2 b. see list pp 53-44 of evaluation report - animatrice mobility has been limited - animatrices are not provided with pills and secondary methods for resupply - animatrice activities refined; training provided; system for measuring effectiveness designed	- inter-Ministerial regulations/issues re "detachment" make participation activity difficult to achieve - MOH/ONFP collaboration is limited at the contract level and sporadic at the regional level  - the rural family planning communication program is restrained in the short-term by lack of human resources

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<u>Activity</u>	<u>Expected Status</u>	<u>Actual Status</u>	<u>Remarks</u>
3. Family Planning Services Development - Peri-Urban Areas	3 a. Outreach IEC activities and referrals by social workers - increase MSA personnel and supervising (midwives) personnel - establish 25 services of family planning in MOH and ONFP facilities  3 b. Recruitment of private physicians for family planning services in 35 peri-urban clinics	3 a. insufficient MSA and supervisory personnel recruited  - insufficient number of sites established  3 b. only 2 physicians were contracted; plus 5-7 provided by the MOH	- MSA personnel not sufficiently motivated to add family planning to their other activities  - there is a lack of coordination with MSA officials  - limited personnel and animatrices mobility to reach service centers  - physician participation in family planning is minimal due to lack of time and motivation
4. Family Planning Services Development Commercial Distribution of Contraceptive	4 a. New CRS program strategy developed  4 b. Operations and marketing research efforts launched	4 a. 5 types of oral contraceptives and one type of condom distributed free to pharmacists and promoted by ONFP employees  - very limited IFC activities  4 b. Very limited progress to date	- The GOT/ONFP has resisted advancement of collaboration with the private sector. The consensus seems to be that the private sector, by its nature, cannot assume or complement the policy and service delivery directives of the public sector

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<u>Activity</u>	<u>Expected Status</u>	<u>Actual Status</u>	<u>Remarks</u>
5. IEC	<p>5 a. Educational campaigns and seminars in rural areas (esp. 14 rural delegations)</p> <p>b. Continued support for press articles and information programs for journalists, and rural promotional materials</p> <p>c. mass media (radio and TV) program</p> <p>d. audio-visual material production, esp. informational brochures for literate and semi-literate populations</p> <p>e. production of flip charts, pocket calenders, training guides for field workers; slides, and duplicating existing forms</p> <p>f. audio-visual equipment, documentation and printing of periodicals and other informational material</p>	<p>5 a. see no A 2 above</p> <p>b. no specific information provided</p> <p>c. 4 weekly radio programs - TV activities below capacity</p> <p>d. informational folders for animatrice use; demonstration case plus samples; loose-leaf guide - 2 simple brochures produced and pretested</p> <p>e. inadequate quantity and quality of didactic and audio-visual support material</p> <p>f. equipment available and satisfactory; periodicals and articles being published</p>	<p>- no increase quantitatively; restructured for effectiveness - TV programming not regular and frequently too medical</p> <p>-delays due to inadequate printing facilities</p> <p>- newspaper affects only higher SES levels, deals with medical and demographic aspects</p>

<u>Activity</u>	<u>Expected Status</u>	<u>Actual Status</u>	<u>Remarks</u>
6. Research and Evaluation	6 a. socio-economic profile and acceptance rate in the 14 rural delegations	6 a. done. Provided baseline information for the Accelerated Rural Project and for establishment of mobile clinic itineraries	- small sample size precludes measuring of changes in each delegation
	b. study of family planning and MCH needs in peri-urban populations	b. done	
	c. studies of program operations; to determine cost-effectiveness and acceptability of each program element (mobile units, sterilization services, IEC programs, and training)	c. behind schedule	
	d. assessment and support of service statistics system (esp. accuracy and reliability)	d. on-going	
	e. other	e. urban contraception study done - voluntary female sterilization study done	- compares characteristics and behavior of different groups vis a vis family planning services/methods
	f. data processing and analysis of service statistics	- sophisticated service statistics system involving computerized data processing and analyses established	

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<u>Activity</u>	<u>Expected Status</u>	<u>Actual Status</u>	<u>Remarks</u>
7. Short Term U.S. or Third Country Training	<p>7. short courses in management, evaluation, communications, monitoring etc.</p> <p>- visits to rural outreach and community-based distribution programs other countries</p> <p>- participation in international conferences</p> <p>8. approximately 10 person months (program planning, management and administration, IEC, research and evaluation)</p>	<p>- little information or details provided by evaluation report</p> <p>(some instructions in video production, US)</p> <p>- training in communication and social marketing (U.S.) for top-ranking staff members of the IEC Division</p> <p>- other international training being identified or proposed</p> <p>8. TA provided in management, administration, AV production, IEC, research and evaluation, statistics</p>	<p>--</p> <p>no discussion of follow-on or application of training</p>

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B. IPAVS

<u>Activity</u>	<u>Expected Status</u>	<u>Actual Status</u>	<u>Remarks</u>
1. Assistance to ONFP to further develop and expand the Tunisian national voluntary sterilization program	1 a. support for female VS program at Ariana and Bardo clinics in Tunis	1 a. support of certain operating and personnel costs; and of costs for administration and management	- is a continuation of original/previous support, with the expectation that the GOT will progressively assume financial responsibility
	b. assistance with the operation of endoscopic repair and maintenance center	b. provision of salary and travel support for technicians; spare parts and supplies for operation of center	- technicians are responsible for training personnel in maintenance
	c. support for voluntary sterilization activities in 14 regional family planning centers	c. some renovation and equipment; support has been given to various personnel categories; i.e. physicians anesthesiologists	- to phase out in 1986  approximately 9000 voluntary sterilizations performed per year.

C. JHPIEGO

<u>Activity</u>	<u>Expected Status</u>	<u>Actual Status</u>	<u>Remarks</u>
1. Physician training	1. three physician training courses (1 week didactic plus 2 weeks clinical) conducted (per year, 82-86) - max. 20 trainees/course	1 a - d in general, the JHPIEGO program is being carried out as programmed	- second generation training for resident physicians is limited by a lack of teaching personnel (most return to private sector or to hospitals)
2. Operating room nurse training	2. two operating room nurse training program (1 week didactic and 2 weeks clinical) - max. 15 trainees/course		
3. Anesthesiologist training	3. two anesthesiologist training programs (3-5 day course combining didactic and clinical training)		- RAM center has played an important part in maintaining the quantitative and qualitative performance of the voluntary sterilization program
4. Medical/educational commodities	4. medical/educational commodities - 10 laproscators and 5 laparoscopes to be provided - educational packages to be provided	- 46 laparoscopes provided to various Tunisian medical institutions	- regional training has been limited by a GOT requirement that Tunisian participants be present in each program.

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**D. INTRAH**

**Activity**

**Expected Status**

**Actual Status**

**Remarks**

1. Training program development

1 a. 500 newly graduated midwives; one week, on family planning clinical and education skills

b. 6 week training for 180 midwives (IUD insertion techniques)

c. 3 day program on population education/motivation, service referral; for 800 dispensary nurses

d. 12 day training program for 1200 social workers

e. clinical training for 125 obstetrical aids

f. training in family education and motivation for 200 nutrition and hygiene specialists

g. training for instructors in health training and social work schools

2. Short term technical assistance

2. TA in curriculum development and program evaluation, trainers

1. specific information on INTRAH-supported training not provided in evaluation report. However, the general opinion is that INTRAH's collaboration in training activities has been extremely fruitful. See also A 2 above.

- training for June and July, 1984 cancelled because of Ramadan and summer hours and could not be rescheduled before the end of INTRAH's contract.

2. provided

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E. IFRP

<u>Activity</u>	<u>Expected Status</u>	<u>Actual Status</u>	<u>Remarks</u>
1. Fertility Research Studies	1. Pilot project to evaluate maternity care in two major hospitals	1. finished	project completed in 1982
	2. monitoring of sterilization services offered in regional ONFP family planning centers - minicomputers and other assistance to develop data processing and analysis capability	2. finished Texas instruments micro-computer installed	
	3. post-partum IUD study (to evaluation effectiveness of Delta T and Delta Loop)	3. finished	
	4. Lactation/Ovulation study	4. finished	
	5. short term TA in conducting above studies		

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F. Westinghouse Health Systems, Inc.

<u>Activity</u>	<u>Expected Status</u>	<u>Actual Status</u>	<u>Remarks</u>
Contraceptive Prevalence Survey and report completed Survey		- preliminary findings reported - final reported expected by the end of 1984	

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(2) Major Outstanding recommendations from last evaluation  
(March, 1980)

- improve and expand supervision, monitoring and feedback, decentralization, information exchange
- promote active participation of key MOH and MSA personnel, physicians and pharmacists
- increase availability of contraceptive methods
- increase effectiveness and efficiency of mobile teams
- develop a training policy and increase medical school education in family planning
- develop educational and audio-visual materials, test and evaluate; improve interpersonal communication skills
- conduct studies on cost-effectiveness; socio-economic factors effecting family planning; biomedical research
- improve personnel management.

3. Major recommendations from evaluation report (June, 1984)  
(see executive summary for a detailed breakdown and listing).

1. The research program should be continued and improved.
2. OR should be pursued with emphasis on management decision making for cost-effective program targetting.
3. Hiring should be targetted to populations served with emphasis on longer retention/reduced turnover.
4. Supervision motivation and performance evaluation need to be improved with emphasis on efforts in the ONPFP regions.
5. Development and modification of service delivery standards should be pursued.
6. Service delivery should be target-specific.

7. Contraceptive distribution should be expanded beyond physicians to other health personnel and to the private sector.

8. Regional decision-making and program design should be encouraged.

9. Inservice education organizations should be developed for each category of personnel.

10. Liaison with health education should be stronger so that ONFP can be more influential in training of medical personnel. The training center of the ONFP should be expanded with appropriate support.

11. ONFP should collaborate with both other agencies and the private sector and should develop a population/development workshop for them for 1985.

12. IEC should be improved and social marketing should be undertaken.

13. In accord with the planned progressive GOT assumption of program costs (including salaries), future external aid should focus on the financing of new and innovative projects -- such as private sector participation in the national family planning program, research in population and development -- and in assistance to program which need reinforcement (training, IEC, evaluation, extension of services into interior areas). In this regard, the ONFP should undertake a study to determine financial and human resource needs and resources relevant to activities programmed in the VIIth Plan. Technical and financial support for such a study is desirable.

## VII. Inputs

No specific discussion or analysis of inputs by intermediary/cooperating agency or by activity is available. In general terms, inputs have been provided along previously established guidelines and schedules as appropriate; and adjusted to the absorptive capacity of the ONFP.

### VIII. Outputs

see section VI. "Progress Since Last Evaluation".

### IX. Purpose

The overall purpose of project activities is to assist the Government of Tunisia in strengthening and expanding family planning services primarily in rural and peri-urban areas. Project activities and implementation have been directed toward attainment of this purpose.

### X. Goal/Subgoal

N/A

### XI. Beneficiaries

Once again, pre-implementation documentation did not specifically identify beneficiary populations. Project activities, however, are directed toward the following major categories:

- MWRA in rural and underserved areas, in all governorates
- all family planning service providers (MOH infermiers itinerants, MSA social workers, midwives, ONPFP animatrices, physicians, and pharmacists)
- all ONFP staff
- other organizations/personnel involved directly or indirectly with the provision of family health services (UNFT, UGTT, UTICA, UNA).

### XII. Unplanned Effects

N/A

## XII. Lessons Learned (USAID's comments)

1. Evaluation scopes of work must be precisely defined in terms of priorities of information required. Also, the evaluation itself is a dynamic process which must involve continuous contact with and feedback from the USAID Mission in charge of oversight.
2. Evaluation findings/recommendations should consolidate to address major defaults, and should propose specific time frames, anticipated outcomes, and responsible entities for follow-up.
3. Evaluation teams must be complete in terms of technical specialities of areas to be evaluated. If this is not possible (e.g. last minute changes, emergencies etc.) serious consideration should be given to re-scheduling the evaluation.
4. Evaluation time-frames must allow for clarification of issues and finalization of report by the entire evaluation team.
5. Project activities via intermediary/cooperating agency mode (devoid of a central, in-country coordination and oversight function) can result in difficult and time-consuming monitoring by limited USAID staff.

## XIV. Special Comments or Remarks

The Tunisian family planning program is presently in a state of transition. The organizational structure under which the family planning office finds itself has been changed from the Ministry of Health to a new Ministry of the Family and the Promotion of Women. The Tunisian financial situation has considerably weakened with respect to projections in the design of the population assistance program. Changes have taken place in the leadership of the program. AID finds itself at a stage where phasing out of the program in Tunisia seems now to be inappropriate. The Mission is proposing a new bilateral agreement to assist the new PDG in developing a cost-effective program with a broader coverage of the population. The emphasis of this program will be on new initiatives, training and operations research. A continuation of centrally-funded assistance, particularly in support of presently centrally-funded program areas would complement the proposed new bilateral assistance.

EXECUTIVE SUMMARY

GOT/USAID EVALUATION  
OF THE  
TUNISIAN FAMILY PLANNING PROGRAM

A Report Prepared By:

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During the Period:  
MAY 9 - JUNE 1, 1984

Supported By The:  
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

## SUMMARY OF MAJOR FINDINGS AND RECOMMENDATIONS

### 1. Introduction

Since 1965, A.I.D. has contributed nearly \$38 million in assistance to the Tunisian population and family planning program. Initially provided under a bilateral agreement, the assistance was centered on the development of infrastructure and the training of personnel to provide the population with family planning information and services. Between 1978 and 1981, \$6.6 million in bilateral assistance was provided to help the Government of Tunisia (G.O.T.) reinforce family planning services, especially in rural areas. A joint G.O.T./A.I.D. evaluation of the program carried out in 1980 recommended a continuation of assistance designed especially to increase the impact of the program in rural areas. To that end, A.I.D. agreed to provide continuing assistance to the program over a five year period (1982-1986) to coincide with the G.O.T.'s Vith Development Plan. As a means of increasing Tunisian responsibility for management of program resources, A.I.D. decided to provide this additional assistance through A.I.D. centrally funded population intermediaries who would work directly under the G.O.T.'s National Office of Population and Family Planning (ONPFP) to design and implement the program. The six organizations selected to participate were The Population Council, IFRP, INTRAH, IPAVS, JHPIEGO, and Westinghouse Health Systems. Midway through implementation of this program, a joint evaluation team, including three external experts and three Tunisian nationals, assessed progress of activities against the Government's mid- and long-term population objectives.

The evaluation team was in Tunisia from May 9 to June 1, 1984 to examine achievements in fields including service availability and delivery; training; information, education and communication; and research and evaluation. Given the growing role played by the private sector in the national family planning program, the team devoted particular attention to this sector. The team also gave special attention to the role of the ONPFP in research on population and development.

### 2. Major Achievements of the 1980-84 Program

During the last four years, important achievements were made in areas covered by the program. These were the result of increased cost effectiveness in the use of human and material resources at both central and regional levels through the improvement and rationalization of management methods; improved planning and followup; bringing services closer to the poorest

rural and urban populations; continued training of staff and field personnel; and the development of a statistical service unit providing more accurate and valid information necessary to program management and decision making.

The intermediaries, through their support of new activities and the reinforcement of existing programs, contributed greatly to continued program development. The President Director General of the ONPFP has warmly acknowledged this contribution.

## 2.1 Demographic Accomplishments

During the last few years, and despite population growth effects due to the population age structure, the growing acceptance and utilization of modern contraceptive methods, along with a rise in the age of women at marriage, have had considerable impact towards the achievement of Vith Plan goals. The prevalence of the use of modern contraceptive methods increased from 29% in 1980 to 35% in 1983; the crude birth rate, at 35% in 1980, decreased considerably in 3 years, falling to 31% in 1983; the natural growth rate fell from 2.7% in 1979 to between 2.3 and 2.4% in 1983. These results are extremely encouraging and confirm the degree of program accomplishments.

Furthermore, during the 1981-83 period, the ONPFP continued development of its regional administrative and technical infrastructure. At present family planning service delivery is carried out in 800 centers of which 762 are serviced by 61 mobile teams and clinics; the remainder consist of 38 Regional Centers of Education and Family Planning (CREPF) and clinics.

Whereas the previous evaluation was concerned with the declining number of new acceptors between 1977 and 1980, it should be noted that, in comparison with 1979, a 68% increase in initial IUD insertions has taken place; also a 14.5% increase has taken place in the number of tubal ligations and a 6% increase in the number of secondary method acceptors. The increasing number of new IUD insertions was paralleled by a decrease in IUD removals and an increase in reinsertions (32% more in 1983 than in 1982). With respect to oral contraception, the decrease in new public sector acceptors (down 34% in comparison to 1979) was largely compensated by an increased private sector participation representing an important source of contraceptive supply and services (mainly pills and secondary methods) for nearly one-fourth of the total number of users. Between 1980 and 1983, the number of pill cycles distributed by the private sector has more than doubled while condom distribution has increased by 40%. The availability of family planning services is practically universal in urban areas and is estimated to be between 50 and 70 percent in rural areas.

## 2.2 Service Delivery

Under the guidance of the ONPFP's Rural Coordination Unit, 6 mobile clinics and 2 mobile teams deliver family planning services to the population of 22 rural delegations in 9 governorates. In addition to the personnel in these units, 40 animatrices were recruited and trained for the program. The main difficulties experienced in this program are: lack of personnel stability (animatrices and midwives); the need for adequate transport for animatrices; and, a certain hesitation of the population to use publicly the services offered by mobile clinics. Although very recent, the program has already achieved positive results both in service delivery and in the development of methodologies and mechanisms to improve identification of the target population, reinforce information and insure improved followup. Use of these management tools has already been expanded to other rural areas outside the geographic limits of the program.

An effort was also undertaken to improve information and access to family planning services in the periphery of Tunis, Sousse, and Sfax. The program aims at opening, within Ministry of Public Health (MOPH) structures, new family planning clinics (25 in Tunis, 2 in Sousse, and 2 in Sfax), as well as at reinforcing information and education activities of animatrices from the ONPFP and Ministry of Social Affairs (MSA). A system of liaison forms has been developed to measure animatrice performance and to identify resistance to contraception. The results of this program vary and are directly related to problems encountered including transportation difficulties and insufficient cooperation with MOPH and MSA personnel who are not always sufficiently motivated. A supervisor was recently appointed specifically to oversee this program in the Greater Tunis area.

In terms of norms and standards of supervision, training, and followup, the team found the quality of family planning services to be very good. There is no major problem from a medical viewpoint. Tubal ligation complications are about 0.25% (including pregnancies) and no criticisms have been expressed by the majority of the medical community regarding the quality of services offered by the program. A certain liberalization of services, particularly pill and secondary method resupply, is already found in certain regions; measures are anticipated at the central level to generalize this policy.

### 2.3 Training

Previously, ongoing training was oriented to the acquisition of new knowledge, and did not address specifically identified program needs. In 1982, the ONPFP reviewed its policy in this field, and ongoing training now aims at problem solving by addressing specific regional characteristics and problems expressed by field personnel. During the last 3 years, central and regional office personnel participated in several workshops which promoted increased management efficiency (problem identification, scheduling of personnel, implementation, evaluation) and improved program performance. Training curricula, along with methodological and pedagogical forms, were developed for various health and special personnel. Recently a set of evaluation forms designed to measure the impact of training on program performance was developed.

For the first time since the program was started, a 10-day optional family planning course will be incorporated in the curriculum of the medical schools for the 84-85 academic year, in addition to the existing 5-hour family planning course for all medical students. This optional program provides an excellent opportunity to reinforce existing relationships with academic authorities, consolidate family planning teaching, and generalize it to all medical students.

### 2.4 Information, Education and Communication

During the 1970's, information activities were mainly aimed at sensitizing and informing the population about family planning questions. During that time, they were based on a strategy of mass information campaigns. Results were rewarding since, by 1983, 90% of Tunisian women knew about the existence of modern contraceptive methods. In 1980, the ONPFP reviewed its strategy and gave an increasingly larger place to individual and group education without, however, abandoning the mass media. Individual education is conducted by ONPFP animatrices as well as by personnel of the MSA, the IPPF affiliate, the Tunisian Family Planning Association (ATPF) and the National Union of Tunisian Women (UNFT). The number of individual contacts went up from 28,000 in 1981 to 97,000 in 1983. Group education is aimed at various audiences -- political, professional, and cultural. Although radio is well used, a certain weakness can be observed regarding the use of television where programming is neither regular nor varied. Newspapers also need to be used to a greater extent. Message content and form should be varied to reach a maximum number of audiences. With respect to audio-visual support material, a particular effort was made in connection with individual

education programs; all animatrices are given demonstration kits as well as folders on IUDs, pills, tubal ligation and secondary methods. The design and production of audio-visual support for group education for each specific target population need, however, to be reinforced.

## 2.5 Private Sector

Private sector participation in the national family planning program has increased considerably during the last few years. At present, it is estimated that nearly one-fourth of contracepting couples go to the private sector, especially for oral contraception and particularly in urban areas where most private physicians and pharmacists have their practices. There is, moreover, a clear tendency, particularly among pharmacists, to settle in smaller cities. The ONPFP has already undertaken a number of steps to insure improved pharmacist and physician participation in family planning activities. Thus, it established within the Medical Division a unit specifically responsible for a decentralized distribution of contraceptives; it organized workshop and information events for private physicians and pharmacists; and it collaborates with medical services in private companies within the framework of their occupational health programs. Although considerable, these efforts need to be sustained and expanded to strengthen private sector family planning activities, particularly in the field of information and education. Another important question related to an increased private sector participation in family planning is the legal framework in which such an expansion is likely to take place (codification, standards, reimbursement for family planning activities, etc.).

## 2.6 Research and Statistics

During the last two years, the Population Division developed its data collection and data processing capabilities, particularly through the efficient use of its microcomputer; this has yielded better data analysis and feedback directly related to program management. Progress achieved in this field is noteworthy and has contributed greatly to the improvement of program performance. Also to be mentioned is the enhanced operations research capacity developed by this Division (field visits, mini-surveys, compilation of activity records, utilization of animatrice followup forms) which constitutes an integral part of the evaluation system. In addition, the Division has undertaken larger surveys. Some, such as the urban survey on fertility and contraception, are excellent; others are less so. The Rural Survey on Family Planning, for example, suffers from methodological errors which restrict its

scope. Preliminary findings of the CPS survey show certain inconsistencies with prevalence estimates based on service statistics. These need to be clarified during the final analysis.

Those interrelations which exist between demographic parameters (mortality - fertility - migration) and social, cultural and economic factors contribute dynamically to the development process. In addition to the usefulness of an improved understanding of these interactions for the elaboration of a long-term development policy, research in population can influence more directly the ONPFP's strategy concerning family planning activities as such. It is, therefore, appropriate that the Population Division encourage and participate in the implementation of research activities on population and development. However, personnel constraints and the numerous and important tasks related to service statistics, special projects, operations research and surveys, limit for the time being the Division's capacities in this field. As the implementation of certain tasks becomes more familiar and "routine" (preparation and processing of statistical tables, prevalence estimation, etc.), the Division's work program will be lighter, and it will probably be possible to devote more time and personnel to research on population.

## 2.7 Program Budget/Management

With respect to management, two aspects need to be mentioned. When the five year intermediary effort was begun, the need to assume a progressive increase in the G.O.T.'s share of the financial support for the program was stressed. Whereas in 1982 the G.O.T.'s share of funding was 56% for the ONPFP, it rose to 63% in 1983, 73% in 1984 and the VIth Plan anticipates an 85% government participation in 1985. It is true that the size of external organization phase-down has been partially compensated by the strengthened dollar. Nonetheless, considering the overall ONPFP budget which only increased by 20% in 4 years -- with 10% inflation a year and 16% salary increases in 1983 -- the team can see that during the same period, because of improved financial and human management a considerable number of activities, listed in this report, were carried out.

Finally, the team notes progress that has been made in decentralization of the management of the ONPFP. Based on ONPFP general policy and in conformity with implementation guidelines issued by the Direction Générale in collaboration with regional officials, regional delegates have been given more flexibility in choosing their priorities and establishing

their work programs which are therefore more adapted to the specific needs of each region. Furthermore, each region has its own bank account, which facilitates its financial management, and is reimbursed, within the limits of its annual budget, in relation to activities performed.

### 3. Transfer of ONPFP Tutelage to the Ministry of the Family and Promotion of Women

During this evaluation the transfer of ONPFP tutelage to the Ministry of the Family and Promotion of Women was officially announced. The law pertaining to this change in the status of ONPFP must yet pass the National Assembly and be signed by the President. Presently a commission has been established to review the practical modalities of this transfer.

One of the principal factors which has permitted sustained growth of the family planning program has been the institutional framework of the ONPFP which has facilitated the development of permanent and mobile infrastructures and the necessary human resources for the operation and management of family planning activities. To reinforce existing activities and to continue expansion of the program, on the basis of its assessment the evaluation team believes that it is essential to maintain the integrity and specificity of ONPFP services in the cadre of a specific institutional framework. The evaluation team was encouraged by assurances to this effect given by the Chef de Cabinet of the MFPP, noting their importance to continued program momentum, especially in the short and medium term.

Also, the evaluation team notes that a certain caution is needed in the introduction of family planning in social programs so as not to create an image of implied linkage between the two types of services.

### 4. Integration of Family Planning Services into the Primary Health Care Structure

With the development of the Primary Health Care (Santé de Base) infrastructure, a question of integration of family planning services arises. If the principle of such integration, to bring service into these new facilities, is not contested, then the evaluation team suggests that all parties concerned (MOPH, ONPFP, MFPP) study all questions related to the long term and progressive transfer of family planning service delivery to these MOPH structures, and specifically to Basic Health Centers, as infrastructure and personnel are available. This could lead to the formulation of an upgrading plan which would normally consider the following four priorities:

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- continued quantitative improvement of family planning services;
- continued qualitative improvement of family planning services;
- continued improvement in availability and accessibility of each contraceptive method; and,
- that the responsibility for establishing quantitative and qualitative family planning norms and standards will be with the ONPFP and the MOPH working in close collaboration.

While establishing this process, it is also important to take into consideration the objectives of the VIIth and following plans.

### 5. Future A.I.D. Assistance

The evaluation team believes that technical and financial aid provided by the intermediaries has been fruitful and has contributed appreciably to the progress of the program over the past years and, similarly, to the constant rise in contraceptive prevalence and the realization of the VIth Plan's demographic objectives. To aid the G.O.T. in realizing its long-term demographic objectives, the evaluation team believes that:

- a) Technical and financial assistance from A.I.D. should continue beyond 1986. Assistance through intermediaries seems a good mechanism for this aid since it is adaptable to specific needs.
- b) Questions related to future assistance modalities should be discussed and acted upon by those involved (ONPFP, A.I.D. Washington, USAID/Tunis and the intermediaries) with consideration given to administrative and financial constraints and possibilities, human resources, and different interested agencies and organizations.
- c) Future assistance should be provided under an agreement protocol between A.I.D. and the G.O.T. which would define the technical and financial framework of assistance after 1986.
- d) The ONPFP should begin to develop perspectives of activities required under the VIIth Plan and should estimate its needs in terms of external aid.

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## 6. Recommendations

The recommendations which follow have been identified in order of priority A, B, and C corresponding respectively to performance over the short, medium and long term.

### 6.1 Population and Development

-A workshop should be developed in 1985 by the ONPFP to examine in depth the ways in which population phenomena interact with development processes in Tunisia. This workshop would have as an objective informing those responsible for the preparation of the VIIth Plan of the implications of population parameters in various sectors. Departments including the Ministry of Plan, MOPH, MFPF, Ministry of the Interior, MSA, and the Ministry of Education should participate in this workshop (see annex to the report). (Priority A)

-Population research studies should be continued following priorities of the program as well as human and material resources. (Priority A)

-Relations with INS and other research institutions should be enhanced to develop better capacities in demography, population and development. (Priority A)

-The ONPFP's participation should be insured in sectoral and synthesis commissions engaged in preparation of the VIIth Plan. (Priority A)

### 6.2 The Private Sector

-The development of the ONPFP contraceptive distribution system to the private sector should be continued with an evaluation of the system -- after a special program of education, information and family planning service delivery activities in that sector is carried out, addressed to pharmacists and private practice physicians. (Priority A)

-The dialogue initiated with medical organizations and associations should be reinforced to develop the practical aspects of an effective collaboration. (Priority A)

-The needs of private physicians and pharmacists in continuing education should be reviewed. (Priority A)

-One or more workshops should be organized under the auspices of the ONPFP to discuss questions related to a broadened role for citizens in bearing contraception costs, (politics of contraceptive pricing, legislation, insurance

reimbursement, etc.). A similar workshop could be held for representatives from organizations representing pharmacists, private practice physicians, representatives from the MOPH and other interested groups. It is desirable that the ONPFP develop a document treating in depth family planning and the private sector and prepare statistical information and other data for use in these workshops. (Priority B)

### 6.3 Family Planning Services

#### Norms and Standards

-The Medical Division should continue the development of norms and standards for each contraceptive method and insure wide distribution to all medical and socio-health personnel concerned. (Priority A)

-The distribution of secondary methods should be generalized to all socio-health personnel, animatrices, nurses, hygienists, social assistants and chief nurses in the dispensaries to facilitate, as fully as possible, their accessibility. (Priority A)

-A system of resupply by animatrices and chief dispensary nurses should be generalized for pill users who present no problems and whose follow-up indicates no contraindications. (Priority A)

#### Supervision

-Supervision visits should be more systematically planned and scheduled. (Priority A)

-Supervision documents should be developed to increase the productivity of on-site visits and to systematize their follow-up. (Priority A)

-The tasks and responsibilities of the physicians in the Medical Division should be more accurately defined. (Priority A)

-Quarterly meetings should be held at the ONPFP level between supervising midwives and the Medical Division. (Priority A)

-A review of options, means, and needs to reinforce interregional supervision should be undertaken. (Priority B)

#### Follow-up

-A simple procedure allowing for a permanent and systematic identification of women to be contacted for follow-up should be encouraged. (Priority A)

-Basic health center personnel should be encouraged to participate in acceptor follow-up activities. (Priority B)

#### Service Availability

-A survey should be undertaken to determine accurately the size and location of and the reasons for unmet demand and obstacles to contraception. (Priority A)

-Secondary methods should be promoted for temporarily separated couples. (Priority B)

-Information and educational materials should be adapted to address misbeliefs. (Priority B)

-Training of animatrices should be reinforced to better prepare them to confront rumors and misbeliefs. (Priority B)

-Information activities for men should be increased. (Priority A)

-Additional efforts should be made to recruit male educators. (Priority A)

-Increased emphasis in IEC should be placed on topics related to mother and child care, particularly concerning birth spacing to encourage younger women with fewer children to use contraception. (Priority A)

#### 6.4 The Rural Program

-The quantitative, qualitative and cost/efficiency aspects of the mobile clinic program in the 22 target delegations should be assessed as a basis for deciding on the best strategy related to the expansion of mobile clinics to other governorates. Activities, including gynaecology activities, undertaken by the mobile clinics and teams should be compared to those performed by other means. (Priority A)

-Animatrice transport needs to be facilitated by an improved coordination of the education team, mobile clinic, and animatrice schedules. (Priority A)

-Vehicle service should be provided with a well-equipped mobile maintenance unit for emergency repair on the spot. This would probably assure the repair of a great majority of the vehicles which break down. (Priority A)

-The MWRA census should be continued using the individual follow-up form. (Priority A)

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-Family planning information and promotion for local officials should be reinforced to further benefit from their collaboration. (Priority A)

-Animatrices should be provided with pills and secondary methods for re-supply purposes. (Priority A)

-The ONPFP should envision means of better responding to expressed needs of the population, such as, for example, treating in the clinics minor gynaecological problems diagnosed but presently referred elsewhere for treatment. (Priority B)

-Collaboration with Social Education teachers should be increased to inform and sensitize men to family planning. (Priority A)

-Groups of women volunteers (such as satisfied acceptors or natural leaders) should be identified who, after adequate training and provided with simple educational support, could sensitize and motivate women in their surroundings, help the animatrices during their visits, and encourage users to obtain followup. (Priority B)

There is no easy solution to turnover of animatrices; one possibility is to consider using social assistants from the Ministry of Social Affairs, similar to the way MOPH medical and paramedical personnel are being used. (Priority B)

#### 6.5 The Peri-Urban Program

-More systematic use needs to be made of data in the liaison forms. (Priority A)

-To improve understanding of resistance factors, mini-surveys should be conducted on women who were interested but who did not return for family planning services. (Priority A)

-Social animatrices should be selected from those who already live in the target districts. (Priority B)

-Private sector collaboration should be increased by establishing liaison between the family planning center and private physicians and pharmacists. (Priority A)

-Workshops involving both social personnel and ONPFP Delegation personnel should be organized to discuss problems and design strategies adapted to the needs of each region. (Priority A)

-The recruitment of full-time physicians who would implement activities in 2 to 3 centers at a time should be considered. (Priority B)

-Socio-demographic mini-surveys in large cities such as Bizerte, Kairouan, Gabès should be undertaken for an improved understanding of suburban district characteristics, and for an intervention adapted to the specific needs and topography of each city. (Priority C)

#### 6.6 Postpartum Program

-The results achieved by various approaches should be examined to determine advantages and drawbacks of each and to develop the most appropriate strategy for the post-partum program. (Priority A)

-The introduction of audio-visual material should be considered for family planning education of mothers during their stay in the maternity clinics. (Priority B)

-The role of supervising midwives for this program needs to be reviewed; their employment, even part-time, in promoting family planning with new mothers may be a poor use of their time. (Priority B)

-The staff of all maternity clinics needs to be motivated to participate actively in family planning work during their daily activities. (Priority A)

#### 6.7 Voluntary Sterilization Program

-Tubal ligation medical files now in abeyance at the ONPFP should be completed by sending them back to delegations which have a correctly completed copy. Medical files need to be analyzed, as described, in late 1984. (Priority A)

-Given the current status, an evaluation of questions of program quality and safety, from a medical point of view, is not needed at this time. (Priority A)

#### 6.8 Contraceptive Prevalence

-All prevalence estimates need to be standardized for correct comparisons and estimates of tendencies. (Priority A)

-Reasons for the inconsistencies between 1983 CPS and other estimates of prevalence need to be determined. (Priority A)

-The ONPFP should continue to compare prevalence performance with VIth Plan objectives. (Priority A)

## 6.9 Management Information

-Activities should be continued in the collection, processing, and analysis of data necessary to the management of current activities and to decision-making. (Priority A)

-The ONPFP Population Division should collaborate closely with other Divisions as well as with the Ariana Clinic to develop new instruments for data collection, processing and analysis to improve their respective activities. (Priority B)

-The ONPFP should continue to expand and improve the information feedback mechanisms already established for the regions and expand these mechanisms to delegations, service outlets and mobile units. (Priority A)

-Standard terminology needs to be developed. Use of different phrases for the same concept or measure leads to erroneous interpretation. The Population Division could prepare a one-page list of the 10 or 12 concepts most often used and could identify the preferred term for each concept. (Priority A)

-The tabulation and analysis of acceptor characteristic data should be completed as soon as possible. This information is important, especially at the governorate level. (Priority A)

-The Population Division training program, begun by a seminar in 1983 and a 3-day program in January 1984, should be continued. (Priority A)

-The number of Population Division staff who can use microcomputers should be expanded. (Priority B)

-Computer capacity should be reinforced and adequate training should be provided to staff. (Priority B)

-Particular attention should be given to the application of scientific research principles (such as identified in the annex to the report) in all surveys and studies. (Priority A)

## 6.10 Basic Training

-The ONPFP should continue its action undertaken with academic authorities. Physician participation in family planning is now voluntary; it is necessary to explore means to reinforce theoretical and applied family planning training in the required curriculum of doctors, pharmacists and midwives. A certificate in family planning might be instituted for particularly interested doctors and

pharmacists. A commission of academic authorities and representatives from the ONPFP, the MOPH and the Ministry of Higher Education and Scientific Research could study aspects of this issue. (Priority C)

-To enhance dialogue with academic authorities, the ONPFP should examine certain needs which have been expressed by academic deans and associate deans. These include providing scholarships for family planning education, financing participation at international family planning conferences, reinforcing bibliographic family planning materials, audio-visual support in family planning and providing visiting professors from abroad. (Priority B)

-In terms of training of obstetrical nurses, the ONPFP could assist in curriculum development and could provide practical training in the CREPF's and in the mobile clinics. (Priority B)

#### 6.11 Continuing Education

-Planned decentralized training activities for the various categories of the socio-medical personnel should be continued. (Priority A)

-The human resources of the Training Center should be reinforced to provide it with the means to improve its preparation, management, and evaluation of training activities, especially given its planned expansion. The Training Center should be headed by a full-time Director seconded by a technical assistant specializing in training. (Priority A)

-The production of audio-visual support materials should be reinforced. (Priority A)

-Emphasis should be placed on training medical and paramedical personnel in basic health facilities, including regional primary health care (Santé de Base) chefs de service. (Priority A)

-Ways of collaborating with MOPH Regional Committees for ongoing training need to be considered. (Priority B)

-About 300 to 350 social education teachers responsible for educational programs in the localities should be trained. (Priority A)

-Training and continuing education activities need to be extended to private physicians and pharmacists. (Priority A)

-Refresher workshops for regional delegates need to be scheduled in the areas of evaluation, communication, personnel management, and methodology for training trainers. (Priority A)

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-The new evaluation instruments recently developed by the Training Center need to be applied. (Priority B)

#### 6.12 Information, Education and Communication

-Specific plans of action for each target group should be developed. An ongoing evaluation methodology for the various IEC activities needs to be developed and applied on a continuing basis. (Priority A)

-Audio-visual material adapted to each target group should be designed and tested. (Priority B)

-The possibility of a wider use of mass media should be studied and a review be made of family planning programming and message formulation for television. (Priority B)

-Cooperation with the private sector should be reinforced to benefit from expertise in audio-visual production. (Priority A)

-The main ONPFP library should be expanded in the areas of human reproduction, contraception, family health, demography, sexually transmitted diseases, sexuality, communication and ecology. French and Arabic bulletins should be available such as those easily obtained from IPPF, The Population Reference Bureau, the UN, WHO, etc. (Priority A)

The IEC Division should review, edit and distribute documents produced by Action Familiale de la Prélature de Tunis. (Priority A)

Consideration should be given to initiation of a newsletter to cover regional delegation initiatives, program evolution, and technical progress as well as to reinstating the Revue Tunisienne de Population. (Priority B)

#### 6.13 Management

-In accord with the progressive G.O.T. assumption of program costs (including salaries), future external aid should focus on the financing of new and innovative projects--such as private sector participation in the national family planning program, research in population and development--and in assistance to programs which need reinforcement (training, IEC, evaluation, extension of services into interior areas). In this regard, the ONPFP should undertake a study to determine financial and human resource needs and resources relevant to activities programmed in the VIIth Plan. Technical and financial support for such a study is desirable. (Priority B)

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-Continuing effort should be devoted to defining the tasks, roles and responsibilities of personnel in each Division in the central office. (Priority A)

-Personnel evaluation mechanisms should be introduced, with priority for technical personnel. These evaluations should be considered for promotions, filling posts, etc. (Priority A)

-The information processing capacity of the ONPFP should be reinforced and the analytic capability enhanced. (Priority B)

-Decentralized management procedures capable of improving the program should be put in place, for example, regional or delegation responsibility for identification of FMAR's and distribution of services. (Priority A)

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