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GOT/USAID EVALUATION

OF THE

TUNISIAN FAMILY PLANNING PROGRAM

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LIST OF ABBREVIATIONS

AID	Agency for International Development
ATPF	Association Tunisienne de Planning Familial
AVS	Association for Voluntary Sterilization
CNSS	Caisse Nationale de Sécurité Sociale
CPS	Contraceptive Prevalence Survey
CREPF	Centre Régional d'Education en Planning Familial
EPE	Enquête Population Emploi
ETF	Enquête Tunisienne sur la Fécondité
IEC	Information Education Communication
IFRP	International Fertility Research Program
INS	Institut National des Statistiques
INTRAH	International Training in Health
IPAVS	International Program Association for Voluntary Sterilization
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
JHPIEGO	Johns Hopkins: Programme International d'Education en Gynécologie Obstétrique
MCH	Maternal and Child Health
MFPF	Ministry of the Family and Women's Development
MOPH	Ministry of Public Health
MSA	Ministry of Social Affairs
MWRA	Married Women of Reproductive Age
ONPFP	Office National de Planning Familial et de la Population
PDG	Président Directeur Général
PSD	Parti Socialiste Destourien
UGTT	Union Générale de Travailleurs Tunisiens
UNA	Union Nationale des Agriculteurs
UNFPA	United Nations Fund for Population Activities
UNFT	Union Nationale des Femmes Tunisiennes
UTICA	Union Tunisienne d'Industrie Commerce et Artisanat
WFS	World Fertility Survey
WHO	World Health Organization

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I. INTRODUCTION

Since the beginning of the Tunisian family planning program in 1965, USAID assistance has amounted to almost $38 million. During the first few years this assistance was focused on the development of infrastructures and the training of personnel. In the years 1975-1977 it was extended to continue institutional development and to provide family planning information and services to the population of reproductive age. From 1978 to 1981 a $6.6 million bilateral assistance program was carried out to help the government reinforce and expand family planning services, particularly in rural areas. In 1981 when the bilateral agreement expired, and in accordance with recommendations made by an evaluation conducted in 1980, AID assistance was continued through intermediary organizations: IPAVS, JHPIEGO, the Population Council, IFRP, INTRAH and Westinghouse Health Systems. The present assistance program in the amount of $9 million covers the period 1982-1986 in the area of service delivery, training, rural program expansion, voluntary surgical contraception, information and education, management, research and evaluation.

1. Evaluation objectives

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 organisations. 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.

2. Evaluation Methodology

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 organisations 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.

(1) Due to personal reasons one team member did not participate in field activities.

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

3. Team Composition

The team consisted of three outside consultants and three nationals:

Dr. Jean Lecomte, Consultant team leader
Mr. Anwar Bachbaouab, Consultant
Mr. Hafidh Chekir, Population Division, ONPFP
Dr. Mahmoud Khiri, Medical Division, ONPFP
Mr. Robert Lapham, Consultant
Mr. Moncef Yousbachi, Human Resources Division, Ministry of Plan

4. Acknowledgement

The evaluation team would like to express its appreciation of the extremely productive participation of their Tunisian colleagues who in addition to their expertise and deep knowledge of the Tunisian context have brought an essential contribution to this evaluation. Their presence at meetings, work sessions and field visits as well as the constructive suggestions they made during the preparation of the evaluation report has indeed enriched this collaborative work. The evaluation team would also like to acknowledge the generous assistance and logistic support of numerous persons particularly Mrs. Souad Chater who has given her time and efforts unsparingly to bring us constant support and advice and generous hospitality. We would also like to thank Ms. Dale Gibb and Mr. James Phippard for their assistance and all the interest they have shown during our work.

II. GENERAL BACKGROUND

The purpose of this chapter is to provide background information for the team's assessment and recommendations presented in this report. The first section provides an overview of demographic trends during the past 20 years, and the second presents a brief summary of Tunisia's population policy. Section 3 reviews the VIth Plan goals (1981-86), and Section 4 traces the implementation of public sector family planning activities.

1. Demographic Trends

Since Independence, both fertility and mortality have declined substantially in Tunisia. Whereas the crude birth rate in the 1950's and early 1960's was around 45 per thousand, by the late 1970's and early 1980's it was around 35. Moreover, vital statistics for 1982 and provisional data for the first half of 1983 suggest a crude birth rate of about 33 declining to 31 per thousand. Among the Moslem populations in the Middle East and North Africa, only Turkey has experienced a comparable decline during the past two decades; other Arab countries with birth rates around 30 are exceptional cases (Lebanon, Qatar, U.A.E.), e.g., age structures are much affected by immigration of males.

Regarding mortality, although the estimates are less certain because of the incompleteness of death registration, it is clear that the crude death rate in Tunisia has also declined substantially since Independence, from close to 20 down to about 10 per thousand. With parallel declines in both fertility and mortality, the rate of population growth has declined much more slowly; indeed, throughout much of the period, the rate of natural increase remained approximately even, with the rate of population growth slightly lower because of net out-migration, especially through the 1960's.

Factors associated with the fertility decline include a rise in age at marriage among women, age structure changes, and increased control of fertility within marriage. Each of these three factors is noteworthy. Compared with 1956 when nearly 40 percent of the women age 15-19 were married, by 1975 only about 11 percent of the women in this age group were married. By then, average age at marriage for women had increased to about 23 in urban areas and 21 in rural areas.

The age structure has had opposite effects on the crude birth rate in the past 25 years. During the 1960's, the relatively smaller population of women in the childbearing ages had a downward influence on the birth rate; some studies showed that this factor accounted for about one fifth of the crude birth rate decline in that period. Since then, this pattern and its resulting effect have reversed. In the 1970's, the baby boom

group born after World War II reached the prime marriage and childbearing ages, so that the age structure effect in recent years has pushed the crude birth rate up. By 1983, MWRA contraceptive prevalence of modern methods of fertility control was 34 percent and an estimated additional 7 percent were using more traditional methods such as rhythm and withdrawal.* Thus, contraceptive prevalence, including both modern and traditional methods, is approaching 41 percent among MWRA. Moreover, the national family planning program has played a major role in the gradual upward trend in the use of modern methods. About 7 in 10 current users obtain their supplies and services from the public sector, and 4 out of 5 current users obtained their initial family planning supplies or services from the public sector program.

2. 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).

3. 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.) Continuing to promote these goals, the VIth Deveopment Plan uses the projections in Table 1 as demographic objectives for the current plan period (1981-86) and for the subsequent 15 years.

*These estimates are based on ONPFP statistics and the 1983 CPS survey. Interpretation problems and data inconsistencies are discussed later in this report.

TABLE 1: VIth Plan demographic objectives

	1981	1986	1991	1996	2001
Total population (in thousands)	6,535.0	7400	8507	9210	10,062
Births (in thousands)	226	231	239	229	216
General fertility rate (per 1000)	148	130	110	96	80
Crude birth rate (per 1000)	34.6	31.2	28.4	24.9	21.5
Deaths (in thousands)	50.5	53.2	54.3	52.4	51.8
Crude death rate (per 1000)	7.8	7.2	6.4	5.7	5.2
Rate of natural increase (%)	2.7	2.4	2.2	1.9	1.6

Furthermore, the VIth 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 Table 2.

TABLE 2: VIth Plan average contraceptive prevalence rates

	1980			1986		
	Public Sector	Private Sector	Total	Public Sector	Private Sector	Total
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

4. The Present Program

Public-sector family planning in Tunisia is carried out within a framework of broad political, religious and legislative acceptance, without great opposition. The ONPFP establishes policies and programs for the delivery of services and supplies. It maintains a nationwide administrative structure, and insures the implementation of a broad range of activities designed to increase the voluntary acceptance and use of modern means of fertility control. A principal objective is to make these modern means more widely and easily available throughout the urban, peri-urban, and rural areas of the country. Related objectives include: establishment and monitoring of standards of service; development of adequate training programs; development of a useful and effective information, education and communication service; administration of program personnel, services and supplies, including the recruitment of necessary staff; implementation of appropriate research and evaluation activities; initiation of special projects when required, and other aspects central to the effective execution of a national population and family planning program.

Two other important tasks of the ONPFP must be noted. First, because many of the public-sector family planning supplies and services are in fact delivered through service outlets of the MOPH, often by MOPH personnel, the ONPFP is expected to coordinate its efforts within the overall health infrastructure of the country. Second, the ONPFP is charged, implicitly at least, with raising sufficient funds to implement a continuous and effective program. Thus, the ONPFP must negotiate with both national and international bodies to carry out this task.

In order to carry out its many tasks the ONPFP has established both central and regional structures. At the central level this structure consists of the Office of the Director, the technical divisions (medical, population, IEC, finance and management) and the training center (see annex 1 - ONPFP organigram). At the regional level the ONPFP has established in each governorate a Regional Family Planning Education Center (CREPF) which acts as a reference center for service delivery, including voluntary surgical contraception. The Center's facilities are also used for training medical and social personnel; its staff manages, coordinates and evaluates all regional family planning activities including the activities of the mobile units.

To carry out the delivery of supplies and services, a network of service delivery points has been established. These consist of:

Permanent facilities

- 2 model clinics in Tunis: Ariana and le Bardo (a third clinic is presently being established);

- a CREPF in each governate (20 CREPF's);

(The above two categories of infrastructure are owned and managed directly by the ONPFP.)

- 30 family planning consultation clinics in the peri-urban areas of Tunis, Sousse and Sfax; and,

- 167 health centers, hospitals and MCH centers of the Ministry of Public Health

Mobile facilities

61 mobile units (55 teams and 6 mobile clinics), each composed of a midwife, a nurse and a driver. These units visit 762 basic health centers and other gathering points. Services rendered include, in addition to family planning, pre- and post-natal and gynecology consultations.

During the period 1981-1983 the ONPFP has continued to develop its activities in order to meet the needs of all regions:

- It has reinforced its regional technical and administrative structures through the establishment of new CREPF's in the governorates of Tunis, Tozeur, Tataouine and Ben Arous, and a new model clinic in Hammam Lif.

- It has completed the installation and set up operation of two CREPF's in Kairouan and Zaghouan.

- It has completed equipping 4 new maternity clinics in Tunis, Sousse, Sfax and Bizerte.

- Finally it has revised and expanded the activities of the mobile units, whose number has increased from 51 in early 1982 to 61 at the end of 1983 providing more coverage of the rural areas.

The ONPFP has also organized 4 family planning clinics in the centers of the Social Security Health Program and the Ministry of Agriculture. It has, furthermore, encouraged several industrial firms to offer family planning as part of services provided in their own medical facilities, and has helped set up 5 family planning clinics in these facilities.

III. FAMILY PLANNING SERVICES

1. Service delivery.

Family planning activities, by type of center and activity are distributed as shown in Table 3.

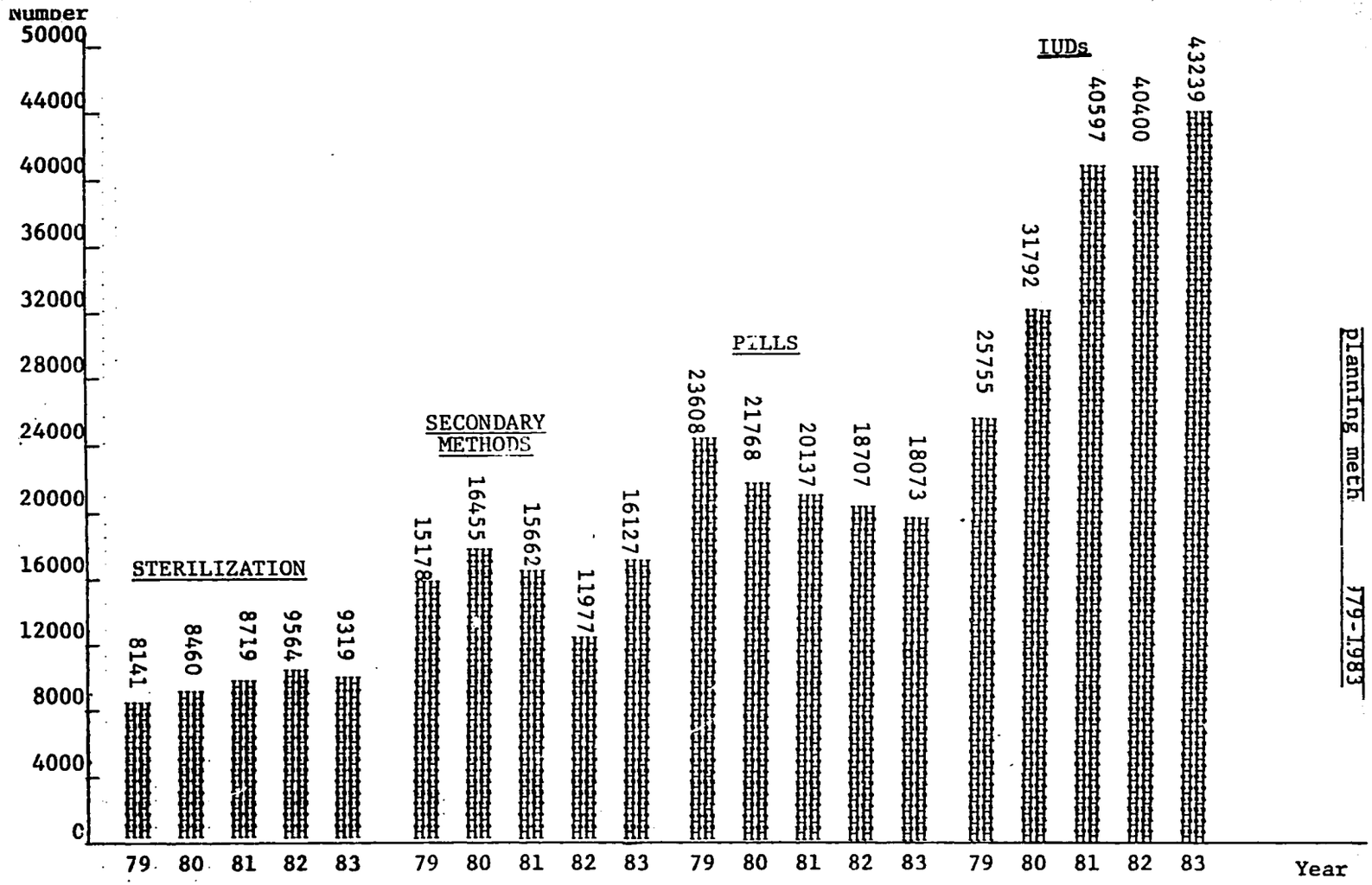
In 1983, 967 centers provided family planning activities, 800 of them serviced by the ONPFP, which directly managed approximately 3% of the total. The ONPFP has conducted 63% of the total number of family planning visits, 64.1% of first IUD insertions, 82.2% of tubal ligations and serviced 57.2% of all new pill acceptors.

The total number of centers where family planning services are provided has increased by 19% from September 1982 to December 1983. This increase is a direct result of the increase in the number of basic Health Centers and the intoduction of mobile clincs in the governates of Tozeur, Sidi Bou Zid, Gafsa, Kairouan, Mahdia, Medenine and Tataouine. The mobile clinics have created new gathering points bringing family planning services closer to the dispersed rural population. Service delivery is supported by group education programs and interpersonal communication activities carried out by IEC staff and rural animatrices (promoters).

In general and as shown in Figure 1 all methods with the exception of oral contraception have seen a positive development between the year 1979 and 1983. During this period IUD insertions increased by 68%, tubal ligation increased by 14% with a light stagnation at the end of the period. New public sector pill acceptors decreased by 34%. (See p. 37 for causes.)

TABLE 3: Family planning (FP) activity - distribution by center and method

	CREPF AND FP CENTERS OFFICE		MOBILE CLINICS AND TEAMS		MOPH		TOTAL	
	1982	1983	1982	1983	1982	1983	1982	1983
Visit Total	28,7	30,0	32,2	33,0	39,0	36,9	640,356	658,534
First IUD insertion	40,8	41,2	21,2	22,9	37,9	35,9	40,000	43,239
N. Pills	25,0	26,7	31,4	30,5	44,2	42,8	18,707	18,173
Tubal Ligations	81,6	82,2	-	-	18,4	17,7	9,564	9,319



* These data do not include activities in the private sector.

The ONPFP has a monopoly on contraceptive distribution in the country. Furthermore, it has undertaken activities to promote the expansion of the role of the private sector in family planning services and the distribution of contraceptive methods. The results obtained are encouraging as shown in Table 4; the number of cycles distributed by the private sector has more than doubled between 1980 and 1983 and condom distribution for the same period has increased by 40%.

TABLE 4: Contraceptive distribution in the private sector

	1979	1980	1981	1982	1983
Pills (cycles)	477,000	417,000	596,000	656,900	902,170
Condoms (unit)	840,000	927,000	1,232,000	1,027,000	1,130,250

2. Service Availability

The question is to what extent family planning services delivered to the population meet expressed needs. It was impossible for the evaluation team to determine precisely the availability and accessibility of family planning to the population. Our impression is that the majority of the country is covered. In the urban context, we can reasonably assume that most of the population has easy access to family planning services, although the situation could be far less favorable in the rapidly increasing peri-urban areas lacking in infrastructure. In the rural context, where the private sector is less developed, accessibility of family planning services is related to the existence of fixed facilities with qualified family planning personnel and to visits by mobile units, particularly in areas of dispersed housing. The increase in the number of mobile units and the multiplication of centers served by these units (615 in 1982 and 762 in 1983) has improved family planning service accessibility and led to a 15% increase of new acceptors recruited through mobile units and clinics between 1982 and 1983 (see Figure 1).

The issue of availability and accessibility was raised during a survey conducted in 1983-84 (Lapham, Mauldin). Table 5 provides a spectrum of answers established by several experts who have a thorough knowledge of the Tunisian family planning program. In addition to unmet demand, however, there still are some obstacles to contraception. Among the major factors responsible for this are:

-medical and paramedical personnel constraints (doctors, midwives, and animatrices);

TABLE 5: Availability of family planning in Tunisia, as judged by knowledgeable experts on Tunisia
(Percent of the couples of reproductive age who have ready and easy access to each method by source.)*

Method	Country Total			By source (not additive, since sources often overlap)					
	Total of all sources			Government Program		Private (mostly private physicians)		Pharmacies (subsidized pills sales, etc.)	
	Rural	Urban	Total	Rural	Urban	Rural	Urban	Rural	Urban
Pills	50-70	95-100	75-100	50-70	95-100	0-10	35-50	0-20	50-100
IUD's	30-70	80-100	55- 85	30-70	70-100	0-10	20-50	———	
Condoms	50-70	80-100	65- 85	50-70	70- 95	0- 5	0- 5	0-20	50-100
Foams, jellies	50-70	80-100	65- 85	50-70	70- 95	0- 5	0-10	0-20	50-100
Abortion	20-50	80-100	50- 75	20-50	75-100	0	30-50	———	
Female Sterilizations	20-50	80-100	50- 75	20-50	75-100	0	30-50	———	
Othe methods	Injectables are available only on an experimental basis Male sterilization is essentially not available								

* Ready and easy access means that the couple spends no more than an average of 2 hours per month to obtain contraceptive supplies and services. Easy access also implies that the cost of contraceptive supplies per month is less than one percent of a month's wages.

-socio-cultural factors specific to a given region: long absence of husband, reluctance of women to be examined by a male doctor;

-the widely held belief that long breast-feeding (2 years and more) is an efficient contraceptive;

-the still high infant and juvenile mortality rates in the governorates of the South;

-rumors, fears and misunderstandings related to contraception;

-the desire to have more children; and,

-opposition of the husband.

Recommendations

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

- Secondary methods should be promoted for temporarily separated couples. (Medium-term)

- Information and educational materials should be adapted to address misbeliefs. (Medium-term)

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

- Information activities for men should be increased. (Short-term).

- 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. (Short-term)

3. Quality of Services

Family planning service quality is assured by the establishment of norms and standards, training and refresher courses, supervision and acceptor follow-up. Each of these areas will be examined in the sections below.

3.1 Norms and Standards

The availability of technical norms related to family planning service delivery varies from method to method. Whereas norms are well established for injected contraceptives (survey underway) and tubal ligations, they are less so for IUD'S and pills. Nonetheless, technical guides and memoranda as well as refresher courses insure high quality delivery. Thus, in all cases, whether in fixed or mobile centers, new pill or IUD acceptors are submitted to extensive questioning, to a medical and gynaecological examination--including an examination of the cervix by speculum--and, given regional capacity, to laboratory tests (glycemia, albuminuria and sometimes even a lipid test). With respect to voluntary sterilization, a medical file which meets AVS norms served as one basis for a survey undertaken recently by the ONPFP concerning quality of the reception, of the technique, and of the acceptor profile for this method. The same file has allowed the organized and systematic control and followup of these women.

For other methods, the medical division is developing norms and standards to be published in late 1984. It is also developing a pre-coded individual medical file including a sociodemographic part common to all acceptors and a medical component specific for each method. To better understand contraceptive failures, a form and instruction handbook is being prepared to track all pregnancies which occur with any method. This form will be distributed to all family planning facilities, to maternity clinics and to the personnel of mobile units, including animatrices.

Recommendations:

-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. (Short-term)

-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. (Short-term)

-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. (Short-term)

3.2 Training and Refresher Courses

The role of training in service quality is discussed in Chapter VII, Training.

3.3 Supervision

At the central level, three doctors within the Medical Division share the supervision of governorates, each being responsible for approximately 7 governorates. Each one makes an average of 2 monthly visits, whether individually or with members of other ONPFP divisions, during which various activities are undertaken, such as:

- material and equipment inspection, requisition of replacements for orders of missing or damaged equipment;
- supervision of aseptic conditions and solution of minor problems;
- identification of defects (e.g., in the maintenance of medical files) necessitating later refresher courses;
- training/information sessions for CREPF and mobile unit personnel; and,
- family planning surgical operations in the absence of a full-time physician within a CREPF.

Improved planning, a more accurate definition of tasks to be performed, and the acquisition and operation of adequate supervision instruments would greatly increase the effectiveness of this activity.

At the regional level, the supervising midwives submit to the Medical Division quarterly reports on various subjects, such as:

- the state of sanitary facilities, and equipment and cleanliness of buildings;
- reception conditions and personnel motivation;
- card index use and organization;
- interpersonal relations in the center; and,
- quality of technical services.

These reports also include comments and followup. They are analyzed at both regional and central levels and permit

immediate decisions to be made or problems to be identified which require ONPFP intervention. These reports are based on supervision forms developed during a works op for ONPFP personnel, supervising midwives and INTRAH technical assistance.

Three doctors share the various activities of this division: administration, supervision of 22 governorates, participation in the Rural Program, contacts with medical files, writing of technical memoranda and directives, participation in IEC sessions, training and continuing education for medical and paramedical personnel, studies and research (biomedical etc.). To optimize the Division's human resources, the evaluation team gives the following recommendations.

-Supervision visits should be more systematically planned and scheduled. (Short-term)

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

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

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

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

3.4 Followup

Acceptor followup is variously undertaken according to method and to region. Ligated women must be and are re-examined one week after intervention, and about 80% are re-examined a second time, 3 weeks after the operation. IUD acceptors are

recontacted after 1 week, 1 month, 3 months, 6 months, and then once a year; pill acceptors are examined once a month during the first three months, and then once every two or three months, according to the number of cycles distributed. Particular attention is paid to copper T acceptors (2.5 to 3-year validity) and to women who show up with the Dalkon shield.

The major element on which followup is based is the individual acceptor file. Based on the compilation of this file, users who need followup are identified, and home visits are made to track them. In some regions, inspection of the file and the list of women to be contacted is undertaken by supervising midwives while visiting the dispensary when the mobile team is on site, but this listing is not systematic. Elsewhere, animatrices spend half a day a week analyzing the files, listing women to be contacted, and classifying them for followup by the mobile unit before departure.

The evaluation team recommendations follow.

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

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

4. The Rural Program

In collaboration with the Population Council, the ONPFP undertook the development of family planning services in 22 delegations located in 9 governorates. These delegations are the lesser developed in the country and lack an adequate health infrastructure. An administrative unit consisting of a principal coordinator, two supervisors and a secretary was created within the ONPFP to carry out this activity. Approximately 40 animatrices and 5 educators as well as 5 mobile clinics were established in the governorates of Gafsa, Siliana, Kairouan, Nahdia, Sidi Bou Zid, Nederine, and Tataouine.

The program started in 1982 with the recruitment and training of personnel (midwives, animatrices, nurses, drivers), the preparation of work documents (activity report and schedule, maps), as well as the implementation of a socio-demographic and contraceptive survey in the project areas. The first mobile clinic became operational in January 1983 and the others were progressively introduced during that year. The last (Kasserine) is still not operational because of the unavailability of midwives.

Program accomplishments are various:

-elaboration of a methodology and various work instruments some of which, such as the activity form for the mobile clinic or the monthly statistics report, are used to evaluate and measure the activity of clinics, and others whose usefulness goes beyond the rural program as such. This is particularly the case for the individual education and followup form, established during the systematic home visits, which allows for a better understanding of the eligible population among MWRA's. This form is already being used outside the rural program target delegations. We should also note the development of an index system which facilitates tracking and followup of women.

-the development of information brochures on contraceptive methods aimed at illiterate women;

-the identification of certain problems such as poor knowledge of contraception on the part of many local officials;

-the recruitment and referral by the animatrices, especially for sterilization during their home visits; and,

-activities of mobile clinics themselves.

In all target delegations the activities undertaken in connection with the rural program have had a positive impact. Thus, in the years 1982-83 the total number of family planning visits increased by 5% from 37,007 to 38,911. The number of new family planning acceptors also increased by 29% from 3557 to 4571. The rural program has contributed to the recruitment of 20% (1982) and 24% (1983) of the total number of new acceptors in the governorates in the project zone. First IUD insertions in these governorates increased by 17% against a 10% increase for the rest of the country. New pill acceptors increased by 5% while the national level showed a decrease of 3%; barrier method acceptors increased from 111 to 846. (Table 6 presents the evolution of family planning activities in the Rural Program target delegation, and Table 7 shows program activities for the first three months of 1984.)

TABLE 6: Evolution of family planning activities in the Rural Program target delegation

	Total visits		New Acceptors		Old Acceptors		Primary Insertions		New users					
									Pills		Condoms		of Jellies	
	1982	1983	1982	1983	1982	1983	1982	1983	1982	1983	1982	1983	1982	1983
Total governorates	163,715	163,595	19,048	20,039	96,376	100,136	9,989	11,053	6,842	6,394	2,018	1,964	569	1,836
Total rural areas	37,007	38,911	3,557	4,571	22,368	24,555	1,884	2,214	1,960	2,066	376	440	111	846
Share of rural areas in Governorate total (percent)	27	28	20	24	28	29	20	21	36	37	22	28	20	50

TABLE 7: Rural Program activities for the first three months of 1984

	Total visit	Gynaeco. visits	Old accept.	New accept.	DIV	N P	NII
6 mobile clinics	2,630	31%	44%	23%	9%	6%	8%
2 mobile teams	1,885	25%	62%	13%	6%	6%	1%
Total	4,515	28%	52%	19%	8%	6%	5%

These figures should be interpreted with caution taking into consideration factors pertaining to each region. If, for example, the 2 mobile teams made the equivalent of 72% of visits carried out by the 6 mobile clinics, it must be noted that the mobile teams visit small villages where the population has been using their services for a long time, whereas mobile clinics stop at more central locations in areas with dispersed housing where women are pehaps more reluctant to accept, in front of others, the services thus provided them.

Right from the start the rural program was, and still is, faced with a number of difficulties. The rural survey should have provided basic information on the areas targetted by the program (about 360,000 people) and permitted measurement of subsequent changes, but it did not fulfill this need. (See Chapter VI, Studies and Research). Consequently, program impact evaluation and the measurement of tendency changes over time can be done only with the development of an appropriate method -- still to be elaborated -- based on program statistics.

Among other major program issues are:

-Personnel shortage. Only 1 or 2 animatrices out of the original 5 who were trained are still in the program. The others left after training which gives them access to examinations for aide-soignante recruitment. The principal reason for these departures is related to their wish for a stable job (animatrices are employed under contract) and not higher salaries. These departures require the ongoing recruitment and training of new animatrices to maintain the quota of 5 per governorate.

-Shortage of midwives also impedes the smooth implementation of the program. Midwives accept placements in rural areas only with great reluctance and are still less likely to accept placement in mobile units. (In 1983, the Gafsa Regional Director asked for 16 midwives and received 8 of which only 2 are still working). Various leaves of absence (disease, maternity, administrative) do not allow for continuity of activity.

-Lack of adequate transport. The animatrices, whose role is vital in sensitizing, motivating, and preparing the population for the arrival of the clinic, have difficulties related to transport. They were given motorcycles, but geographical and cultural constraints have left them almost unused except in Mahdia. Animatrices use other staff vehicles whenever these are available.

-Mobile clinic breakdowns.

-Socio-cultural difficulties. Some women, reluctant to use mobile clinics because they are too visible, ask the midwife to examine them in their homes.

-Hostility of neighboring villages which requires continuous readjustment of clinic itineraries.

-Difficulties inherent in the "newness" of this program: the need to seek new strategies (realjustment of itineraries, elimination of clinic stops "on demand" rather than according to a pre-established schedule); the development of data collection instruments and analysis.

Recommendations

-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. (Short-term)

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

-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. (Short-term)

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

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

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

-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. (Medium-term)

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

In Sousse, a permanent consultation site was developed in Cite Ezzouhour where the dispensary had been visited only once a week by the mobile team. Also, a permanent consultation site was developed in Ouled Naouar serving the populations of Taffala, Biz Chobbek, Cite El Aouina and Kedonet Naled.

In Sfax, the first consultation site was created in Cite El Habib (30,000 inhabitants). The second was for the populations of Oued Erremel, Biz Kharroub, and Cite El Bahri (15,000 inhabitants). A supervisor was appointed 7 months ago to be responsible for all motivational activities (ONPFP animatrices and MSA social staff) in those governorates which are neither part of the rural program nor in Tunis.

Liaison forms were designed for all motivation personnel. These forms are given to interested women during home visits. These should, in principle, facilitate measuring the performance of each type of personnel and, through on-site investigations, identify women interested in family planning but who did not return for services. These forms should also serve to identify restraints and obstacles to contraception. The main obstacles facing the peri-urban program are:

-In spite of the increasing number of general practitioners available, it has been difficult to interest them in a part-time (2h/day) activity in these peripheral consultation sites. Thus, only two physicians were contracted for this program.

-Transport difficulties limit the scope of action for animatrices who travel with the mobile team. (Only in Sfax, are motorcycles culturally and traditionally well accepted in the city).

-Difficulties exist in collaboration with the social affairs personnel who are not always sufficiently motivated to add family planning to their other activities.

-There is a lack of cooperation with MSA officials who, for example, may not tell the delegue about a midwife departure, transfer, or leave, which sometimes leaves a dispensary without personnel for family planning services.

-There is a lack of physician participation in family planning activities due to lack of time and motivation.

We should, however, observe that there are important regional variations. For example, in Sfax the collaboration of the Regional Delegue with the social and medical communities is good. These variations are also to be found from one health center to another in the same region.

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Recommendations

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

-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. (Short-term)

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

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

-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. (Short-term)

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

-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. (Long-term)

6. Postpartum Program

Immediately after the establishment of the national family planning program, each CREPF was provided with two animatrices whose activities were mainly centered on contacting postpartum women in the maternity clinics, to promote family planning and refer them to the nearest family planning center. Aware of the impact which the education and motivation of pregnant women could have on the program, the ONPFP decided to reinforce and expand this activity which was becoming routine.

Thus, four efforts are now underway:

(1) Sfax

At the Sfax medical school maternity clinic, a special consultation was created for the mother and her baby to come on the 40th day postpartum during which, after a medical checkup,

the mother is encouraged to use the contraceptive method which is best suited to her.

(2) Tunis

The 5 social workers in the CREPF as well as the 4 supervising midwives share the responsibility of the program in the four major maternity clinics in Tunis (Habib Thameur, Charles Nicolle, Wassile Bourguiba, and Khereddine). A team of one social worker and one supervising midwife visits a given maternity clinic each afternoon to promote family planning with the mothers. A three-page reporting form is used to insure the liaison between the maternity clinic and the parturient, and between the parturient and the family planning center. One part is given to the mother, the second is sent to the family planning center selected by the woman and the third remains in the clinic record. This form facilitates the evaluation of promotional input by the supervising midwife and permits an assessment of the number of women who attended. If the woman does not attend, she is visited in her home by the social worker.

(3) Monastir

On a monthly basis, the Municipality provides the CREPF with a list of new-born babies; this list enables the CREPF animatrices and the supervising midwife to visit mothers in their homes on the 40th day and to give them a liaison form for a family planning consultation. Moreover, the animatrices make systematic daily visits to maternity clinics in the region to encourage mothers individually and give them a liaison form. The structure of this form, however, does not allow followup.

Since the animatrices are overworked, the family planning regional delegue has considered involving all midwives working in maternity clinics in the program after adequate training and motivation.

(4) Mahdia

An experiment to increase the effectiveness of family planning services is underway. Among its goals is postpartum followup in the Bou Merdes delegation. An animatrice was appointed in this area and was provided with the necessary support and means to carry out this activity including an educational programming form and a monthly list of the newly-born.

Each of these experiments is original in its own way. A comparative study will later help determine the most suitable approach for program expansion.

Recommendations

-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. (Short-term)

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

-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. (Medium-term)

-The staff of all maternity clinics needs to be motivated to particpate actively in family planning work during their daily activities. (Short-term)

7. Voluntary Sterilization Program

Almost all of the 9000 sterilizations performed each year in the family planning program are made by laparoscopy. The ONPFP centers provide maximum safety in voluntary sterilization conducted by a trained gynaecologist assisted by a team which includes a trained anesthesiologist. However, the absence of a complete set of monitoring equipment (cardioscopes, respiraters) and of laboratories in the CREPF should be noted.

From 1974 to mid-1984, out of 49,500 operations, 2 deaths were recorded, one in 1978 and the other in 1980. During the 1981-82 period, out of 18,283 voluntary sterilizations, 47 abnormal cases were recorded (including 13 pregnancies), that is to say 0.25%, distributed as follows: 1 annexite, 2 shocks, 15 uterine perforations, 2 ovary wounds, 1 acute lung edema, 1 infection of the pelvis, 1 torn ligament, 2 uterine wounds, 2 spica eviscerations, 2 tubal sections, 1 round ligament section, 1 wall infection, 1 colon wound, 1 hemorrhage (following culdoscopy), 1 cardio-breathing stoppage (recuperated), and 13 pregnancies.

No criticism seems to have been expressed by the medical community concerning technical quality, age of operated women, parity, or the recruitment procedure concerning voluntary sterilization coverage. Demand is met wherever there exists a gynaecologist either employed by MOPH or contracted by the ONPFP. The presence in some governorates (Gafsa, Tozeur, Kasserine, Medenine) of cooperating foreign physicians who are relatively conservative concerning contra-indications has sometimes led to their refusing operations on the basis of mild

medical contra-indications. Transport of women for tubal ligation does not seem to be a problem. They come either by their own means or are transported in CREPF vehicles. Quite frequently, the procedure is performed in the morning and the woman leaves late in the afternoon. Before any operation is performed, systematic laboratory tests including blood-group, glycemia and uraemia are performed in the Regional Hospital. There are no women on waiting lists. The maintenance service carries out its work correctly and no operation is delayed because of lack of equipment.

The medical files were reviewed in 1983. Their completion by the same cooperating foreign personnel caused a few technical problems which led to a continuing education workshop. Since then, file quality has greatly improved. The 1983 analysis remains to be done, largely because the files are incomplete.

The ONPFP has recruited a physician specializing in anaesthesia and resuscitation; he supervises anaesthesiologist technicians working in the various facilities offering voluntary sterilization services. The most frequently used anaesthetic technique is deep epanthale anaesthesia for a brief period which does not require intubation or use of curare. In these conditions the procedure does not take more than 2 minutes. The patient wakens "on the table". This technique eliminates the need for surgical followup by specialized personnel. General anaesthesia with intubation and euranization is only used for operations carried out by laparascopy trainees who have not acquired surgical dexterity and rapidity to permit a shorter operating time. Conscious sedation, advised in the JHPIEGO program for training anaesthesiologists, is not part of the procedure yet, more because of French-school influences than for technical reasons. It is to be observed, however, that the psychological preparation required for this technique increases total operation time and that some surgeons who tried it and returned to deep anaesthesia complained of bad abdominal slackening, of "painful" reflex at tubal seizure and of abdominal contractions which disturb the operation.

In conclusion, the tubal ligation program does not have major problems, at least from a qualitative viewpoint. Quantitatively it has reached a ceiling of about 9,000 acceptors per year. The 20,000 acceptor objective is probably too ambitious. Nonetheless, it is difficult (no attempt has been made), to know if a larger number of gynaecologists would increase these figures, and if so in what proportion.

Recommendations:

-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. (Short-term)

-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. (Short-term)

IV. CONTRACEPTIVE PREVALENCE

One of the most important management questions concerns the levels and trends in the use of family planning in the country as a whole, in the regions, and among different parts of the population. Equally important is information on where couples obtain their family planning supplies and services, e.g., public sector, mobile teams, MOPH health centers, pharmacies, or private physicians. Thus, the direct measurement and indirect estimation of contraceptive prevalence levels and trends are crucial management and evaluation tools.

1. Prevalence Trends in Tunisia

At first glance, the estimates of contraceptive prevalence in Tunisia for recent years appear to be inconsistent; thus, readers of various documents are confused and unsure about the "real" prevalence rate during a given period or year. However, a more detailed investigation reveals that the various estimates are quite consistent. Moreover, this consistency adds an element of validity to recent prevalence information which has been obtained independently.

A major reason for confusion arises from the use of different definitions of prevalence. Specifically, different denominators have been used when reporting study results. The 1978 Enquête Tunisienne sur la Fécondite (ETF) defines "prevalence" as current use of contraception among "exposed women" (femmes exposées), which means that pregnant women and women who are infertile are excluded from the denominator, as are women who are not currently married. The 1980 Enquête Population et l'Emploi (EPE) goes in the opposite direction, by defining prevalence as current use of contraception among all non-single women, i.e., including women who are married, widowed, and separated. Although EPE has tables that show prevalence using the same denominator as the EPE, the numerator for these tables includes both modern and traditional methods.

The recently released 1983 Contraception Prevalence Survey (CPS) presents prevalence estimates in terms of current use of contraception among married women of reproductive age (MWRA) (in French: femmes mariées en age de reproduction (FMAR)). This definition is appropriate, and, in the following discussion, the data are standardized so that all estimates are comparable. Specifically, each estimate is recalculated so that the numerator refers to married women of reproductive age who are currently using contraception, and the denominator refers to MWRA. Furthermore, the estimates refer to the use of modern methods of contraception: pill, IUD, female sterilization, condoms, injectables, and other scientific methods. Note that abortion is not included in the prevalence estimates nor are the traditional methods. (The ETF collected information on the use of traditional methods such as withdrawal and periodic abstinence, as did the CPS study).

A technical note prepared for the ONPFP in August 1984, "Contraception Prevalence in Tunisia: A Comparison of Estimates from Various Sources" by R. J. Lapham, provides details on the different definitions and how to make them comparable. Therefore, it is not necessary to repeat those details here. Instead, we turn to the actual comparison of standardized prevalence rates, shown in Table 8. Note that for the total country, prevalence among MWRA appears to have increased from about 25 percent in 1978 to 29 percent in 1980 and to about 35 percent in 1983. The data on the proportions of the MWRA served by the public and private sector are not consistent, although it is likely that the problem here arises from the CPS estimates.

There are two reasonable conclusions from this evidence. First, prevalence has been going up steadily for several years, with an average of 2 percent net additional MWRA becoming current users of contraception each year for the past 5 years. A continuation of this rate of increase through the end of the VIth Plan period would mean the achievement of the Plan goal of 40 percent prevalence (of modern methods) by 1986. Second, although the trend is not measured well at this point, the private sector is an important source of contraceptive supplies and services for approximately one in four current users. In addition, these upward trends are occuring simultaneously with a modest but steady decline in the crude birth rate, which after a period of stagnation of approximately four years (1976-80) at 35% is now around 31%. Based on a comparison with pill distribution recorded, the CPS estimate for pill prevalence appears to be too low. On the other hand, the CPS estimate for MWRA having had a tubal ligation is much higher than estimates based on service records.

A conclusion to be drawn is that caution is warranted in the use of these preliminary CPS data. In addition, attention should be

TABLE 8: Prevalence estimates - current use of contraception among MWRA, total Tunisia, from various sources (in percents)

	Date to which Estimate Refers				
	Mid-1978	Mid-1980	End-1980	End-1982	Mid-1983
Public Sector					
ETF	18.0				
EPE		20.0 (5/80)			
ONPFP			21.4	22.4	
CPS					27*
Private Sector	6.8	8.7			8*
Total Country	24.8	28.7			34.7

*This preliminary result from the CPS is inconsistent with other information that suggests increased private-sector use. Thus, it is possible that the public/private sector proportions of prevalence in 1983 are 25 to 1 rather than 27 to 8.

given to sorting out or explaining the inconsistencies during the forthcoming visit of Population Division staff to work on CPS data analysis and report writing in Columbia, Maryland.

2. Population Division Prevalence Estimation Procedure

The Population Division of the ONPFP has written computer programs that calculate prevalence on the basis of two sets of data: (1) number of acceptors of each method during the last several years; (2) assumptions about continued use of that method (or a life table in the case of sterilization acceptors). The continuing users of each monthly or annual cohort of acceptors (e.g., from 1975, 1976, etc. up to 1983) are summed to obtain the numerators, and census-based estimates of MWRA are used for the denominators. Although the arrays of data are large, the computer can do the arithmetic without difficulty. In addition, an important step adds a measure of consistency between the obtained estimates and independent survey measures: the assumed continuation rates are adjusted so that the prevalence estimates match reasonably well with the survey results, e.g., with the 1980 EPE prevalence results for the public sector.

This procedure provides program managers with an important evaluation tool, namely prevalence levels and trends for the country, for regions, for governorates and for delegations (for methods other than sterilization because for this method the data recording is by CREPF center rather than by delegation of residence of the acceptor). The procedure is just at the point of final development and initial implementation. We urge its quick and universal use, with feedback of results to the délégués and delegations as well as to office program managers. The Division deserves much credit for working out the rather tedious and complicated programming required to make the procedure workable.

3. Prevalence Trends: Actual and Revised VIth Plan Objectives

As noted, the current five-year program is on track to reach VIth Plan 1986 prevalence targets if the recent trend continues. There are a number of details that merit some attention, but this is not the place to present long discussions of them. (For example, the 27 percent starting point for 1980 stated in the VI Plan, is taken from the 1980 EPE survey, but that survey did not use MWRA as its denominator. Adjusted to MWRA the percentage is 28.7. Therefore, should the end point Plan target for 1986 be adjusted also? From 40 to 42 percent?). Using 40 percent as the assumed MWRA target, the Tunisia totals are given in Table 9.

TABLE 9: Adjusted VIth Plan goals

	1980	1983	1986
VIth Plan Target	27	33.5	40
VIth Plan Target, 1980 Adjusted	28.7	34.3	40
VIth Plan Target, 1980 and 1986 adjusted	28.7	35.3	42
Results		34.7*	

* Provisional CPS Estimate

There is, however, much variation among governorates. Also the above summary deals neither with the separate targets specified for urban and rural areas, nor with the targets for the public and private sectors. Regarding governorate trends, an analysis in 1983 showed that public-sector prevalence had declined slightly between 1980 and 1982 in several governorates: Le Kef, Kasserine, Gafsa-Tozeur, Gabes-Kebili, and Nabeul. Thus, other governorates were contributing more than an average share toward the achievement of national objectives.

We encourage the ONPFP to use the newly available Population Division prevalence trend estimates to compare governorate performance against VIth Plan objectives that are transformed from the national objective to governorate objectives. The latter can easily be calculated by using 1980 prevalence levels as starting points and calculating targeted percentage increases. With a little more work, the national milieu (rural and urban) objectives can be incorporated by consideration of the urban and rural proportions of the population in each governorate. This matching of governorate performance with VIth Plan targets would provide ONPFP central management with a most useful management evaluation tool for dialogue and performance assessment discussions with regional délégués.

Recommendations

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

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

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

V. STATISTICAL EVALUATION

The statistical evaluation system was expanded during the last few years to allow for an improved followup of family planning program activities. The system was reinforced on three levels: data collection, data processing, and information dissemination (feedback).

The purpose of these changes is to allow for constant feedback between the central and regional levels and to provide the ONPFP Direction Générale with an ongoing observation system allowing for the immediate readjustment of field activities and to detect without major delays any failings in program implementation in the field. It is to meet this functional concern that the population division changed its methodology for collecting, analyzing, and processing service statistics.

1. Data Collection

Codification Scheme for Sanitary Facilities

To insure exhaustive collection of statistical data, the ONPFP initiated a comprehensive census of all health facilities in the country, and a codification system for these facilities was established. The code for each center includes two digits for administrative location (governorate and delegation code), two digits for center category (rural dispensary, hospital, etc.) and a third two-digit set for family planning services (fixed center, CREPF, centers visited by mobile team). This census has enabled the ONPFP to determine, region by region, the proportion and the number of centers covered by family planning services according to center category, thus enabling the Direction Générale to extend coverage in certain governorates. The center code is an easily updated dynamic system, allowing for the monthly study of each center's activity.

Improvement of Collection Forms

The activity book and the statistics form, formerly separated, have been merged into a single document which facilitates the task of recording data for personnel responsible. In particular, the statistics form has now been redesigned to facilitate its processing. The summary statement, a document used by regional services to summarize the activities of each center, was simplified to facilitate work at the regional level and attenuate error risks. Also, the monthly mobile team and clinic records were improved. These allow for better supervision of mobile team activity according to clinical time

and distances covered daily; this should optimize their efficiency by adapting their itinerary to regional and local requirements.

2. Data Processing

Processing of documents used by the ONPFP was facilitated by the acquisition of a micro-computer in July, 1982. Initially meant for a small project, this computer was used to its maximum capacity for the needs of the population division and, within a relatively short period, it proved insufficient to meet the needs of management.

The utilization of this computer has given flexibility to the coding system and for updating codes, taking into consideration new center creations or terminations, new administrative divisions in the country and changes in the center category. A computer program was developed to produce a comprehensive list of health facilities every 3 or 4 months. Furthermore, this program contains a module which shows center distribution according to type, category, and governorate.

The recording of the summary statement, sent by the regions and controlled by the population division, allows for the monthly production of an index including all centers scheduled for that month. This index delivers monthly results in table form by governorate, delegation, and center type: fixed centers, mobile team or clinic, and CREPF. These tables also show activity increments from the beginning of the year and similar results from the previous year. Monthly data for each governorate are stored in simple indices to be used for comparing two different years and tracking the monthly evolution of each item. Based on this monthly index of center activity, it is possible to obtain center distributions by method and by governorate. Thus, it is easy to know the proportion and number of centers, for each governorate which have been visited by more than 4 and fewer than 9 women or, for example, the proportion of centers where there have been no IUD insertions or new pill acceptors. Such tables constitute the primary elements which permit a better knowledge of center efficiency; this approach will be strengthened in the future to optimize output. Mobile teams, center followup and detection of failures constitute another focus in this management approach.

Processing the Statistics Form

Processing of the statistics form yields information on program qualitative evolution. A new acceptor profile is indeed a good indicator of this evolution. The statistics form includes the following information: age, marriage duration, number of

children, delegation of residence, time since last pregnancy, and new or old acceptor status. The processing of this form is not exhaustive, but is carried out on a stratified sampling basis according to the contraceptive method. The 1984 data will be used for comparison with available results (cf. Revue Tunisienne des Etudes de Population No. 1) from the 1976-77 period.

Utilization of the mobile clinic and mobile team records allows for constant followup of their activity. A form is used by each team or clinic. The form includes monthly results achieved by the team or clinic in relation to other parameters such as distance and clinical time.

The population division is now developing a program to follow up activities on a monthly basis through an indicator system. The main indicator used at present is the protection rate (calculated on the basis of service statistics using constantly adjusted rates). These are used as tendency rather than level indicators. At present, this rate is available for each governorate at the end of each month.

3. Information Dissemination

All tables are generally ready by the end of the month which follows service delivery and are immediately sent to the Direction Générale which insures distribution to regional delegations and other divisions. Some of these tables are used during periodic meetings of regional secretaries. These meetings were initiated in 1983 to exchange views on statistics between the population division and regional secretaries. They can, in a way, be considered a continuing education for this category of personnel. During these meetings, data collection problems in the field are discussed and group decisions are made.

Evaluation efforts should be continued to cover other aspects of the program: training, information education, and communication activities. Attempts have been made in this area but are insufficient in comparison with the magnitude of the task.

Recommendations

During the last few years, the Population Division has focused on the task of reinforcing its capability in order to meet the needs of the ONPFP in this particular aspect of the program. The evaluation team gives the following recommendations to the ONPFP:

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

-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. (Medium-term)

-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. (Short-term)

-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. (Short-term)

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

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

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

-Computer capacity should be reinforced and adequate training should be provided to staff. (Medium-term)

-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. (Short-term)

4. Statistical Findings

Since 1979, results have progressed, particularly for tubal ligations and IUD's; with regard to the pill, the number of new public sector acceptors is declining whereas the number of cycles distributed by the private sector is constantly rising. Thus, the number of tubal ligations rose from 8,141 in 1979 to 9,564 in 1982 and to 9,319 in 1983, with a 14.5% increase in comparison to 1979. This progress is not, however, the same in all regions of Tunisia: in certain regions such as Bizerte, Beja, Jendouba, Sfax, and Mahdia the figure decreases from one

TABLE 10: Evolution of tubal ligation acceptance, 1979 - 1983

Governorate	1979	1980	1981	1982	1983	Percentage 1983 variation compared with 1979	1980	1981	1982
Tunis	2086	2306	2478	2706	2720	+ 30.39	+ 17.95	+ 9.76	+ 0.51
Zaghouan									
Bizerte	1101	902	874	825	785	- 28.71	- 12.98	-10.19	- 4.85
Beja	966	927	925	921	827	- 14.33	- 10.79	-10.60	- 10.21
Jendouba	412	396	357	291	257	- 37.63	- 35.11	-28.02	- 11.69
Le Kef	722	553	344	327	352	- 51.25	- 36.35	+ 2.32	+ 7.64
Siliana	-	18	311	344	364	-	+100	+17.04	+ 5.81
Kasserine	234	42	154	118	128	- 45.30	+100	-16.88	+ 8.47
Sidi Bouzid	-	-	49	320	213	-	-	+100	- 33.43
Gafsa	91	73	27	44	151	+ 65.93	+100	+100	+243.20
Tozeur	-	-	15	21	70	-	-	+100	+233.30
Medenine	79	67	175	155	143	+ 81.01	+100	-18.28	- 7.74
Tataouine									
Gabès	302	200	269	284	305	+ 0.99	+ 52.50	+13.38	+ 7.39
Kebili									
Sfax	832	1046	745	851	754	- 9.37	- 27.91	+ 1.20	- 11.39
Kairouan	273	272	393	855	750	+200	+100	+90.83	- 12.28
Mahdia	341	408	330	313	232	- 31.96	- 43.13	-29.69	- 25.87
Monastir	142	269	227	245	271	+ 90.84	+ 0.74	+19.38	+ 10.61
Sousse	305	448	470	341	456	+ 52.45	+ 1.78	- 2.97	+ 33.72
Nabeul	255	533	576	603	534	+100	+ 0.18	- 7.29	- 11.44
Tunisia	8141	8460	8719	9564	9319	+ 14.46	+ 10.15	+ 6.88	- 2.56

TABLE 11: Evolution of IUD acceptance, 1979 - 1983

Governorate	1979	1980	1981	1982	1983	Percentage 1983 variation compared with 1979	1980	1981	1982
Tunis	6472	7834	10211	10668	10999	+ 69.94	+ 40.40	+ 7.71	+ 3.10
Zaghouan	349	482	738	485	658	+ 88.53	+ 36.51	- 10.84	+ 35.67
Bizerte	2108	2150	2473	2226	2271	+ 7.73	+ 5.62	- 8.16	+ 2.02
Beja	1227	1697	1951	1839	1830	+ 49.14	+ 7.83	- 6.20	- 0.49
Jendouba	919	946	1908	1612	2193	+100	+100	+ 14.93	+ 36.04
Kef	1591	1360	1901	1727	1832	+ 15.14	+ 34.70	- 3.63	+ 6.07
Siliana	648	799	1455	1681	1861	+100	+100	+ 27.90	+ 10.70
Kasserine	995	1239	1275	1367	1422	+ 42.91	+ 14.76	+ 11.52	+ 4.02
Sidi Bouzid	228	464	1185	1332	1927	+645.70	+100	+ 62.61	+ 44.66
Gafsa	1147	1032	834	908	1010	- 11.94	- 2.13	+ 21.10	+ 11.23
Tozeur	-	-	612	601	768			+ 25.49	+ 27.78
Medenine	600	759	870	1023	1211	+100	+ 59.55	+ 39.19	+ 18.37
Tataounine	-	-	39	263	233			+100	- 11.40
Gabès	597	827	823	884	1018	+ 70.51	+ 23.09	+ 23.69	+ 15.15
Kebili	-	-	-	29	88				+100
Sfax	1923	3442	4007	3553	3809	+ 98.07	+ 10.66	- 4.94	+ 7.20
Kairouan	476	495	1640	1676	1665	+249.80	+100	+ 1.52	- 0.65
Mahdia	701	1065	1129	1138	936	+ 36.37	- 10.23	- 15.32	- 15.99
Monastir	1244	1729	1946	1836	1968	+ 58.19	+ 13.82	+ 1.13	+ 7.18
Sousse	2585	3141	3404	3372	3339	+ 29.16	+ 6.30	- 1.91	- 0.97
Nabeul	1945	2331	2199	2180	2181	+ 12.13	- 6.43	- 0.81	+ 0.04
Tunisia	25755	31792	40597	40400	43239	+ 67.88	+ 36	+ 6.50	+ 7.02

TABLE 12: Evolution of pill acceptance, 1979 - 1983

Governorate	1979	1980	1981	1982	1983	Percentage 1983 variation compared with			
						1979	1980	1981	1982
Tunis	3888	3665	3290	3507	2985	- 23.22	- 18.55	- 9.27	- 14.88
Zaghouan	455	452	436	320	270	- 40.66	- 40.26	- 38.07	- 15.62
Bizerte	1452	1305	1133	1189	1389	- 4.33	+ 6.43	+ 22.59	+ 16.82
Beja	507	493	436	379	403	- 20.51	- 18.25	- 7.56	+ 6.33
Jendouba	1635	1541	1126	1316	1527	- 6.60	- 0.90	+ 35.61	+ 16.03
Le Kef	1383	1089	1253	816	713	- 48.44	- 34.52	- 43.09	- 12.62
Siliana	1164	935	966	763	741	- 36.34	- 20.74	- 23.29	- 2.88
Kasserine	1594	1301	1156	920	673	- 57.78	- 48.27	- 41.78	- 26.84
Sidi Bouzid	604	498	718	524	502	- 16.88	+ 0.80	- 30.08	- 4.19
Gafsa	2530	2568	1961	1661	1008	- 60.15	- 60.74	- 48.59	- 39.31
Tozeur			492	540	622			+ 26.42	+ 15.18
Medenine	1216	853	968	1156	1538	+ 26.48	+ 80.30	+ 58.88	+ 33.04
Tataouine			51	336	509			+100	+ 51.48
Gabès	1681	1711	1711	829	831	- 50.56	- 51.43	- 51.43	+ 0.24
Kebili				365	209				- 42.74
Sfax	968	879	739	705	699	- 27.79	- 20.47	- 5.41	- 0.85
Kairouan	661	880	392	259	235	- 64.44	- 73.29	- 40.05	- 9.26
Mahdia	880	761	882	683	566	- 35.68	- 25.62	- 35.82	- 17.13
Monastir	10[illegible]1	1016	1003	1058	1357	+ 26.70	+ 33.56	+ 35.29	+287.26
Sousse	[illegible]92	771	571	545	557	- 28.77	- 27.75	- 2.45	+ 2.20
Nabeul	1137	1050	853	836	739	- 35	- 29.62	- 13.36	- 11.60
Tunisia	23608	21768	20137	18707	18073	- 23.44	- 16.97	- 10.25	- 3.39

VI. SURVEYS AND RESEARCH

Surveys and research have been important parts of the family planning program for many years. During the past 2 1/2 years the ONPFP has attempted to streamline the work of its Population Division, and orient current and new activities toward the goal of providing program managers, including especially the P.D.G., division directors, and délégués, with information that is directly relevant to better understanding of the program and how it might be improved. We encourage a continuation of this orientation.

1. Surveys

At the beginning of the current five-year program, the Population Division had on its agenda several surveys in various stages of completion (or non-completion, especially with respect to analysis and report writing). The longest of these was the Tunisian Fertility Survey (ETF), part of the WFS program, and the others including surveys of continuation rates and abortion. Staff from an intermediary organization (Population Council) recommended that some of these existing projects be dropped, on the grounds that their poor sample completion rates (e.g. only half of the sample reached for interview) would make the results unreliable. A few comments on each of the others and on new surveys are presented below.

1.1 Tunisian Fertility Survey (1978)

The 2-volume report on this major study was completed in 1983, and distributed internationally as well as in Tunisia. Division staff collaborated with WFS staff, and the computer tabulations were prepared in London. Much secondary analysis could be carried out with the data from ETF, and some Division staff would like to do so. However, given the many needs for information more directly relevant to current program management, it seems appropriate to encourage other researchers in Tunisia to further analyze ETF data. Thus, the ONPFP could encourage greater use of this survey by making the tape available, and perhaps by commissioning specific studies. In addition, the ONPFP could achieve greater use of this important body of data by allowing the international research community access to the data tape, perhaps on the condition that a Tunisian scholar be involved in any given secondary analysis study. It should not be too difficult for non-Tunisian researchers to find appropriate Tunisian scholars with whom to collaborate.

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1.2 Contraceptive Prevalence Study (1983)

The initial results from this important study were discussed above. The study has been carried out with assistance from Westinghouse Health Systems, Inc. Because of the data inconsistencies noted earlier, particular attention to the CPS data quality will be necessary in the forthcoming analysis. This is particularly important because periodic national prevalence studies, possibly every three years, would be a very useful evaluation tool for the ONPFP and the Tunisian Government.

1.3 Rural Survey (1982)

This study was initiated to provide baseline information for the Accelerated Rural Project. It has also served as a baseline for the establishment of mobile clinic itineraries, particularly through mapping work, and has helped animatrices to become familiar with field conditons. These animatrices were used as interviewers during the survey. Unfortunately, included in the survey data is information relative to ineligible women, thus jeopardising the quality of the survey's scientific standards. Another methodological error is related to the desire to obtain detailed information for each of the 22 delegations of the project area, in order to measure changes in each one of them. The very small size of the sampling prevented this envisioned analysis. Thus, many of the comparisons made in this report may mislead readers who are not familiar with problems caused by results based on very small samples. Moreover, even technical readers of this report are not provided with the basic sample-size information that would help them interpret the findings. (The report notes that sample details are available in Annex II, but Annex II is not part of the report.) In addition, a presumed scientific report of this type should include a table showing confidence intervals, e.g., two standard errors on either side of estimates for percentages and means, as used in other Population Division work such as the ETF report.

1.4 Urban Contraception Studies (1982-1984)

Initiated in Tunis, followed by survey in Sousse and Sfax, these studies attempt to compare the characteristics and behavior of different groups, such as couples who turn to the private sector for contraceptive supplies and services, with those who turn to the public sector. Some of the findings are very interesting and useful for program planning; also, in addition to reaching Tunisian audiences with the report(s) on this work, probably these would interest many readers of international population literature, such as readers of Studies in Family Planning. This set of studies will continue in 1984 with surveys in Bizerte and Nabeul.

1.5 Voluntary Female Sterilization Study

This new study is part of a six-country comparative project organized by IPAVS, but its principal purpose in Tunisia is to provide information for program improvement. The study is currently underway.

1.6 Other surveys

The Divison plans to initiate in 1984 a study of family planning acceptance in the postpartum period, and the Division will collaborate with the MOPH, INS, and the Institute de l'Enfance on an infant mortality study. The Division also plans to carry out a study of the effectiveness of the mobile teams, an activity probably best carried out on a short-term management evaluation basis (using field trips and on-the-spot examination of mobile team operations), rather than by means of a survey.

Also on the Division calendar for 1984 is a multi-round survey on the qualitative aspects of family planning service delivery mechanisms. A related objective would be to measure the underregistration of vital events. Unfortunately, team members were able only to initiate a discussion of appropriate study design, and what is and is not possible. Therefore, we can only suggest that although the goal of analyzing the qualitative aspects of family planning service delivery mechanisms is excellent, the planning and implementation of this study will require much care if the results are to be useful for program managers. The same comments apply to the Division's planned survey on the role of family planning centers in the communities in which they are located.

1.7 Conclusion

During the past 2 1/2 years, the Population Division has increasingly provided information and analyses that are directly relevant for program management. This is a good trend, and the most important and directly useful improvements have been in the area of program statistics collection, tabulation, and feedback. The Division should be particularly complimented for its progress in the service statistics area: the PDG and other program managers now have much more information about program results; the current work on estimating prevalence trends from routine statistics will add to these management tools. An important aspect of this progress is the Division's very effective use of the micro-computer obtained from IFRP (now FHI) in 1982. In sum, the Division appears to have an excellent grasp of its role, day-to-day processes, and reporting mechanisms for program statistics.

On the other hand, underlying scientific principles and procedures are not routinely used in the more difficult areas of sample surveys and research generation studies. We have listed in Annex 3 basic research methodology principles that merit more attention in Division work.

2. Operations Research

Starting in 1980-81, the ONPFP adopted operations research as a tool for rapid and efficient investigations and to resolve, within a relatively short time, problems encountered at the field level. This type of research has taken three forms:

- field visits
- mini site surveys
- utilization of statistical data

As of 1981 field visits had become a current practice at ONPFP. These visits are made at the request of regional délégués to help resolve certain problems that might arise during implementation of activities, and at the request of the ONPFP general management which, on the basis of statistics received from the regions, might call for a visit to a particular area. The visits are carried out by teams usually composed of three persons from each of the ONPFP main divisions (Population, Medical and Communication) and a representative of the rural program unit. The evaluation, the planning and the establishment of itineraries for family planning mobile teams and clinics constitute the bulk of this activity. Thus in 1983 an operations research activity was conducted prior to the introduction of mobile clinic services. The team in charge of this research visited each of the target areas, selected the meeting points for the clinic and established itineraries as a function of distances and population distribution. Other operations research was conducted for evaluation purposes and to readjust activities.

In addition the decision to create a family planning consultation or its cancellation and replacement by a mobile team is subject to a brief study by a multidisciplinary team which includes the regional délégué.

Other types of operations research have been conducted to evaluate the educational program of animatrices and social workers and to measure the degree of their motivation. As an example, in the region of Mahdia and Monastir a mini-survey is presently being carried out to evaluate the social workers inputs in the family planning program. This will be achieved

TABLE 13: Secondary Methods, by governorate, 1979 - 1983

Governorate	1979	1980	1981	1982	1983	Percentage 1983 variation compared with			
						1979	1980	1981	1982
Tunis	2384	2711	1899	1923	1769	- 25.79	- 34.74	- 6.84	- 8
Zaghouan	492	516	574	330	662	+ 34.55	+ 49.22	+ 15.33	+100
Bizerte	783	840	857	330	604	- 22.86	- 28.09	- 29.52	+ 83.03
Beja	135	78	103	82	165	+ 22.22	+100	+ 60.19	+100
Jendouba	609	467	440	357	557	- 8.58	+ 19.27	+ 26.59	+ 56.02
Le Kef	76	75	178	66	48	- 36.84	- 36	- 73.03	- 27.27
Siliana	25	84	100	64	136	+112.50	+ 61.90	+ 36	+100
Kasserine	144	279	207	115	451	+292	+ 61.64	+100	+100
Sidi Bouzid	305	547	490	267	334	+ 9.50	- 38.94	- 31.83	+ 25.09
Gafsa	731	789	452	410	631	- 13.68	- 20.02	+ 39.60	+ 53.90
Tozeur			125	112	162			+ 29.60	+ 44.64
Medenine	1323	1323	1417	954	717	- 45.80	- 45.80	- 49.40	- 24.84
Tataouine			3	129	689			+100	+434.10
Gabès	1222	1358	1402	774	1664	+ 26.17	+ 22.53	+ 18.68	+115
Kebili				102	130				+ 27.45
Sfax	3312	3171	3351	2533	3523	+ 6.37	+ 11.10	+ 5.13	+ 39.08
Kairouan	406	483	135	55	138	- 66.01	- 71.42	+ 2.22	+100
Mahdia	273	490	552	481	542	+ 98.53	+ 10.61	- 1.81	+ 12.68
Monastir	943	1022	950	830	967	+ 2.54	- 5.38	+ 1.78	+ 16.50
Sousse	584	589	700	533	604	+ 3.42	+ 2.54	- 13.71	+ 13.32
Nabeul	1431	1633	1727	1153	1634	+ 14.18	+ 0.06	- 5.38	+ 41.71
Tunisia	15178	16455	15662	11600	16127	+ 6.25	- 1.99	+ 2.96	+ 39.02

through the analysis of liaison forms and statistical records which will help identify those women referred by social workers and their socio-economic characteristics. This mini-survey should also provide information on the proportion of women referred to ONPFP centers who fail to show up, and help determine the causes of these failures. Another example is the study of voluntary sterilization potential acceptors. This study provides a comparison between the number of "decided" tubal ligations and those actually performed. It has been conducted in the governorates of Beja and Gafsa. Results indicate that only 55% of the total decided tubal ligations had been carried out. The findings of this study have been reviewed with the regional délégués and measures were taken to reinforce follow-up of women who have chosen tubal ligation.

The new system of follow-up forms now being utilized by the animatrices will open new possibilities for operations research particularly in the IEC field in both urban and rural areas.

Operations research constitutes a necessary complement to the evaluation system of the ONPFP and creates occasions for added cooperation and coordination between the various departments of the ONPFP. It is also an excellent tool to meet the needs of the ONPFP in the areas of:

- service delivery and the improvement of service quality;
- follow-up of acceptors;
- cost effectiveness and efficiency of mobile teams and clinics;
- animatrices'IEC activities;
- evaluation of specific IEC interventions;
- rational and optimal use of human resources; and,
- evaluation of training needs.

3. Biomedical Research

The Center for Studies and Research on Human Reproduction is located in the Ariana clinic. During the last 5 to 6 years and with the assistance of the World Health Organization, the Center's Director has built up a research team including 1 professor, 2 biochemists, 1 pharmacist, 1 radio-immunologist, 3 senior laboratory technicians and one midwife. This team has

now acquired the methodological and technical knowledge necessary to undertake activities with maximum efficiency. Various studies on contraception and human reproduction were and still are undertaken by the Center, such as: progesterone vaginal loops, injectables, motivation and resistance to contraception (doctoral thesis), establishment of Tunisian norms for reproduction phases, metabolic effect of hormonal contraceptives on insulin receivers, etc.

Within the framework of WHO international research, a study on injectable contraceptives - Enanthale Nonethendrone - is nearing completion. This study was conducted in collaboration with the ONPFP which developed instruction manuals, supervised the study on site, and provided assistance through its own facilities and personnel. About 1,000 women participated in the survey and were followed for 1 year. Data analysis is anticipated for 1985, in Geneva.

This survey led to the publication in opposition papers of articles highly critical of this contraceptive method. Due to the Director's efforts (workshops and information round tables) the medical community, specifically gynaecologists, who were initially reluctant, are now convinced that this method is efficient and innocuous. In the light of findings, MOPH will have to make a decision whether or not to introduce injectable contraceptives in Tunisia.

The Center is soon to conduct a survey on Norplant. The Director has already informed around thirty gynaecologists, general practitioners and midwives about this study. During the evaluation, the evaluation team took part in a round table on this type of contraception held in Sfax and attended by 20 physicians and 40-50 midwives. The survey is expected to cover 2,000 to 3,000 women and to last 2-3 years. It will be conducted by physicians and will be simultaneously carried out in both urban and rural areas. Ultimately, if Norplant is approved in Tunisia, medical personnel including nurses could be trained to safely deliver this method.

It should be noted that the ONPFP Population Division has cooperated with the Ariana Center in some of the above mentioned research work. It has also provided assistance in the development of a questionnaire and data analysis method for a survey on puberty. This cooperation is expected to expand further in the forthcoming years, particularly in the field of data analysis.

The main issues facing the Center for Studies and Research on Human Reproduction are:

-Maintenance of equipment, as failures could stop continuation of research for several weeks,

-Space limitations which hamper the expansion of Center activities (e.g. genetic research).

4. Research on Population

There is a need for additional serious scientific research on population topics in Tunisia. The country has experienced several major social changes since Independence, such as an increasingly educated population, currency devaluation, external migration and now return migration, and changing values about family formation (later marriages, fewer children, etc.). In addition to the usefulness of increased knowledge in these areas for the overall development of the country, research on population topics could have a more direct effect on the activities of the ONPFP, both in the direct family planning work and in the proposed new work on population and development relationships. Therefore, it is appropriate that the Population Division carry out or at least participate in population research studies. This work can make use of the increasing number of data sets available in recent years, most notably the ETF, and EPE, and the 1984 census, but there may also be studies that require new data collection.

However, a severe personnel constraint exists. Research studies require the time of qualified staff for conceptualization, computer work, analysis, and report writing. (Haphazard research of any type is useless.) But the number of staff in the Division is limited, and the important tasks regarding program statistics, special projects, and surveys require large, if not complete, proportions of the time of Division staff. Thus, while recognizing the importance of population research of the type described, the team realizes that adding projects of this type would detract from the important tasks of helping program managers understand and improve the ONPFP programs.

As the current work of the Division becomes more routine, especially the processing and tabulation of program statistics and prevalence estimates, it may be possible to reorient some of the human resources in the Division toward research on population, especially topics on the relationships between population and development. A question will be raised about the appropriate division of time between family planning program managment and population research activities. How much Divison time should be devoted to population research? We can only suggest that the ONPFP recognize the importance of population

research, try to fit it into the existing work program, but assure that necessary existing Division activities are not compromised.

Recommendations

-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). (Short-term)

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

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

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

VII. TRAINING

1. Basic Training

Medical schools give little space to family planning in their curricula both from the viewpoint of time allocated (5 hours for medical students and 10 hours for mid-wives in three years of study) and in its approach, focusing on the study of contraceptive methods within the obstetrics and gynaecology classes.

The three schools have about 2,600 medical students enrolled and 280 mid-wifery students (Tunis: medical 1,300 - 1,400, midwives 100; Sousse: medical 699, midwives 9; Sfax: medical 531, midwives 90). Approximately 80 to 85% of medical students will work either in MOPH services or as private physicians. It is true that some of them attend training workshops and information events in family planning organized by the ONPFP after their

graduation from university; but their gathering in the three schools* offers an excellent opportunity to train and make these future doctors conscious of the multiple facets of family planning: medical, sociological, and even demographic and economic. Contacts between the ONPFP and the heads of the obstetrics and gynaecology departments and medical school professors have often allowed for calling on academic resources to train and/or retrain medical and paramedical personnel at both central and local levels. Very recently, these ties were reinforced and the ONPFP and the head of the obstetrics and gynaecology departments agreed to establish a 10 day specialized family planning training program each month for 5th year students in Tunis and 10 days every two months for the Sousse and Sfax students. Each session involves 10 students. Attendance at this training is on a voluntary basis and the teaching is provided by medical school professors, Ariana Clinic physicians and ONPFP personnel. UNFPA will fund this activity until late 1984. With the establishment of this program, dialogue and collaboration with the academic community were considerably widened and the introduction of family planning in medical curricula was enhanced.

To alleviate the present shortage of midwives, the MOPH is considering the creation of a new cadre of personnel called obstetrical nurses. Their training--initiated a year ago in Gafsa--would be in the regional nursing schools. The midwives, being university graduates, rarely accept appointments in rural areas, particularly in mobile units. The new program could be operational in September 1984 in 10 to 15 nursing schools with an initial recruitment of about 15 students per school. The syllabus for this training has not been definitively decided upon but it seems that it will be centered on obstetrics and family planning.

Recommendations:

-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

*A fourth school in Monastir provides medical teaching up to the fourth year.

representatives from the ONPFP, the MOPH and the Ministry of Higher Education and Scientific Research could study aspects of this issue. (Long-term)

-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. (Medium-term)

-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. (Medium-term)

2. Continuing Education

2.1 Objectives and Training Tools.

Since 1979 the Training Center has developed, scheduled, organized, and coordinated all training activities. The Center is headed by a part-time Director seconded by a physician and managed by an Administrator with two typist secretaries. Until 1981, training was seen as a necessary addition to the acquisition of knowledge without addressing specifically identified needs. From 1982 onwards, the Center revised its training policy adopting a cycle of diagnosis, scheduling, training, and evaluation. It aims at solving problems and meeting regional characteristics and needs expresssed by the personnel.

In order to implement this new policy and to decentralize training, a "Training for Trainers" cycle was organized for ONPFP regional personnel (délégués, supervising midwives, secretaries) with INTRAH technical assistance.

The cycle of workshops which took place in 82-83 dealt with the following topics:

-IEC (techniques and methods);
-diagnosis, scheduling;
-training methodology;
-curriculum design;
-audio/visual support; and,
-evaluation.

These workshops were instrumental in the creation of a service for training support instruments including:

-training curricula for field midwives for promotion of family planning;
-training curricula for field social workers for promotion of family planning; and,
-methodogical and pedagogical instruments.

In addition, a set of eleven forms was developed by the Training Center with the collaboration of all ONPFP Divisions. These aim at orienting the lecturer in evaluating knowledge acquisition, training quality and performance of personnel after training. Very recently made available to the regions, these forms will provide an improved understanding of the variables and parameters which affect outcomes of regional activities.

2.2 Training Activity.

Training activities are decentralized in terms of scheduling and implementation; they are coordinated by the Training Center. Following is a summary of categories and numbers of personnel trained in 81, 82, and 83.

International Training.

In 1983:

-3 training sessions in laparascopy for 58 Tunisian and foreign gynaecologists and surgeons; and,

- 1 session for Tunisian and foreign nurses.

In 1982:

-2 training sessions in laparascopy for 28 Tunisian and foreign gynaecologists and surgeons;

-2 sessions for Tunisian and foreign anaesthesiologist technicians

-2 family planning training sessions for 24 Tunisian and foreign midwives; and,

-2 training sessions in operating room care for 22 Tunisian and foreign nurses.

In 1983:

-3 training sessions in laparascopy for 39 Tunisian and foreign gynaecologists;

-1 family planning training session for 17 Tunisian and foreign general practitioners;

-1 sensitizing session on conscious sedation techniques for 11 Tunisian and foreign anaesthesiologists

-2 family planning training sessions for 34 Tunisian and foreign specialized nurses and midwives;

-1 training session in operating room care and equipment maintenance for 21 Tunisian and foreign nurses; and,

-1 training session for a 12 person Zairian team concerning the creation of a family planning project in a rural context.

National Training

a) Training Activities by the Training Center.

In 1981:

-6 refresher courses for 68 midwives;

-3 workshops for 55 social workers;

-8 refresher courses for 158 social workers;

-2 workshops for 70 UNFT staff; and,

-1 course cycle for the personnel of a MCH center.

In 1982:

-1 session for medical services;

-2 sessions for 23 newly graduated midwives;

-1 session for 4 social workers in the Tunis Clinic;

-1 session for 10 field midwives;

-1 session for 20 Tunis social workers;

-1 session for 41 rural animatrices; and,

-6 sessions for 129 office regional staff.

In 1983:

-2 sessions for 33 newly graduated midwives; and,

-1 training session for 45 ONPFP social animatrices and educators.

b) Regional Activities.

In 1981:

-16 refresher courses for 36 paramedical personnel;

-7 MCH/Family Planning workshops involving 405 participants;

-7 refresher courses for 139 social workers;

-3 refresher courses and workshops for 125 medical staff;

-3 ongoing training cycles for 89 CREPF personnel; and,

-2 workshops for staff from 45 national organizations.

In 1982:

-1 workshop for 29 Sidi Bou Zid physicians and midwives;

-1 workshop for 70 MCH/Family Planning midwives;

-1 workshop for 70 pharmacists;

-1 medical event for 70 private physicians in Sfax;

-1 round table for 40 Bizerte physicians; and,

-1 training refresher course for 25 doctors heading basic health services.

In 1983:

-2 training sessions for 52 newly graduated midwives from Sousse and Sfax; and,

-1 training event for 90 physicians and midwives from Nabeul, Bizerte, and Zaghouan.

c) Other Types of Training.

Given the lack of personnel and resources available in each governorate, certain continuing education workshops were organized at the interregional level with participation of technical personnel from the ONPFP. In addition to scheduled training activities, individual training efforts are undertaken

at the regional level when, for example, a midwife or a gynaecologist is appointed (e.g., training in IUD insertion and in laparascopy).

As part of the INTRAH program, 470 persons will be trained during 1984 in 37 workshops. A workshop for the evaluation of family planning training programs was held in January for 20 ONPFP staff members (central and regional) with INTRAH technical assistance. No other workshops were scheduled until the month of May when the new instruments (evaluation form and training curricula for hygenist-nurses and social educators) were developed and became available. A 3-day workshop then took place in May for 20 hygienist and basic nurses in Monastir. During this workshop, problems concerning per diem were raised; the rate was insufficient to cover participant expenditures and caused delay in program initiation. A re-scheduling effort was undertaken to hold all other sessions, initially scheduled for May, in June and July.

The JHPIEGO program for 1984 is summarized in Table 14. The JHPIEGO schedule is being carried out as programmed.

2.3 Conclusion

It is doubtless that efforts to train ONPFP personnel during the last two years have been fruitful. At present, ONPFP personnel at both central and regional levels have acquired a methodology and a work spirit which meet INTRAH objectives, that is to say: improvement of ONPFP personnel capacities in identifying, scheduling, implementing, and evaluating all activities. Furthermore, the development of various training instruments (curricula, modules, pedagogical forms, etc.) has permitted improvement of the quality and specificity in training. Finally, evaluation instruments will, in the near future, allow for the ongoing readjustment of the training policy formulation and the development of training strategies increasingly adapted to field problems and situations. With the decentralization of training, however, problems were raised concerning preparation, organization, management, and coordination which the central office, with its limited resources, cannot face easily. Problems related to the management of a decentralized policy for continuing training deserve careful study to insure success for this new strategy.

Recommendations:

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

TABLE 14: ONPFP/JHPIEGO Cooperation Program
Course schedule: 1984

No.	Category	Period	Participants Tunisian	Participants Foreign	Dates
1.	Resident physicians	3 weeks	10	5	March 5-23, 1984
2.	Anaesthetist technicians	2 weeks	10	5	April 10-21, 1984
3.	Midwives	3 weeks	8	7	May 7-26, 1984
4.	Anaesthesiologist technicians	2 weeks	10	5	July 9-21, 1984
5.	General practitioners	3 weeks	10	5	Sept. 10-29, 1984
6.	Resident physicians	3 weeks	10	5	Oct. 22 - Nov. 10, 1984
7.	Midwives	3 weeks	8	7	November 12-30, 1984

-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. (Short-term)

-The production of audio-visual support materials should be reinforced. (Short-term)

-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. (Short-term)

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

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

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

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

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

VIII. INFORMATION, EDUCATION, COMMUNICATION (IEC)

The Tunisian experience in family planning has always placed substantial emphasis on information and education. During the seventies, activities undertaken aimed mainly at informing the population about family planning matters and raising awareness of demographic issues and their impact on the family and on the economic and social development of the country. This strategy, which relied mainly on mass information and motivation and education campaigns had positive results as far as knowledge and, to a lesser degree, the practices of family planning are concerned. The 1983 prevalence survey undertaken in collaboration with Westinghouse Health Systems to measure contraceptive method prevalence in Tunisia showed that 90% of target women know about the existence of modern contraception methods.

Given this favorable evolution of the knowledge of the Tunisian population about family planning, the ONPFP based its action early in the 1980's mainly on interpersonal communication which responds better to the specific information needs of the couple, and on group education aimed at audiences belonging to a professional, social, or cultural segment of the population. Moreover, the ONPFP continued its information activities through the mass media and print materials, and, in 1983, encouraged the development of information events conceived for specific objectives and using several information methods (public meetings, film shows, home visits, posters, etc.)

1. Interpersonal Communication.

In its 1983-84 workplan, the ONPFP gave priority to interpersonal communication. This activity started within the framework of a special project for rural areas carried out in collaboration with the Population Council. Given the highly positive results of this project, the ONPFP undertook a similar action in peri-urban areas where originally rural squatter settlements had developed. This activity is now expected to be progressively expanded to all regions in the country. This program is carried out by the ONPFP animatrices who, through their visits to homes and to health facilities, have direct access to married women of reproductive age (MWRA) to discuss with them their personal attitudes toward contraception and advise them to adopt a family planning method. It should be noted that the ONPFP animatrices are often supported by the socio-educational personnel of the Ministry of Social Affairs and non-governmental organizations such as UNFT and ATPF. Local authorities also collaborate in the organization and implementation of this effort. Thus 28,000 individual contacts were made in homes in 1981. This number rose to 56,000 in 1981 and 97,000 in 1982.

Expansion of the rural family planning communication program to all regions is restrained in the short term by a lack of human resources. In order to circumvent this situation, the ONPFP considers further rationalizing the animatrice work to optimize their performance and initiate increased participation on the part of socio-educational personnel working under other institutions and ministries.

2. Group Education

With group education, the ONPFP aims at reinforcing a socio-political environment favorable to family planning, at strengthening cooperative relationships with its partners, and at insuring a more efficient participation of economic and socio-cultural organization to family planning activities. This action is directed towards the following target groups:

-socio-political staff of the various regional and local organizations of the PSD, UGTT, UTICA, and UNA (respectively, party, union, business, and agriculture organizations);

-local administration and community staff; agricultural youth, cultural services, municipal agents;

-influential individuals in various circles: omdas, imams, matrons;

-young people attending training centers and youth clubs;

-workers in industrial and agricultural firms (directly and in collaboration with occupational health and agricultural staff);

-regional Office staff: midwives and animatrices;

-medical staff: MOPH doctors, private physicians;

-MOPH paramedical staff: MCH nurses, dispensary nurses (specifically rural), hygienist nurses; and,

-social staff from Social Affairs, UNFT, ATPF.

Activity planning is undertaken quarterly and in accordance with priorities by ONPFP regional staff in cooperation with personnel from the Communication Division. The activities which include meetings accompanied by film shows, small workshops and education sessions, group panels etc. are generally implemented by the CREPF staff with only limited technical inputs from central level personnel.

Some of the difficulties and problems identified by the regional staff are related to insufficient backstopping on the part of the central staff in the organization and execution of the program; the limited availability of qualified lecturers, panelists and other trained IEC personnel at the local level; and, the inadequate quantity and quality of didactic and audio-visual support material. Audio-visual equipment is available in sufficient quantity and does not seem to raise any problem. Aware of these difficulties through periodic meetings with the region's délégués, the ONPFP envisions conducting an in-depth evaluation of each component of this program in order to introduce necessary improvements.

3. Mass Media Information

The ONPFP continues to encourage the use of mass media. Radio, television and newspapers at both national and regional levels are widely used. Although from the quantitative point of view programs have evolved very little, the ONPFP centered its efforts during the last few years on improving existing production. Thus, the four weekly programs broadcast by the various channels of Tunisian radio have been restructured to make them more effective.

Concerning message conceptualization, the content of these programs has been enriched. They are now designed to interest the rural population who, as a general rule, have no other means of information. Medical advice, information on the various methods, and family planning concepts are included in these programs; specialists (physicians, midwives) as well as the population itself participate.

With respect to television, activities are still below capacity. Programs are not regular and they are frequently too medical, with the exception of extracts from President Bourguiba's speeches on family planning and indirect messages included in social programs. The ONPFP should undertake an indepth study of this information medium to determine both the best form and content of TV messages to make it effective while respecting Tunisian socio-cultural characteristics.

Newspaper information continues to affect only that very specific section of the urban population with a high intellectual level (students, government personnel, etc. . .), in spite of major ONPFP efforts to train journalists and to increase their awareness of family planning issues at both national and interregional levels. Newspaper articles generally still deal with medical and demographic aspects at levels beyond the grasp of readers at a more modest level. Here again, the ONPFP would gain from varying the content and degree of sophistication of messages to cover the maximum number of social groups. It would be useful to continue to organize workshops for journalists at both the national and interregional levels. This action, initiated by the ONPFP in 1983, could give more importance to reviewing the necessary means for an improved use of journalistic information techniques to extend various family planning messages to a wide range of audiences.

4. Audio-visual Supports

The ONPFP made a particular effort to prepare audio-visual material aimed at strengthening individual information and

education actions in rural and peri-urban areas. Animatrices have appropriate visual material including four well-illustrated folders on IUD's, pills, tubal ligation, and secondary methods; a demonstration case with samples of contraceptive products; and a practical guide in the form of a loose-leaf binder. This material was entirely designed and developed by the ONPFP; it was tested, evaluated, and is now available to all animatrices.

Other than this material, ONPFP production is limited to promotion material such as diaries, murals and pocket calendars for various uses such as school holidays, football season and Ramadhan timetables. Plastic bags mentioning the ONPFP address and telephone number as well as those of the regional delegations are distributed to pharmacists. We think that the ONPFP should, as a priority, give particular attention to designing and producing audio-visual material for its group education programs and for each of the target groups of concern to the program. The ONPFP should also consider producing appropriate material for the private sector (private physicians and pharmacists).

Recommendations

-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. (Short-term)

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

-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. (Medium-term)

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

-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. (Short-term)

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

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. (Medium-term)

IX. PRIVATE SECTOR

In Tunisia, the private sector has always played an important role in the country's health system. This is particularly true of private physicians and of pharmacists who, due to their daily practice, are faced with and try to meet the needs and demands of the population in general health matters. This prime relationship between the population, the physician and the pharmacist was judiciously used in the recent past in the general framework of vaccination campaigns, erradication of infectious vectors, and the control of infectious diseases.

Although hard to quantify, the magnitude of private sector participation in family planning gave considerable input to the national family planning program, particularly oral contraception in urban areas. This contribution was less in rural areas as a result of the high density of physicians and pharmacists in cities. Out of a total of approximately 600 private physicians, 50% are working in Tunis; of a total of 800 pharmacists nearly one-fourth are practicing in the Greater Tunis area and another 200 in the larger coastal cities. This inequality between the various regions of the country tends, however, to be attenuating gradually. The number of physicians and pharmacists is constantly rising; there is a definite tendency among pharmacists, and to a lesser degree among physicians, to settle outside the large coastal urban areas. Private sector evolution characteristics by governorate are summarized in the Tables 15 and 16.

TABLE 15: Evolution of the number of private pharmacists, 1980 - 1984

Year	Number of Pharmacists
1980	552
1981	579
1982	640
1983	689
1984	746

TABLE 17: Contraceptive distribution, by sector, in 1982 and 1983

Contraceptive Brand Name	1982		1983	
	Public Sector	Private Sector	Public Sector	Private Sector
Anovlar	46,253	236,900	37,212	216,300
Neugynon	60,453	237,800	55,812	218,100
Noriday 1/50	72,213	132,200	71,712	181,090
Minidril			35,549	166,980
Microgynon			28,498	120,170
Pill Total	178,919	656,900	284,498	902,640
Condoms	261,268	765,900	385,400	1,130,250

This brief analysis shows that the significant part played by private physicians and pharmacists is expected to become increasingly important in the country's health system. Capitalizing on this evolution, the ONPFP has undertaken a number of actions within a strategy aiming at insuring expanded participation of both the medical and pharmaceutical private sectors in the family planning activity. ONPFP actions are aimed at the achievment of three major objectives: an improved supply and distribution system for contraceptives; improved information for physicians and pharmacists; and, strengthening of ongoing training of physicians and pharmacists in family planning matters.

1. Activities Carried Out by the ONPFP in the Private Sector in the 1981-1983 Period.

1.1 Contraceptive Supply and Distribution.

Five types of oral contraceptives and one type of condom are available in Tunisia. These are distributed free of charge by the ONPFP to pharmacists who, in turn, sell them at nominal prices: 50 millimes for a pill cycle and 30 millimes for a three-condom packet.

Supplying pharmacies with these products was the responsibility of the Pharmacie Centrale de Tunisie before 1982; then, this supply function was gradually taken over by ONPFP regional structures; in 1983, it was generalized to the whole of Tunisia. The ONPFP does not, however, supply pharmacies with barrier contraceptive products such as spermicides, jellies, etc. IUD's, of which two types are now being used in the program (the Lippe's Loop and the copper T) are distributed without charge to those gynaecologists who order them, and are not sold in pharmacies. The ONPFP continues to re-package oral contraceptives and condoms in a locally designed pack. It employs two pharmacists and one medical visitor to promote its products, manage stocks and maintain relations with the medical and pharmaceutical sectors. The evolution of private sector contraceptive distribution is summarized in the Table 17.

TABLE 19: Funding sources - national family planning program, 1982-1986 (1)
(000 US$)

Funding Source	1982	1983	1984	1985	1986
UNFDP	424	400	375	230	--
Population Council	1,967	1,410	925	625	277
JHPIEGO	262	269	255	50	50
INTRAH	150	100	117	102	102
IPAVS	469	366	245	100	--
Westhinghouse		136			
Sub-Total	3,272	2,681	1,917	1,105	--
	(44%)	(37%)	(27%)	(15%)	
Government	4,124	4,612	5,244	6,260	7,200
	(56%)	(63%)	(73%)	(85%)	
Grand Total	7,396	7,293	7,161	7,365	

(1) UNFDP Project TN/80/P04 March 1983 revision.
USAID 1983/ONPFP/Population Intermediaries
Budget Summary 82-86
Figures in this table are indicative especially from 1985 onwards.

Dissemination of information to private physicians and pharmacists is achieved through a single medical visitor for the entire country and through information and education events at the national and interregional levels which are organized in collaboration with professional organizations such as the Société des Sciences Pharmaceutiques and the Pharmacist Association. The ONPFP also contributes from time to time to the publication of articles on family planning and contraception in magazines published by the various national associations of physicians and pharmacists. Since 1981, the ONPFP has not organized national information events, but in 1982 it increased its information activities at the regional level, organizing three such activities in Tunis, le Kef, and Sfax (approximately 186 pharmacists attended these activities). In 1983, the information and education effort was considerably expanded; 8 workshops and information events were organized and covered other regions such as Sidi Bou Zid, Mahdia, Medenine, and Tozeur; approximately 100 pharmacists and 100 physicians attended these activities.

The collaboration established with the private sector in the framework of occucaptional health is another interesting aspect of activities achieved by the ONPFP in this field. After launching this program in 1978-79, the ONPFP continued during the period 1981 to 1983 to develop and improve its actions. A national workshop involving physicians working with private firms has been organized every year as have regular activities for the paramedical/social personnel of these firms. Approximately 70 physicians and 150 other personnel were involved in this program. In addition, the ONPFP encourages those private firms which have their own health care facilities to include a family planning consultation in them.

2. Major Findings.

It is doubtless that ONPFP efforts to reorganize its distribution network will allow for an improved appreciation of private sector participation in family planning activities. They will also provide increased control of supplies and storage of contraceptives at the pharmacy level with, as a consequence, rapid solutions to problems of over-stocking and preemption of products. For the immediate future, the ONPFP's task is therefore to consolidate the new distribution network being implemented and to obtain further physician and pharmacy compliance in maintaining family planning statistics and communicating them to the ONPFP. (The liaison form system adopted in Sfax could be generalized).

The ONPFP should examine with authorities as well as with the various associations of physicians and pharmacists the

possibility of selling IUD's in pharmacies.

With respect to information and education activities designed for the private sector, those established by the ONPFP, although considerable, are still below the needs of this sector. At present, activities are neither regular nor sufficient in number. They need to be rationalized and decentralized, and their numbers need to be increased to become accessible to the majority of physicians and pharmacists. These activities would also profit from being designed in close collaboration with professional associations and scientific societies to make them as effective as possible. They could also be supported by the distribution of appropriate and more ample written information (brochures, publications and scientific articles on family planning and contraceptive technology) as well as audio-visual aids designed to meet the needs of these audiences.

Recommendations:

-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. (Short-term)

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

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

-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. (Medium-term)

X. FINANCIAL AND ADMINISTRATIVE MANAGEMENT

1. Funding

70% of ONPFP resources are provided by the Tunisian Government which funds infrastructure development and operation costs (excluding MOPH personnel secunded to the ONPFP and whose salaries are still paid for by the Ministry). The remaining 30% comes from foreign investments distributed as follows (1):

- Intervention for Development Program (operation costs) 40%
- Information, Education, Communication 13%
- Personnel Training 10%
- Research and Evaluation 9%
- Contraception, A/S and medical equipment 19%

Funding sources are given in the Table 18.

TABLE 18: Funding of the national family planning program, 1982-1986 (2)
(in thousands US dollars)

Source	Government	AID	UNFDP	Other	Total
Amount	27,440	8,748	2,500	500	39,188
Percentage	70%	23%	6%	1%	100%

An important element during the last three years in the program was the development of a gradual local takeover plan for program funding. Table 19 summarizes the evolution of Tunisian and foreign participation in the family planning program, and Table 20 presents distribution of the local portion of the budget across program areas.

(1) Case Study - WHO 1980
(2) Budget Summary 1982-86

TABLE 16: Private sector establishments, by governorate, in 1980 and 1982

Establishments: Governorates	1980 clinics	1980 pharmacies	1980 laborat.	1982 clinics	1982 pharmacies	1982 laborat.
Tunis	19	208	19	19	243	21
Zaghaouan	-	10	-	-	17	-
Bizerte	2	34	1	3	43	1
Nabeul	1	35	1	1	43	1
Sousse	2	33	2	3	44	3
Kairouan	1	18	1	1	22	1
Mahdia	-	14	-	1	19	-
Monastir	-	27	-	-	36	-
Sfax	4	61	2	4	71	4
Gabes		21	1	1	24	2
Kebili					3	
Medenine		23			22	
Tataouine					5	
Gafsa		7			15	
Tozeur		3			5	
Sidi Bouzid		8			10	
Kasserine		7			7	
Jendouba	1	7			12	
Le Kef		7			11	
Siliana		5			8	
Beja		11			14	
TOTALS	30	539	27	33	674	33

TABLE 20: ONPFP budget distribution, 1980-1984
(000 Tunisian Dinars) (2)

Item	1980	1981	1982	1983	1984
Operation	594	740	1,138	1,574	1,774
Investment	1,800	1,800	1,820	938	942
Contraception transport	60	140	109	177	250
Sub-total	2,454	2,680	3,067	2,689	2,966
	(60%)	(60%)	(63%)	(60%)	(66%)
Foreign	1,631	1,759	1,780	1,752	1,529
Funding	(40%)	(40%)	(37%)	(40%)	(34%)
Grand Total	4,085	4,439	4,847	4,441	4,495

The size of donor phase down was in a way compensated by the rising value of the dollar, which allowed the ONPFP to invest funds thus liberated to expand its activities.

Although foreign participation to the ONPFP budget in 1983 and 1984 was respectively 37 and 27% in US dollars, it in fact kept at 40 and 34% in TD equivalent.

With only a 10% increase in the total budget in 4 years, and in spite of an estimated 10% inflation rate per year as well as 16% salary raises in 1983, the ONPFP has, in the same period and due to improving human and financial management, achieved several activities already described in this report.

In 1984, the Government took over 50% of contraceptive costs. It also increased its participation in personnel salaries. In 1980, half the personnel cost was funded by foreign organizations in comparison with only 1/3 in 1983 (see Table 21). This gradual increase in Government participation in personnel and program operation costs (14% in 1980, 39% in 1984) is encouraging and should be continued in the future.

TABLE 21: Personnel numbers and salary payments by the ONPFP, 1980-1983

Funding Source	1980	1981	1982	1983
Operation budget	235	264	326	383
Foreign Organization Loans	310	295	193	224
Other (Affectés...)	79	73	75	77
	624	632	594	684

NB: These figures correspond to personnel numbers on Dec. 31 of each year. Part-time personnel figures are mere approximations as these are constantly changing.

2. Management

As we have often indicated in this report, the ONPFP has improved its management procedures in a number of fields during the last few years. Some of these improvements are given here.

- Improved personnel management through a more accurate definition of tasks. The ONPFP developed formal job descriptions for CREPF personnel (regional délégués, supervising midwives, regional secretaries) and is now doing the same for central level personnel.

- In July 1984, a system of analytical accounting will be introduced for financial management, and will contribute to an improved evaluation of actual costs of family planning acts and optimize ONPFP human and material resources.

- Decentralized scheduling and activities will allow for improved adaptation to specific regional problems.

- Decentralized ongoing training and refresher courses are being offered.

- Decentralized budgeting: each region has its own bank account and is reimbursed - within the limits of an annual budget - in relation to activities performed.

3. Recommendations

-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. (Medium-term)

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

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

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

-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. (Short-term)

XI. RELATIONS WITH OTHER DEPARTMENTS.

1. Ministry of Public Health.

In its effort to improve health service quality and provide coverage to the entire population, the Government has engaged in a policy of developing a basic health infrastructure. With assistance from the World Bank and USAID, the MOPH started in 1981 establishing basic health centers in 12 governorates and a second project covering 9 governorates in the south is being considered.

With the development of this infrastructure the issue of integrating family planning services in basic health care

delivery was raised. If the principle of this integration, conceived as a way to extend family planning to new structures, is not questioned, then methods of carrying it out are faced with several constraints:

-At the national administrative level there is a lack of consultation to discuss all technical and financial questions related to this integration;

-At the regional level, situations are varied, but there is generally an inadequate exchange of information and dialogue between the Regional Délégué and the Regional Health Director and the Basic Health "Chef de Service";

-At the level of health centers, relations between the mobile team and MOPH personnel are sometimes excellent and lead to effective cooperation, but sometimes they are practically absent, varying according to individual temperaments.

In spite of these varied constraints, which have delayed the development of long term guidelines for an integration policy, a case by case integration is being achieved whenever infrastructure and trained personnel are amenable.
Thus, in 1983 the mobile team stopped its activities in 3 MCH centers, 4 communal dispensaries, 1 rural dispensary, and 1 rural hospital where full-time MOPH midwives had been appointed.

2. Ministry of the Family and Women's Development. (MFPF)

During the course of 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.

Early in November 1983, the MFPF was created. Among its goals were to:

-develop and implement the government's policy concerning the family and the promotion of women;

-design and implement action aiming at safegarding the family and promoting the conditions for its prosperity;

-develop and implement a family planning policy, insuring equilibrium and well-being in the family, in collaboration with other concerned departments;

-develop measures and programs aiming at reinforcing the

role of women in society and their participation in development and evaluate their role in the family; and,

-encompass institi ons and organizations whose activities are directly rel , to the family and the promotion of women.

To accomplish its man MFPF contemplates developing its activities along four r guidelines:

-develop associations with organizations such as the Tunisian organization for Education and the Family and act on the family unit component through existing organizations;

-undertake research studies in such fields as the sociology of the family, demography and population;

-reinforce the family as such in the sectorial policy of the various departments and organizaions concerned (health, housing, CNSS, old age insurance, PDRI, etc.); and,

-undertake its own programs of action to promote and develop rural and urban women (training, cooking, small scale breeding, etc.)

The MFPF anticipates the promotion of information and education in family planning matters by grafting this information component on various social projects; for example, the PDRI plans to study the possibility of taking legislative measures to encourage couples to space births. It also sees the possibility of introducing family planning.

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 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.

3. 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.

4. The Ministry of Plan.

Population issues are closely linked to the development process and Tunisia has stressed this link with planned development since the beginning of its experience. Attention was early drawn to the negative effects of a chaotic demographic increase which would disturb all development plans. Moreover, it has been recognized that control of a certain number of problems, and specifically those related to employment, depend in a large proportion on the control of demographic problems.

The ONPFP is now, more than ever, called on to reinforce its family planning activity to reduce the acute demographic problems. In this respect it has participated in several preparatory commissions with the Ministry of Plan:

-During the development of the Vth Plan (81-86), the ONPFP was part of the National Commission on the Health Sector. In addition, the ONPFP participated in the work of the subcommittees on Basic Health Services, the "demography" group, and on Pediatric Gynaecology, Obstetrics, and Family Planning.

In addition to this participation, the ONPFP continues to provide planners with documents on population projections. The ONPFP should continue to participate actively in the work of the synthesis committee on "Demography and Employment".

5. Ministry of Social Affairs.

In the recent past collaboration between the ONPFP and MSA was primarily in the form of training and continuing education for several members of the staff of this department. Training curricula were thus developed for the continuing education of newly graduated social workers. Family planning training is provided for students in the Siliana School of Social Work by ONPFP and Regional Delegation Medical and paramedical staff; this is in addition to family planning training they receive as part of their Family Education course. Out of 1,200 employees in this department, nearly 800, including the teaching personnel of the Centres de la Jeune Fille Rurale, received continuing education in regional workshops.

At the regional level, the degree of practical collaboration between the ONPFP Délégue and the Social Action Chef de Service varies, depending primarily on individual relations between the two persons. When collaboration occurs, it usually takes the form of joint scheduling and organization of awareness campaigns, carried out in common at district or village levels by ONPFP and MSA personnel. Social workers also participate in IEC activities and assist by referring potential family planning acceptors in the peri-urban program. The Director of the Social Development Division is open to any suggestions to reinforce and further systematize these collaboration efforts.

6. The Tunisian Association for Family Planning (ATPF).

Since its creation, ATPF, the basic voluntary organization for family planning action, has played an important role in the advancement of the family planning program through its efforts to stimulate political leaders at all levels and its pilot service activities. The Association is now orienting most of its efforts to rural areas. The approach it has selected is the development of a community development program which integrates

family planning in the larger context of development and employment generating projects for women. This operation is conducted in three governorates (Le Kef, Gabes, and Nabeul) and two peri-urban areas (Tunis-Kram nord and Cité Ehadhamen). The Kef activity, evaluated by IPPF, was deemed extemely positive.

For its educational activities ATPF employs 16 animatrices and 6 educators located in 12 governorates; in addition it continues to manage four clinics in Sousse, Sfax, Gabes, and Bizerte. ATPF cooperates with the ONPFP which provides considerable logistic assistance particularly for on-site activities. It should also be noted that ONPFP regional délégués are voluntary members of the regional structures of the Association and also participate in its activities. ATPF's financial resources include an IPPF grant and an MOPH donation provided through the ONPFP. ATPF encourages the development of its relations with the ONPFP to further promote and consolidate its activities.

7. The Social Action Service of the Prelacy of Tunis.

The members of the evaluation team had a discussion with the officer who organizes consultations in the Bach Hamba MCH center in Tunis and Mellassine. These efforts are particularly centered on natural contraception "which requires self-knowledge and self-responsibility from the couple." Project activities are organized at two levels: the MCH center level for promotion and awareness activities, and home visits For home visits, the family action team developed a document in Tunisian Arabic explaining the male and female reproduction system. This document is useful during home visits and is left for couples who have been visited. The project has already trained 4 women, including two in poor districts, who advise women on their cycles and teach them about reproduction and how to make good use of natural contraception.

The ONPFP has actively participated in a workshop on natural contraception organized by the Institut de l'Enfance. Three researchers from the Population Division presented papers at the workshop which was opened by the PDG of the ONPFP.

XII. INTERMEDIARIES.

1. AVS.

AVS participation in the family planning program started in 1977 with financial assistance to the Ariana Clinic. It then expanded to include 14 CREPFs, 2 other clinics in the Greater

Tunis area, the establishment of a maintenance center (taken over by JHPIEGO in April 1983) and a contribution to operation costs of the Tunis Training Center. By 1983, this financial assistance was mainly used to renovate CREPFs and clinic equipment and to pay operation and technical personnel costs.

A phase-down financial chart has been proposed to the ONPFP to prepare itself to fund the entire voluntary sterilization program by 1986. AVS participation decreased from 71% in 1982 to 50% in 1983, 36% in 1984 and it is expected to further decrease in 1985 and to terminate in 1986. Up to the present, the Tunisian Government has been able to face its increasing participation in the program without quantitative or qualitative performances being affected (see Table 22).

TABLE 22: Number of tubal ligations
1st quarter 1982 - 1983 - 1984

Year	January	February	March	Total 1st Quarter
1982	738	865	999	2,602
1983	830	937	966	2,733
1984	796	930	880	2,606

It should be noted however, that the rising value of the dollar on financial markets has artifically facilitated increased Government participation in the program.

Starting in 1984, a new formula was initiated; out of an estimated cost of $80 AVS would reimburse $35 per act in 1984 and $15 per act in 1985. This new formula allows for greater management flexibility. The ONPFP can thus re-schedule activities from region to region and avoid losing funds not used of which nearly 25% otherwise would be returned to AVS. The present formula seems well adapted to the situation and we recommend that the Government continue its efforts gradually to take over program operation costs. If, however, the proposed phase-down of financial assistance were to prejudice the quality and number of voluntary sterilizations achieved -- which could only be evaluated late in 1984 and particularly in 1985 -- the proposed formula should be readjusted to maintain existing levels of performance.

Male Sterilization. Male sterilization has been minimal - not a single incident has been recorded in the public sector. There is, however, some demand in the private sector. The Tunisian Association of Voluntary Sterilization (ATSV), includes about a hundred Tunisians with 6 regional committees. ATSV has, with ONPFP support and AVS funding, organized information programs on vasectomy in approximately 3-5 of the governorates. A guidance, information and vasectomy delivery center will open in Tunis (an urologist will be present twice weekly) under the ATSV's auspices.

The evaluation team recommends that AVS continue its efforts to develop, through ATSV, a modest program in male sterilization, supported by clear and appropriate information. AVS contribution to such a program could take the form of financial support in the following areas:

-personnel training: surgeon, urologist, psychologist, marital advisors, assistantes sociales, nurses;

-equipment and operation costs of some private clinics (Tunis, Sousse, Sfax, etc.) likely to undertake vasectomy activities;

-information programs on the role, responsibilities, and participation of men in planning the size of their families.

Such a program, modest in its beginnings, could continue to develop beyond 1986 as could, accordingly, AVS assistance.

2. JHPIEGO.

Second Generation Training.

In 1978 and 1983, 145 Tunisian surgeons, gynaecologists and gynaecology resident physicians were trained in laparascopy as part of the JHPIEGO program. Out of these 145, only about 20 practice at university hospitals, the best facilities to insure the training of future generations. Most of the others switched to, or were already in the private sector, or they practice in hospitals where there are no gynaecology residents. In addition to the fact that relatively few women go to university hospitals for tubal ligation (to such a point that assistants are frequently present with residents who practice laparascopies (ligation or diagnosis)) the main issue facing second generation training for resident physicians is a lack of teaching personnel. In Tunis, for 5 OB/GYN services totaling 30 to 35

resident physicians, there are one chef de service, 5 appointed professors, 2 full professors, and approximately 12 assistants. In addition to responsibility for training resident physicians, and for other normal clinic activities this cadre of teaching staff is also responsible for training 40-45 interns, 200 externs, and about a hundred midwives. In Sousse, the situation is no better; one Tunisian chef de service and 2 foreign gynaecologists train 6 residents, 700 medical students, and 90 midwives. Sfax has only one chef de service and one assistant facing similar problems. This situation has been perpetuated in all university hospital facilities which have similar shortages of teaching personnel (full professors, assistants, maitre assistants) so that even delivery of the theoretical component of the curriculum cannot be guaranteed.

The various obstacles facing young gynaecologists who wish to have an academic career are, however, being reduced and, for example, in Sousse, the dean can definitely rely on having produced 4 or 5 national gynaecologists within two years.

Second generation training is therefore mainly to be found in the JHPIEGO training program, supported by a national teaching staff either on a contractual basis or on the payroll of the ONPFP. Practical training is carried out in the Ariana or Bardo clinics as well as in the Beja hospitals, Habib Thameur, Menzel Bourguiba, the Sousse and Sfax CREPFs.

Laparoscope Utilization.

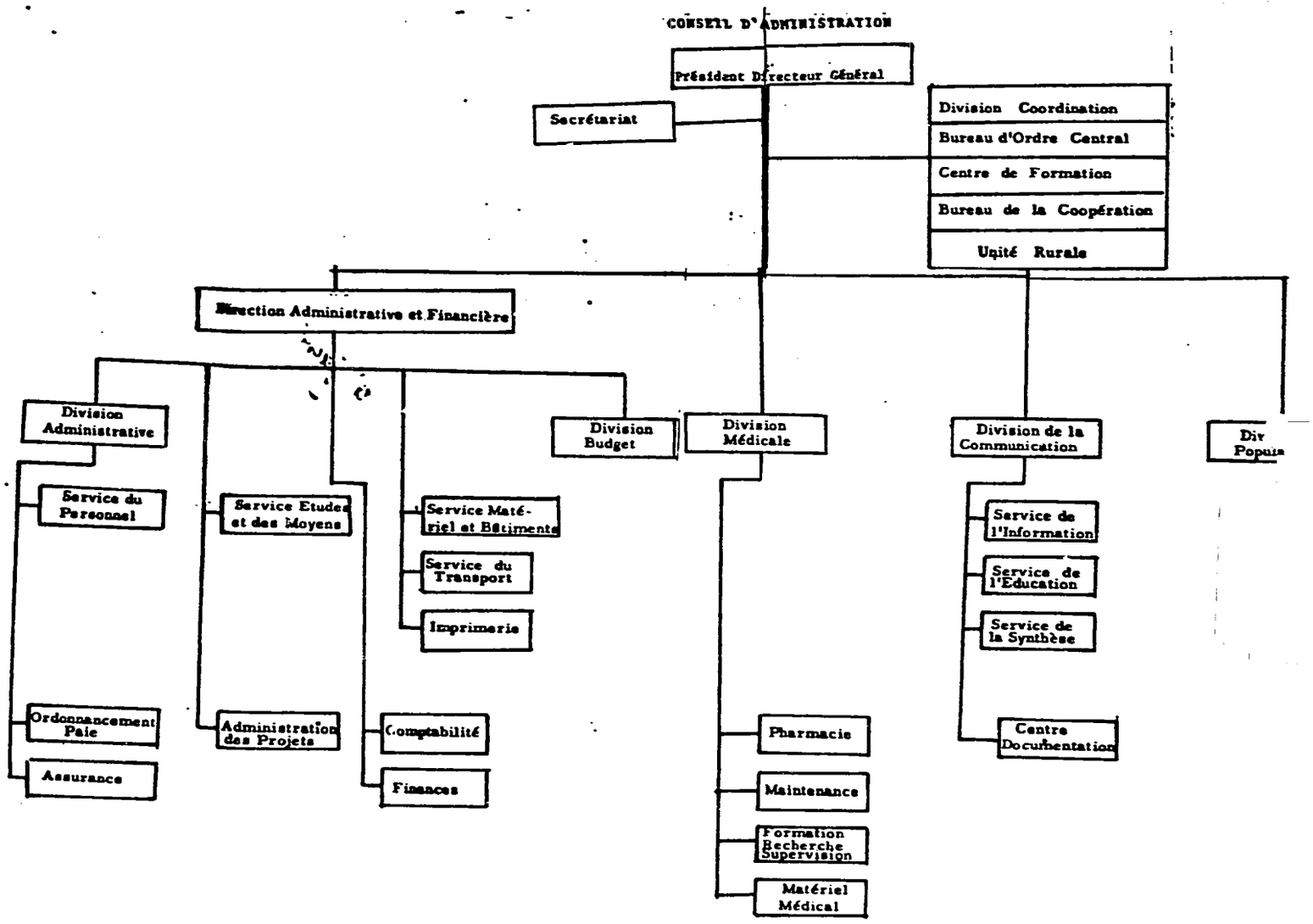
46 laparoscopes have been provided to various Tunisian medical institutions. Table 23 shows how they are distributed. It was not possible to know the number of diagnostic laparoscopies performed in each of these institutions.

Future Assistance.

There are several problems concerning JHPIEGO's future role in Tunisia beyond 1986.

A. The National Program

With respect to the training of gynaecologists in laparoscopy, and given the shortage of teaching staff in university hospitals, we recommend continuation of gynaecologist training in the JHPIEGO program. The decision to center such training on gynaecology resident physicians is good because future university staff will be recruited from among them rather than among already established private gynaecologists. It is


CONSEIL D'ADMINISTRATION
Président Directeur Général
Secrétariat
Division Coordination
Bureau d'Ordre Central
Centre de Formation
Bureau de la Coopération
Unité Rurale
Direction Administrative et Financière
Division Administrative
Service du Personnel
Ordonnancement Paie
Assurance
Service Etudes et des Moyens
Administration des Projets
Service Maté-riel et Bâtiments
Service du Transport
Imprimerie
Comptabilité
Finances
Division Budget
Division Médicale
Pharmacie
Maintenance
Formation Recherche Supervision
Matériel Médical
Division de la Communication
Service de l'Information
Service de l'Education
Service de la Synthèse
Centre Documentation
Div Popula

desirable to select candidates among first and second year rather than third and fourth year residents so that they can benefit from this training during the course of their academic studies.

With respect to anaesthesiologist training, the fact that conscious sedation is not yet in general use requires continuation of training for this class of doctors. To sensitize both surgeon/gynaecologists and anaesthesiologists, we recommend that surgeons and gynaecologists continue to be invited to participate in the practical training of anaesthesiologists.

The training of general practitioners and midwives can be provided in existing educational structures, following proposals already discussed in this report and/or undertaken in ONPFP regional facilities.

B. The International Program

During the last few years, the JHPIEGO international training program in Tunisia gained a worldwide reputation, especially in French-speaking African countries. With the intoduction and development of family planning programs in an increasing number of African countries, the need to continue such training will gradually increase in the 1980's. Consequently, the evaluation team recommends that JHPIEGO assistance be maintained to assist the Tunisian family planning and laparascopy training programs.

C. Equipment Replacement and Maintenance

The existence of RAM has undoubtedly played an important part in maintaining the quantitative and qualitative performance of the voluntary sterilization program. The MOPH is in great need of maintenance services and we recommend that this activity be continued -- including the aquisition of replacement equipment -- while encouraging national authorities to strengthen their capacities in this field.

D. Basic Training

It would perhaps be useful to consider JHPIEGO technical and financial participation (lectures, study trips, documentation, etc.) to assist and motivate concerned staff to institutionalize and consolidate family planning teaching in the formal curricula of medical and paramedical studies.

3. The Population Council.

The Population Council assistance to the Tunisian family planning program covers several areas: research and evaluation, the rural and peri-urban program, IEC, commercial distribution of contraceptives, as well as grants for study trips and Tunisian participation in workshops. Activities undertaken in the various fields of action by the Population Council are discussed elsewhere in this report.

Concerning future assistance, the evaluation team recommends that the Population Council continue its technical and financial assistance beyond 1986 in the following fields:

-family planning services in rural areas should be expanded using, in addition to mobile clinics, service delivery via other means such as community participation in promotional activities, and further participation of paramedical and health-social work personnel in family planning service delivery.

-Operations research and ongoing program evaluation necessary to improve planning, mamagement and decision making should be enhanced.

-Support in IEC materials particularly in evaluation should be reinforced.

-Reoriented assistance concerning commercial distribution of contraceptives should be encouraged

-It is probably desirable to reinforce assistance from a wider viewpoint to further promote private sector participation in the national family planning program.

-Assistance specifically aimed at reinforcing ONPFP capacities to participate further in research on population and development should be considered.

4. INTRAH

As previously noted in this report, INTRAH's collaboration in training activities has been extremely fruitful. The evaluation team recommends that INTRAH's technical and financial assistance be continued.

The areas likely to require such assistance are:

-workshops to enable central-level and regional staff to benefit from evaluation instruments recently developed and, based on their analysis, to identify parameters likely to improve matching of training with the needs of the various activity programs;

-workshops for ONPFP and regional staff dealing with human resources issues, applied communication, evaluation and training of trainer methodology;

-revision of training curricula for midwives and social workers (ONPFP and on-site) in the light of experience gained;

-development of a strategy, methodology, and a training program for private sector physicians and pharmacists.

-development of family planning curricula for university training (physicians, pharmacists, midwives) and for the Regional Health Schools (obstetrical nurses); and,

-training of staff in charge of such teaching, specifically for health school advisors.

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.

Table 23: Laparoscope distribution in 1983

Institution	No. Beds	Institution	No. Beds
Monastir Reg. Hosp.	36	Ch. Nicolle Hosp.	239
Monastir CREPF	235	Ariana	953
Beja Reg. Hosp.	823	Wass. Bourguiba Mat.	605
Jendouba Reg. Hosp.	257	Bardo	730
Jendouba CREPF	0	Marsa Univ. Hosp.	60
Kasserine CREPF	128	Bizerte CREPF	376
Kairouan CREPF	728	Bizerte Reg. Hosp.	50
Gafsa CREPF	151	Sfax CREPF	475
Siliana CREPF	364	Hedi Chaker Maternity	276
Sidi Bou Zid CREPF	213	Sousse CREPF	411
Tozeur CREPF	70	Univ. Hosp.	45
Kef CREPF	352	Habib Thameur Hosp.	134
Gabes CREPF	262	Zarzis Hosp.	69
Mahdia CREPF	220	Kelibia Reg. Hosp.	7
Mahdia Reg. Hosp.	20	Military Hosp.	0
Nabeul CREPF	451	Medenine CREPF	37
Nabeul Reg. Hosp.	76	Menzel Bourguiba Hosp.	356

ANNEX 2

WORKSHOP ON POPULATION AND DEVELOPMENT

Introduction.

As described earlier, regarding population policies and family planning programs, Tunisia is in the forefront of Middle East and North African countries, and among the most forward-looking even on a world basis. These population policies and activities have given primary attention to family planning service delivery systems implemented to help achieve long-range demographic objectives. In addition, since independence, there has been strong policy support from the head of the government for the improvement of women's status, with attention to the legal status of women, female as well as male education, higher age at marriage, and greater involvement of women in the modern economic sector.

In this section of the report, we suggest a logical next step in the further development of appropriate population policies in Tunisia: an assessment of the interactions between population and development. Furthermore, we suggest that this assessment be initiated by means of a workshop organized by the ONPFP. The first of the following three subsections presents a general discussion. The second is an example to illustrate the relationships, and the third is a brief list of steps to implement this recommendation.

A. General Discussion.

Population phenomena - fertility, mortality and migration - interact with development processes in many and varied ways. An improved health infrastructure lowers mortality and assists in the achievement of a more healthy population; as more young people obtain higher levels of education, the nature of migration flows within and outside the country shift, along with the changed expectation of these young people regarding employment; as families have fewer children, more mothers may seek employment in the modernizing economic sector; and so on. A glance at the list of ministries in Annex 4 quickly suggests the many ways in which development processes interact with, affect, and are affected by population phenomena.

The population policies and fertility-reduction programs in Tunisia have resulted in part from an examination of some of these relationships. Thus, for at least a decade, the Ministry of Plan has considered country resources, needs for schools and housing, job creation, etc., when setting long-term demographic

targets. Given the reductions in both mortality and fertility during the past 15 years, a comprehensive assessment of population and development relationships seems most appropriate as a next step, expecially given the forthcoming preparation of the VIIth Development Plan for the period 1986-91. Moreover, as the government unit responsible for family planning and population, it is appropriate for the ONPFP to take the initiative in this matter.

B. An example: The Young Adult Population.*

Table 24 shows observed trends in the size of the Tunisian young labor-force-age population, persons between 20 and 40, during the 1960's and 1970's and projected trends of the same population from 1980 to the year 2000. This table should be of interest to planners concerned about labor force trends in Tunisia and their interactions with economic development goals and political processes.

Why concentrate attention on changes in the size of the 20 to 40 age group? There are two answers to this question. First, changes in the numbers of young adults are of special economic, political and demographic significance. Growth in this age group is closely linked to the rate of entry into the labor force. Persons in this age group have the highest level of labor force participation. They acquire and accumulate productive skills at the highest rate, at least if circumstances permit. They form new housholds, have children, and bear prime responsibility for raising the next generation. Labor mobility is at its peak during the young adult ages, as is the propensity to migrate. Migration in Tunisia takes place in several ways: rural to urban; urban to urban; rural or urban to foreign countries for either short or extended periods; return from countries. Satisfaction or frustration of economic expectations within this age group may also be related to political stability or lack of it.

Secondly, projecting the number of young adults for the medium term - say the next twenty years - is exempt from most of the errors that tend to affect population projections. Those who

*This example, including some text, is based on a recent presentation by Paul Desseny before a subcommittee of the Joint Economic Committee, Congress of the United States. See "A Note on Global Population Growth and its Influence on the World Economy", Population Notes No. 53, Center for Policy Studies, The Population Council, 21 March 1984.

TABLE 24: Young adult (20-40) population in 1960, 1980 and 2000

	Young Adult Population (millions)			Growth Rate (percent)		Absolute Increase (millions)	
	1960	1980	2000	1960-80	1980-2000	1960-80	1980-2000
Tunisia	1.14	1.67	3.23	1.93	3.29	.54	1.56
West Africa & North Afr.	33.60	55.60	104.80	2.52	3.17	22	49.2
Developing Countries	589.90	945.30	1580.2	2.36	2.57	355.40	634.90
Developed Countries	280	339.50	359.40	0,96	0.28	59.50	19.90

Source: Based on United Nations population projections as assessed in 1982.

will be 20 to 40 years old in the year 2000 have already been born. Mortality trends for these ages affect the precision of forecasts only negligibly. However, Tunisian gross and net external migration trends can be projected only with less precision. Nevertheless, the data in Table 24 represent a rather rare example of a significant aspect of the future that can be predicted with reasonable certainty. They also present an opportunity to compare in accurate quantiative terms an important feature of the observed past - in this instance the experience of the period 1960 to 1980 - with analogous changes in a comparable period that is yet to be experienced.

The above data show an overall tendency of accelerating growth of young labor force participants in Tunisia. Whereas the absolute number increased by .53 million from 1960 to 80, it will increase by 1.56 million from 1980 to 2000. Although this acceleration is less than the average for all West Africa and North Africa countries, it is substantial.

The economic implications of this demographic trend in Tunisia merit attention in the recommended workshop. Several questions could be addressed. Will the trend retard the tempo (in relative terms) at which productive skills are accumulated, already-existing advanced technologies are introduced, and labor-saving and labor productivity-increasing innovations are developed and adopted? Exploiting the advantages of being a technological follower will be more difficult. Will the process of eliminating the structural backwardness in these economies be slower than could be the case with less rapid rates of expansion of the labor force? How can the country best accomodate, within the traditional sector of the economy, the population not absorbed into the modern sector? Finally, how much will economic and political processes be affected by full and partial unemployment? The attention to these and other questions would naturally take into account the enlightened education policies and their results that Tunisia has followed since independence.

C. Steps to Develop the Workshop.

The example just presented illustrates one of several topics that might be elaborated in a workshop on population and development. We turn next to several steps to plan and implement the workshop.

1. The workshop objectives need to be determined. One objective would be to examine the ways in which population phenomena and development processes interact, and, possibly, to suggest mechanisms for ongoing assessments of population and

development relationships. A related second objective would be to bring about better understanding of population and development relationships by Tunisian policy makers in both the public and private sectors. A third objective would be to provide more input for the VIIth Plan. These objectives should be modified as necessary, and then added.

2. A background paper that would provide more detail on population and development relationships, and on the questions to be addressed in the workshop must be prepared. (If short-term consultant technical assistance is needed to facilitate this task, we recommend that AID provide necessary funding.)

3. A steering committee of perhaps 6-8 members to plan the workshop should be formed; in addition to about 3 ONPFP staff, other members of the steering committee might be drawn from the following groups: (a) relevant ministries such as Plan, Health, National Economy, Education; (b) the academic and research communities; (c) the private sector, e.g. Chamber of Commerce; (d) labor unions.

4. Workshop themes and questions must be developed; commission brief background documents on each, to serve as discussion guides at the workshop.

5. The list of invited participants must be developed. The goal should be to have broad involvement from the public and private sectors. However, because a workshop cannot operate efficiently if it is too large, perhaps 30-40 participants is an appropriate size. With this number, for part of the workshop subgroups can be formed for detailed examination of specific topics.

6. Hold the workshop early enough in 1985 for the results to be useful for persons developing the VIIth Plan. Probably a one-week workshop is appropriate.

ANNEX 3

METHODOLOGY PRINCIPLES FOR SURVEYS AND RESEARCH.

1. Sample size.

Small samples do not permit the precision frequently desired; thus, choices must be made. The principle is this: it is the absolute size of the sample that determines error limits, rather than the size of the population studied (except for very small populations where the proportion of that population selected for the sample is important). Although this sounds illogical, it is the "law of statistics", according to sampling specialists. Thus, if a given level of precision in information is desired, say an error level of 5 percent in the prevalence estimate, the same size sample is needed for a delegation as for all of Tunisia. More detail is available in standard methodology textbooks.

2. Show sampling and estimated nonsampling errors when presenting data or findings.

No statistical system or survey yields perfect information. Two main sources of error are a) sampling error and b) non-sampling error, the latter often called bias. Again, this is not the place to provide details available in many articles and books. (For a summary statement, see pages 18-20 in the National Academy of Sciences Committee on Population and Demography series Data Collection: A Statement for Administrators, 1981.) However, two examples may help to clarify this basic point. First, consider a survey of 150 persons, and say that 24 persons report current use of contraception. The estimated prevalence rete is 24/150=16 percent. However, using a .95 confidence level (2 standard errors), for this sample of 150 persons the prevalence estimate could lie anywhere between 10 percent and 22 percent. And these estimates take into account only sampling error. If allowance is also made for interviewer bias, interviewer error, respondent error, etc., the best one might be able to conclude from the 16 percent estimate is that it represents a range from under 10 percent to above 22 percent, within which interval the true prevalence rate lies, with 95% probability. Note that this level of confidence (under 10% to over 22%) is especially unappealing if one is interested in measuring trends, for example change in prevalence in the Rural Project delegations.

The second example concerns comparisions of cells within a table constructed with data from a small sample. Consider that within

such a table the comparision is between two age groups, for which the measured prevalence rates are 18 percent and 30 percent, and that there are 50 cases in each age group. Using the .95 confidence level, and taking into account only sampling error, and further assuming that simple random sampling is involved, the conclusion would be that the 18 percent and the 30 percent are not significantly different, since the difference would have to be about 17 percentage points or more in order to reach the two standard error significance level.

For its research reports, the Population Division should prepare and present tables showing sampling error or otherwise indicate which numbers and differences are statistically significant.

3. Standardize results when necessary.

If for two groups of people, e.g., users in the private and public sectors, the distributions by age (or other relevant characteristics) are different, comparisions between the two groups are meaningful only if the data are standardized. For example, if one is comparing average numbers of living children among users and nonusers, but the users tend to be older on average than nonusers (which is particularly so among public sector users), then a comparision without standardization is mearsuring age differences as well as prevalence differences. The Population Division should take the lead within the ONPFP in making sure that research comparisions among groups are valid comparisions, and certainly Division staff should not brush aside this principle.

ANNEX 4

LIST OF PRINCIPAL PERSONALITIES MET

Office National du Planning Familial et de la Population

Mme Souad Chater	President-Director General
Mr. Ahmed Jelal	Administrative and Financial Director
Mr. Salah Messaoudi	Head of the Budget Division
Dr. Farouk Ben Mansour	Doctor, Medical Division
Mr. Taoufik Kilani	Coordinator of l'Unité
Mr. Rachid Abdelaziz	Supervisor of l'Unité Rurale
Dr. Habib Ben Rejeb	Supervisor of Activités d'animation
Mr. Mohamed Ben Salah	Head of the Communication Division
Mr. Abdelkrim Yahia	Head of the Information Service
Mme Najoua Safi	Chargée for education
Dr. Rachid Boujemâa	
Mle Samira Zghal	Pharmacist of the ONPFP
Mr. Habib Fourati	Researcher, Division of Population
Mr. Mohamed Baraket	Researcher, Division of Population
Mr. Touhami Alaoui	Researcher, Division of Population
Mr. Arbi Azouz	Researcher, Division of Population

Ministry of Public Health

Mr. Mourad Ghachem	Chargé de Mission
Dr. Mohamed Boukhris	Chargé de Mission
Dr. Ridha Chadi	Director of Santé de Base
Mr. Mekki Chekir	Head of the Division of Study and Planning
Mr. Mohamed Seghir	Regional Director intérimaire Sfax
Dr. Khaled Khaireddine	Regional Director of Health, Gafsa

Ministry of the Family and Promotion of Women

Mr. Taoufik Cheikhrouhou	Chef de Cabinet of the Minister

Ministry of Plan

Mr. Zein Mestiri	Directeur General of International Cooperation
Mr. Bouhaouala	Associate Directeur of International Cooperation
Mr. Taoufik Baccar	Director of Human Resources

Ministry of Social Affairs

Mr. Mohamed Karboul	Director of Social Development
Mr. Noureddine Fessi	Associate Director of Social Development
Mr. Mohamed L. Fehri	Regional Head of Service

Conseil de l'Ordre des Pharmaciens

Dr. Ridha Jazi	President of the Society of Pharmaceutical Sciences

Conseil de l'ordre des Médecins

Dr. Mohamed Boukhris	Secretary General

Faculty of Medecine of Tunis

Dr. Mohamed Ben Amor	Chief of Obstetrical and Gynecological Service

Faculty of Medecine of Sfax

Dr. Rachid Fourati	Associate Dean
Dr. Saïda Rekiki	Chief of Obstetrical and Gynecological Service

Faculty of Medecine of Sousse

Dr. Ben Zakoura	Dean
Dr. Abdallah Béchir	

Ariana Clinic

Dr. Rafik Boukhris	Director, Research Center Ariana
Dr. Abdelatif Maaref	Gynecologist in human reproduction Ariana

National Statistics Institute

Mr. Chedly Tarifa	Director

Training Center ONPFP

Mr. Mongi B'Chir	Director
Mme Najet M'henni	Administrator

Tunisian Association of Family Planning

Mr. Lotfi Labbene	Executive Director

National Institute for Child Health

Dr. Béchir Hamza	Director

Action Familiale Prélature de Tunis

Sister Odile Payan	Director

Regional Delegation of Tunis

Mr. Fathi Ben Messaoud	Regional Delegue

Dispensary of Ettadhamen

Mr. Saïfeddine Akkassi	
Mme Saloua Berrarri	Midwife
Mme Fatma Tounsi	Supervisory Midwife (South Tunis)
Mme Latifa Fredj	Supervisory Midwife

Governorate of Sfax

Mr. Abdelkader Zitouna	Governor
Mr. Abdelkader Nsiri	1er délégué

Regional Delegation of Sfax

Mme Fatma Gargouri	Regional Delegue
Mme Siala	Supervisory Midwife

Dispensary of la Hencha

Mme Assia Siala	Control Midwife
Mme Ben Ali	Midwife of the équipe mobile
Mme Cheour	Supervisory Midwife
Dr. Fouad Maazoun	Center Physician

Regional Delegation of Sidi Bou Zid

Mr. Mohamed Aid Kaddoussi	Regional Delegue
Dr. Trifanov	Gynecologist - Public Health
Mme Trifanov	Contractor Midwife

Bir El Haffey Center

Mle Saïda Niri	Supervisory Midwife
Mme Amen Daoud	Midwife of the équipe mobile
Mle Najoua Baccari	Nurse aide-soignante

Regional Delegation of Gafsa

Mr. Amor Chihi	Regional Delegue, ONPFP
Mme Naii Rekaia	Supervisory Midwife
Mr. Jilani Mohamed	Secretary General

Regional Delegation of Tozeur

Mr. Ahmed Abdennadher	Regional Delegue

USAID Mission

Mr. James R. Philippard	Director
Mle Dale Gibb	Chief of the Health and Population Division
Dr. James Vermillion	Health and Population Officer

IPAVS

Mr. Fathi Dimassi	Regional Director
Mme Phyllis Butta	Associate Regional Director

United Nations Development Program

Mr. Riadh Tabbarah	Resident Representative
Dr. Marco Cittone	Representative of the FNAP

LIST OF MINISTRIES IN TUNISIA

Prime Minister's Office
Foreign Affairs
Finance
Plan
Justice
Interior
Defense
National Education
Higher Education
Health
Family and Women's Welfare
National Economy
Tourism and National Crafts (Artisanat)
Agriculture
Housing
Infrastructure or Public Works
Youth and Sports
Public Administration
Transportation and Communications
Social Affairs

ANNEX 5

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