

UNCLASSIFIED

INTERNATIONAL DEVELOPMENT

COOPERATION AGENCY

AGENCY FOR INTERNATIONAL DEVELOPMENT

Washington, D.C. 20523

PROJECT PAPER

TUNISIA: Family Planning & Population Development
(664-0331)

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE: A (Add), C (Change), D (Delete). Amendment Number: _____

2. COUNTRY/ENTITY: Tunisia

3. PROJECT NUMBER: 664-0331

4. BUREAU/OFFICE: ANE

5. PROJECT TITLE (maximum 40 characters): Family Planning & Population Development

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM DD YY: 06/30/89

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4):
A. Initial FY: 85, B. Quarter: 4, C. Final FY: 86

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY 85			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	3,500		3,500	7,500		7,500
(Grant)	(3,500)	()	(3,500)	(7,500)	()	(7,500)
(Loan)	()	()	()	()	()	()
Other U.S. 1.						
Other U.S. 2.						
Host Country		421		1,610		1,610
Other Donor(s)				3,000		3,000
TOTALS	3,500	421	3,500	12,110		12,100

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) ESF	400					1,000		5,000	
(2) DA	400					818		2,500	
(3)									
(4)									
TOTALS						1,818		7,500	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 400

11. SECONDARY PURPOSE CODE: 440

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each):

A. Code	BWW	RPOP				
B. Amount	6,500	1,000				

13. PROJECT PURPOSE (maximum 480 characters):
To increase contraceptive prevalence by 9 percentage points by 1988 through demographically-focussed family planning interventions, contraceptive social marketing, and improved family planning organization, management, evaluation and cost effectiveness.

14. SCHEDULED EVALUATIONS: Interim MM YY: 06/88, Final MM YY: _____

15. SOURCE/ORIGIN OF GOODS AND SERVICES: 000, 941, Local, Other (Specify) _____

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)

17. APPROVED BY: James R. Phippard, USAID/Tunis, Mission Director. Date Signed: MM DD YY: 08/23/85

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY: _____

MISSION COMMITTEE

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Ernest S. Hardy, Controller

PROJECT AUTHORIZATION

Name of Country/Entity: Tunisia

Name of Project: Family Planning
and Population Development

Number of Project: 664-0331

1. Pursuant to Sections 531 and 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Family Planning and Population Development Project for Tunisia (the Cooperating Country) involving planned obligations of not to exceed \$7,500,000 in grant funds over a three year period from date of authorization subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the project. The planned life of the project is three years and nine months from the date of initial obligation.

2. The project consists of the provision of technical assistance, training and commodities to the Cooperating Country in order to increase the contraceptive prevalence (modern methods) by 9 percentage points by 1988 through demographically-focused family planning interventions, contraceptive social marketing, and improved family planning organization, management, evaluation and cost effectiveness.

3. The Project Agreement(s) which may be negotiated and executed by the officer(s) to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

a. Source and Origin of Commodities, Nationality of Services

Commodities financed by A.I.D. under the project shall have their source and origin in the Cooperating Country or in the United States, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have the Cooperating Country or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing.

Ocean shipping financed by A.I.D. under the project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.

b. Condition Precedent. The Grant shall contain in substance the following Condition Precedent:

Prior to any disbursement, or to the issuance of commitment documents under which disbursements may be made, under this project after the release of the VIIth Development Plan, the Cooperating Country shall provide to A.I.D. in form and substance satisfactory to A.I.D. evidence that subsidies on contraceptives on sale in pharmacies have been substantially diminished and prices increased to a level which provides adequate incentive for pharmacists and wholesalers and helps to meet recurring costs of the Office National de la Famille et de la Population (ONFP).

c. Covenants. The Grant Agreement shall contain covenants in substance as follows:

(1) The Parties agree to establish a Project Evaluation program. Except as the Parties otherwise agree in writing, the program will include, during the implementation of the Project and at one or more points thereafter: (a) evaluation of progress toward attainment of the objectives of the Project; (b) identification and evaluation of problem areas or constraints which may inhibit such attainments; (c) recommendations as to how such problems or constraints should be addressed; and (d) evaluation, to the degree feasible of the overall development impact of the Project. The ONFP, in collaboration with the institutions responsible for technical assistance under the Project, will develop an information system which will satisfy A.I.D. project evaluation requirements. The periodic evaluations required by this Section will be carried out by teams composed of representatives of A.I.D. and Government officials appointed by the ONFP.

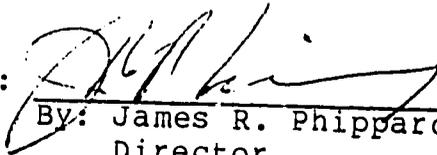
(2) The Cooperating Country and ONFP agree to study and implement management and administrative changes that will assist the ONFP to achieve its mandate more efficiently and effectively. The study will address the role of the ONFP in relation to the role of the Ministry of Public Health (MOPH), the private sector, pharmacies, and medical schools. This study will be completed by September, 1986; this project will provide technical assistance to the ONFP as needed for this study.

(3) The Cooperating Country agrees to require method-specific promotion of contraception in pharmacies within 120 days of the effective date of the Agreement and to allow method-specific promotion of contraception in mass media by the second year of the project.

(4) The Cooperating Country agrees to increase the contribution of the MOPH as a provider of family planning services, particularly in the areas of providing tubal ligations, distribution of IUDs and pills, pre-and post-partum family planning counseling and rural service delivery and to develop a stronger coordination between the MOPH and the ONFP with respect to family planning service delivery.

Within six months of the signing of the project agreement, the ONFP and the MOPH will develop a plan and a timetable for actions leading to an increased contribution of the MOPH in these areas.

(5) The Cooperating Country agrees that none of the funds made available under the Grant may be used to finance any costs relating to (a) performance of abortion as a method of family planning, (b) motivation or coercion of any person to undergo abortion, (c) biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion as a method of family planning, or (d) active promotion of abortion as a method of family planning.

Signature: 

By: James R. Phippard
Director
USAID/TUNIS

8.23.85
Date

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I. PROJECT RATIONALE, BACKGROUND AND SUMMARY DESCRIPTION

A. Project Rationale

The Tunisian family planning program has been supported by A.I.D. for 20 years, yet the needs of this program for selected technical supports continue. Thus, USAID/Tunis has identified population as an area for support for the period 1986-1988.

Changes in the Tunisian program have recently taken place which allow for project activities in areas which previously had not been emphasized in A.I.D. family planning projects in Tunisia. For example, in January, 1984, the Office Nationale de la Famille et de la Population (ONFP) was shifted from under the Ministry of Public Health (MOPH) to within the organizational structure of the new Ministry of the Family and of the Promotion of Women (MFPF). Since then, the ONFP has announced a new focus on the social marketing of contraceptives. In addition, USAID/Tunis was assured that lines of communication with the MOPH and other involved government ministries are being strengthened.

In dialogue with the ONFP and the MFPF, USAID/Tunis has been assured that the program of the ONFP will include: 1) an increased role for the private sector, 2) more liberal distribution of contraceptives both by physicians and by non-physicians, 3) careful examination of program effectiveness and costs; also, USAID/Tunis has been assured that the Government of Tunisia (GOT) is open to policy dialogue with USAID.

The identification of the ONFP's programmatic needs comes at a time when Tunisia's economic situation is deteriorating. Analysts have projected that Tunisia will shift from a net oil exporter to a net oil importer by 1990. A recent decision by the World Court in favor of Libya concerning an offshore oil find has made the prospects of further Tunisian oil exploitation bleak. Tourism, the second largest foreign exchange earner for Tunisia, has declined significantly over the past few years. Accordingly, A.I.D. has decided to reverse its phase-out decision. Assistance to the population program is planned for FY 86 through FY 88.

The USAID/Tunis mission strategy, which will be amplified in the upcoming CDSS, focuses on three priority areas, with strong emphasis on the private sector:

- Directing resources where there is significant potential for policy dialogue,
- Promoting technology transfer, and

- Strengthening Tunisian institutions which A.I.D. has previously assisted.

The proposed population program will provide assistance in each of these three areas. Specifically, the proposed project will:

- work with the MFPP and the ONFP to support the GOT's commitment to a long-range population and family planning strategy,
- continue to encourage greater cooperation between ministries at the central and regional levels for the provision of family planning services,
- help expand private sector contraceptive sales,
- promote identification and adoption of other effective and efficient modes of service delivery, and
- fund research as a basis for program targetting and management decisions.

This strategy is consistent with the overall U.S. objectives.

B. Project Background and Problem Statement

A.I.D. has provided assistance to the Tunisian family planning and population program since 1965. Over the course of A.I.D. involvement, demographic gains have been achieved with a drop in the birth rate from 45.1 in 1966 to 31 in 1983. In addition, the natural growth rate fell from 3.0% to 2.5% over this same period. The 1984 census reports the natural growth rate at 2.6%¹. With a corresponding average annual net growth rate of 2.5% Tunisia's population of 7 million will double in just 29 years.

The GOT has supported population programs since independence. Strong governmental support for the program has consistently been provided and, along with women's rights, it is a priority in Tunisia. A.I.D.'s support to the Tunisian

1. Population and Development in Tunisia, Republic of Tunisia, Ministère de la Famille et de la Promotion de la Femme, August, 1984, page 1.

program was in the form of bilateral assistance through 1981. At that time, A.I.D.'s support to the GOT was to be phased down, and activities were to be minimal after 1986. Accordingly, the A.I.D. bilateral population program ended in 1982 and was replaced by a centrally-funded program through cooperating agencies, primarily the Population Council, Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), the International Training Program in Health (INTRAH), the International Program of the Association of Voluntary Sterilization (IPAVS) and to a lesser extent Westinghouse Health Systems, Inc. and the Integrated Population and Development Planning Project (IPDP) of Research Triangle Institute (RTI). Project activities under these centrally-funded programs included technical assistance in the areas of information, education and communication (IEC), research and evaluation (including operations research) and support for the rural program by the Population Council; training of para-professionals by INTRAH; professional training and technical support by JHPIEGO and IPAVS; technical assistance and support in development of the Contraceptive Prevalence Survey (CPS) by Westinghouse; and, technical assistance and provision of computer hardware and software for demographic projections by IPDP. These activities will continue as scheduled and will be in addition to activities of this project.

During the period of centrally-funded activities, the population growth rate did not decline appreciably. While it is difficult to ascertain exactly why the program has not had increasing impact, the 1982 UNFPA evaluation and USAID's May, 1984 evaluation of Tunisia's family planning program identified key problems. These problems are summarized below and provide the basis for the design of project components.

- Availability and accessibility of services and contraceptives: public sector distribution has followed strict medical protocols excluding many potential acceptors. Also, distribution in the rural areas has depended on a system of mobile clinics and teams parallel to the existing infrastructure of the MOPH. The proposed project will work with the ONFP to create alternatives in service delivery both through the MOPH and other GOT agencies to develop the private sector.
- High costs and inadequacy of mobile clinics in rural outreach programs: current approaches have increased coverage, but with an extremely high unit service delivery cost. The proposed project will seek alternative service delivery mechanisms, including paraprofessional distribution (perhaps in a door-to-door approach), greater private sector distribution, and a broader role for the MOPH clinics.

- Lack of momentum on social marketing: social marketing has been avoided in the past primarily due to management decisions by the ONFP. The MFPP, under which the ONFP now falls, and the ONFP have both stated that social marketing will now be a major focus in the family planning program. The proposed project will provide assistance to the MFPP and the ONFP in developing a broad-based social marketing program.
- Ineffective communications: IEC efforts have been primarily aimed at individuals and groups as opposed to being problem and needs oriented. In addition, materials and programs have not been aimed at specific target audiences. The proposed project will work with the ONFP in developing IEC materials and programs for specific target groups including prenatal and postnatal clinic visitors, unions, men, women's groups, local political leaders, students and military personnel.
- Policy issues: program administrators have not to date addressed several policy issues inhibiting broad scale contraceptive distribution. The proposed project will include initiatives to address policy barriers to liberalized contraceptive distribution and institutional barriers to broader family planning services in the infrastructure of the MOPH.
- Limited integration and coordination with other ministries: the ONFP has run a service delivery system parallel to other existing systems; this has led to an expensive and less than optimal approach to delivery of family planning services. The proposed project emphasizes the coordinating role of the ONFP in the area of family planning and de-emphasizes its role in provision of direct services. At least half of the funding for resource targetting under the project will be restricted to activities involving the MOPH or other non-ONFP service providers.
- Insufficient training at all levels: training has been primarily focused at professionals and para-professionals in the health field. While this training has, on the whole, been very satisfactory, it is limited in scope and has not been based on an identification of needs within an overall training plan. The ONFP is presently developing a training plan which will cover training needs through 1990. Future training under centrally funded projects will follow training needs identified in the plan. The proposed project will provide training to individuals identified as vital to GOT efforts for achieving the EOP status. Target groups for this training will be traditional birth attendants (TBAs), social workers, local political leaders, and family aides. Also, there will be

a strong training of trainers component to permit assumption of basic training by the faculties of the professional schools.

- Low quality research and evaluation: conclusions which are being drawn in several demographic studies are not based on statistical principles; also, operations research is behind schedule and not being used in management decision making. The new project will provide technical assistance and training in the area of research design and statistics for both fertility research and operations research.

Summary Problem Statement:

The Tunisian family planning program is technically competent in many respects and has been able to develop and expand viable family planning and population activities. However, many elements of the program have been characterized by inadequate planning, management, monitoring and feedback, and lack of focus on the alleviation of constraints to increased contraceptive prevalence. Contraceptive distribution has been falling off and contraceptive prevalence appears to have been declining for at least the past few years. In addition, emphasis is needed on developing more systematic program review so that the Tunisian program can become independent of significant donor support. Support for transfer of service delivery to the private sector and to GOT agencies other than the ONFP, as well as for prerequisite training and promotion is also needed.

C. Summary Project Description and Budget

Goal: The long-term goal for the population project presented in this PP is the reduction of fertility in Tunisia. The necessity to implement measures to achieve this goal is cited in the A.I.D. Policy Paper Population Assistance. (September, 1982) which notes that

"...continued high rates of population growth significantly increase the cost and difficulty of achieving basic development objectives by imposing burdens on economies presently unable to provide sufficient goods and services for the growing population."

This goal is consistent with Tunisia's national goal to reduce the fertility rate to 119 per 1000 by 1988 and to reduce the growth rate to 2.3% by this same time.

Purpose: The project's purpose is to increase contraceptive prevalence (modern methods) by 9 percentage points by 1988 through demographically-focussed family planning interventions, contraceptive social marketing, and improved family planning organization, management, evaluation and cost effectiveness.

This will be accomplished under four project components:

1. targetted and evaluated IEC activities;
2. contraceptive social marketing;
3. targetted and evaluated training (by category of personnel and region); and,
4. program focussing, including demographic and operations research, identification of alternative public sector delivery mechanisms.

This purpose relates directly to Tunisia's stagnating contraceptive acceptance rate, despite the country's liberal population policy, level of sophistication and the important sums of money invested in family planning over the past twenty years. The project activities (see outputs) will seek to correct the program's weaknesses (discussed in Section I.A. Project Background) and lead to increasing contraceptive prevalence.

End of Project Status

Objective indicators of Project Purpose attainment will include:

- (A) Contraceptive prevalence (using modern methods) of 42.7% of the married women of reproductive age (MWRA) among the target population of this population/family planning project.

This assumes that resources will be focussed on high population density/low contraceptive prevalence geographic areas. It also assumes that the CPS estimate of contraceptive prevalence (33.7%) is an accurate figure for 1985. Other relevant criteria for focussing family planning efforts include potential impact (e.g. family size and reproductive history) and accessibility. Baseline data will include the results of the recent CPS survey as well as results of the knowledge, attitudes and practices (KAP) survey to be conducted in the early phases of the project.

- (B) Contraceptive purchases through pharmacists increased by 52%.

This EOPS condition assumes that social marketing will be socially, politically and administratively acceptable, and that pharmacists have an interest in and commitment to serving as informed providers of health education as well as providers of commodities and that contraceptive pricing will be modified to provide incentives for pharmacists to stock and sell contraceptives..

Assumptions relating to EOPS

Achievement of the desired end of project status requires a number of assumptions about family planning in Tunisia, specifically,

- The ONFP will continue to be the focal point for family planning and population decision making in Tunisia.
- The MOPH is willing to assume a greater family planning service delivery role.
- The ONFP is willing to develop its coordinating role and relinquish redundant service delivery functions.
- The ONFP and MOPH will permit contraceptive method-specific (ideally, brand-specific) promotion.
- A "realistic" pricing structure for contraceptives will be established for the private sector.
- Pharmacists will be sufficiently motivated to maintain adequate supplies of contraceptives.
- Policy changes will have a favorable impact on contraceptive prevalence.

TABLE 1.1: Total Project Budget by Component

Component	YEAR 1		YEAR 2		YEAR 3		TOTALS		
	AID \$US 000	GOT TD000	AID \$US 000	GOT TD000	AID \$US 000	GOT TD000	AID \$US 000	GOT TD 000	GOT \$US 000
#1	729.9	16.5	633.6	37.9	620.4	66.4	1,983.9	120.8	137.3 (\$1=.88TD)
#2	422.5	105.8	274.2	138.4	193.8	174.7	890.5	418.9	476.0
#3	314.6	49.3	269.1	76.4	220.7	86.9	804.4	212.6	241.6
#4	541.4	250.1	860.7	179.1	600.6	199.0	2,002.7	628.2	713.9
Contra- ceptives	405.4	\$0.0 0.0	404.0	\$76.5 67.3	385.3	\$184.8 162.6	1,194.7	229.9	261.3
Adminis- tration	153.1		307.9		162.8		623.8	0.0	
TOTALS	2,566.9	421.7	2,749.5	499.1	2,183.6	689.6	7,500.0	1,610.4	1,830.1

I. DETAILED DESCRIPTION OF PROJECT COMPONENTS AND BUDGETS

The project can perhaps be most clearly understood by focusing on the project components, including a description of the specific outputs, inputs required to produce these and their associated financial requirements.

Component No. 1: Information, Education and Communication

The May, 1984 evaluation of the ONFP information, education and communications (IEC) program concluded that the program has not evolved in a coordinated and effective fashion, with family planning services related to population needs, and that there is no systematic approach to IEC activities. The result is ineffectiveness in reaching specific audiences with specific messages.

In view of this situation, the IEC component of the project will focus on the provision of technical and financial assistance to the ONFP to develop and strengthen its capacity in the following areas:

- research, evaluation and design of materials to improve the quality and targetting of IEC activities;
- design and implementation of a multi-media communication program, based on evaluation research, to inform specific audiences about contraceptives and available family planning services; and,
- development and distribution of effective IEC materials to meet the family planning and contraceptive information needs of different categories of potential users of family planning services.

The ONFP has recognized that there is little purpose in continuing to focus its IEC efforts on developing awareness and knowledge about family planning when over 90% of married women of reproductive age apparently know about family planning². To date the ONFP's IEC campaigns have been general and unfocussed. In order to reach the approximately 66% of MWRA not using modern contraceptive methods, it is essential that further IEC efforts be targetted to specific segments of this potential market. Furthermore, content of messages must become more specific.

2. Contraceptive Prevalence Survey, 1983, conducted by Westinghouse Health Systems

The ONFP has also recognized that an expanded involvement in outreach activities to individuals will impose serious constraints on the limited financial and human resources of the ONFP. It has therefore decided to shift the emphasis of IEC efforts, from general audience education to interventions which will involve:

- increased use of media communications (particularly radio and television) to reach audiences with specific messages on contraception and services;
- increased use of print and audio-visual materials that offer culturally acceptable family planning information to various specific audiences based on their profiles and needs;
- substantial participation of health sector and education institutions in carrying out family planning education and promotion; and,
- pre-natal and post-natal counseling services in health facilities and outside them (motivation/education of traditional birth attendants - TBAs.)

The extent to which these interventions will be developed depends upon several factors. There must be a greater complementarity between public and private sector, closer cooperation between the ONFP's IEC and research and training divisions, as well as some changes in the conduct of communication activities. Another critical element to the success of the program is the availability of effective feedback mechanisms to link the IEC staff with implementing agents at the central and field levels.

The prime contractor under the project will work directly with the ONFP to develop target audience specific strategies and messages. In addition, the contractor will develop messages for media and public display specific to promotion of contraceptive distribution in the private sector.

The ONFP has stated that method-specific promotion in pharmacies will be permitted; in addition, the ONFP has indicated that contextually appropriate method-specific promotion in the mass media will be allowed. The requirement for method-specific promotion is addressed by a covenant in this project paper.

The IEC Division of the ONFP has identified specific

audiences for which it will develop IEC activities. During the first year of the bilateral project the ONFP will conduct research and experimentation with communication materials such as radio and television spots, mini-series, video tape strips and slide shows. These materials will be employed to promote use of family planning services. Technical assistance will be required to support these activities, including:

- research and analysis of audiences (i.e. youth groups, military personnel, potential public sector acceptors, field work personnel etc.);
- elaboration of a media plan for these audiences;
- conceptualization, development and pretesting of relevant communication materials; and,
- development of an IEC evaluation plan.

The Research Director of the Social Marketing Division, within the ONFP's IEC Division, will be responsible for developing (in consultation with the Marketing Manager) a research strategy and for overseeing its implementation. In addition, technical assistance will be provided under the project. A local firm, with experience in conducting quantitative research for commercial and government clients, will be subcontracted and will work with the contractor and the ONFP to conduct a series of focus groups among current and potential contraceptive users. While the final decision as to the number and content of specific focus groups will be specified in the research strategy, it is expected that approximately twelve groups will be organized, for example:

<u>Participants</u>	<u>Number of Groups</u>	<u>Sites</u>
Newly married men	2	urban, peri-urban
Newly married women	2	" "
Men whose wives use no contraception	2	" "
Women who use no contraception	2	" "
Women who formerly used contraception	2	" "
Men who have used condoms	2	" "

Analysis of the results of these focus group studies will provide: 1) the basis for development of preliminary messages prior to availability of quantitative data and 2) the basis for

developing a questionnaire to be used in a national KAP survey. Results from the KAP study will be used for development of consumer profiles and market segmentation of potential contraceptive consumers as well as for baseline data for evaluation of the project.

Message Development. The Media Director in the IEC Division of the ONFP will be responsible, in conjunction with the ONFP's Marketing Manager, for developing a preliminary media plan and overseeing its implementation. Technical assistance will be provided under the project by the CSM contractor. Following completion of this plan, and upon availability of the focus group results, message development will begin. During Year 1 of the Project, general messages will be developed to increase awareness of benefits of contraception. In Year 2, while these general IEC efforts will continue to be conducted by ONFP, method-specific messages targetted at segments identified in the qualitative and quantitative research phases will be developed. The media strategy will be expanded accordingly to include these activities.

One or more advertising agencies will be subcontracted for the production of print and broadcast messages and to assist in media planning and placement. While the media plan will contain details of the campaign to be conducted, it is expected that activities which will be included will be:

- TV: 30 and 60 second "flashes" to be aired at least twice weekly;
- Radio: 30 and 60 second messages (perhaps in conjunction with existing public service announcement spots such as Dr. Hakim) to be aired at least twice weekly;
- Outdoor panels and billboards: to be placed in urban and peri-urban areas;
- Cinema messages: 2-4 sixty-second messages to be shown before movies;
- Posters: 4-6 method-specific (and later perhaps brand-specific) posters for display in pharmacies and in maisons de culture, youth clubs, and work places.

Other media materials which should be considered include 15-minute short subjects for movie theaters and/or TV; audio or visual presentations for women's groups, occupational health facilities, and similar groups.

TABLE 2.1: Project Implementation Schedule: Component #1
Information, Education and Communication

ACTIVITY	YEAR 1				YEAR 2				YEAR 3			
	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Research and Media Strategy	X											
Qualitative Research		X				X				X		
General Messages			X	X	X	X	X	X	X	X	X	X
KAP Study			X				X				X	
Consumer Profiles				X	X			X	X			
Targetted Messages				X	X	X	X	X	X	X	X	X
Qualitative Res. Revised						X					X	
Evaluation							X					
Res. and Media Strategies Revised								X		X	X	

TABLE 2.2: Project Component #1:
Information, Education and Communication

Activity	YEAR 1		YEAR 2		YEAR 3		TOTALS	
	AID	GOT	AID	GOT	AID	GOT	AID	GOT
	\$US 000	TD000						
Mass Media								
T.A./Staff								
*Person months	6.0		2.0		2.0			
Salary	36.0	15.0	12.0	15.0	12.0	15.0	60.0	45.0
Per Diem	13.5	0.0	4.6	0.0	4.6	0.0	22.7	0.0
Travel/Misc.	9.0	0.0	6.0	0.0	6.0	0.0	21.0	0.0
Overhead	60.0	0.0	20.0	0.0	20.0	0.0	100.0	0.0
Research								
*Focus groups	15.0	0.0	12.0	3.5	9.0	7.0	36.0	10.5
*KAP Survey	200.0	0.0	200.0	0.0	200.0	0.0	600.0	0.0
Message Development & Broadcasting								
*TV, Radio & Cinema	200.0	0.0	200.0	0.0	200.0	0.0	600.0	0.0
Videotape	30.0	0.0	24.0	0.0	20.0	2.5	74.0	2.5
Print Materials Development and Printing	80.0	0.0	60.0	11.8	40.0	23.5	180.0	35.3
A/V Equipment	20.0	0.0	10.0	0.5	0.0	0.5	30.0	1.0
Subtotal								
FX	663.5		548.6		511.6		1,723.7	
LC		15.0		30.8		48.5		94.3
Inflation								
FX (5%)			27.4		52.4		79.9	
LC (12%)				3.7		11.9		15.5
Contingencies (10%)	66.4	1.5	57.6	3.4	56.4	6.0	180.4	11.0
Totals	729.9	16.5	633.6	37.9	620.4	66.4	1,983.9	120.8

Pretesting of all messages/materials developed will be particularly crucial in the project, given cultural sensitivities and past experience in attempts to develop contraceptive promotion in Tunisia. Technical assistance will be provided in the pretesting of messages to determine their acceptability by various key audiences.

Finally, a limited amount of audio-visual equipment will be provided by the prime contractor to the ONFP's IEC Division to enable its staff to develop IEC strategies and messages for select target audiences.

Component Number 2: Contraceptive Social Marketing

The contraceptive social marketing (CSM) component of the project is designed around the following basic activities:

- strengthening of an existing marketing unit with expertise in the design and implementation of marketing research, communications, and management;
- reinforcement of the role of the private pharmacist in serving as an informed provider of contraceptive information and supplies;
- sensitization of physicians to the utility of family planning and to their role in assuring that contraceptives are accessible to all couples wishing to use them; and,
- strengthening the system of contraceptive distribution to ensure an uninterrupted supply of contraceptives.

Issues relating to implementation of the activities fall into four categories:

- Technical assistance,
- Contraceptive pricing,
- Legal issues, and,
- Product lines.

Technical Assistance. Effective functioning of the marketing unit of the ONFP requires that appropriate staff be in place to carry out activities in the areas of marketing research, marketing communications, and marketing management. The importance of selecting the appropriate persons to fill positions and providing training in each area cannot be overemphasized, given the need to create a durable structure which will continue to function effectively once assistance is phased out. Thus, it is important to provide highly specialized short-term technical

assistance during the research and early planning stages of the activities. When implementation gets underway, and during the phases in which pricing structures and the distribution system will be studied and planned, it would be desirable for the project to provide consistent technical assistance in the development of CSM activities (for a period of approximately one year). This would be accomplished by alternating visits of two experts in the areas of marketing research and marketing strategies, with each visit lasting approximately six weeks. In addition to training key personnel in the marketing unit, these technical assistants would arrange for other short-term technical assistance in specialized areas, as needed.

Contraceptive Pricing. The existing fixed price for contraceptives in the private sector presents problems for the development of self sufficiency of the social marketing activity. Pharmacists receive pills and condoms free of charge, but it is unknown whether the profit on sales is sufficient to motivate pharmacists to stock and sell contraceptives, or to determine resupply needs. Also unknown is whether the current price provides a reasonably adequate profit for wholesalers (presently fixed at 10% of sale price of medications) to distribute the contraceptives to pharmacists. Present contraceptive sales can not provide cost recovery to meet the GOT's recurring costs related to distribution and education of providers, since contraceptives are provided free of charge to pharmacists. The question of an increase in the price of contraceptives will need to be addressed by the GOT with study of implications, both in terms of demand and recurrent costs, during the life of this project. Given indications of need for increased prices, policy dialogue at appropriate levels with GOT officials will take place. In particular, the GOT will need to be sensitized to the implications of maintaining a highly subsidized price, particularly as the GOT will increasingly assume more of the costs of contraceptives and related support costs in distribution and public education. Under the CSM activity, the GOT will develop a study of the elasticity of demand for contraceptives which will propose an importation, distribution and pricing structure which will not diminish demand for contraceptives and which will provide sufficient incentive for pharmacists to promote their sale and for wholesalers to promote their distribution. One possibility which will be examined is the introduction of more than one brand so that there can be price variations on the market. The contractor will provide TA to the ONFP to assist in the development and execution of this study.

Legal Issues. The importation and sale of contraceptives in Tunisia is regulated by law. A contraceptive (as with any medication) which has not been previously imported requires an entry permit from the Commission d'Agreement of the MOPH.

Product registration is under the control of the Institut National de Normalisation et de la Propriété Industrielle, in the Ministry of the National Economy. USAID has been assured that if a new contraceptive product is to be brought in under the project, there will be no delay in obtaining a permit for importation.

Legislation regarding the distribution of oral contraceptives is somewhat problematic, but in fact distribution is reasonably liberal. Law No. 69-54, 26 July, 1969, and Law No. 61-7, 9 January, 1961, regulate contraceptives. The latter revoked the French legislation of 1920 which prohibited importation of contraceptives. The 1969 law stated that oral contraceptives would require a physician's prescription. While distribution of oral contraceptives is legally restricted, in practice it is actually quite liberal. Pills are widely sold to women on request in pharmacies. Resupply of pills is now permitted in the public sector without a prescription. A.I.D. has decided not to seek changes in legislation regarding contraceptive distribution since there is a possibility that this could lead to stricter enforcement of existing laws and consequently to barriers in contraceptive availability and since the GOT is presently looking at ways to liberalize contraceptive distribution.

The final legal issue regards regulation of advertising of pharmaceutical products (including contraceptives), covered by Chapter IV of Law No. 73-55, 5 August, 1973. According to this law, advertising of medical products can be conducted only with the authorization of the Ministry of Public Health. While the law goes on to say that conditions regulating advertising will be determined by a later decree, none has been enacted. Thus, decisions concerning advertising of contraceptives remain with the MOPH. Promotion of specific methods without using brand names is, however, within the realm of the ONFP. The law also states that advertising in windows and other points visible from the exterior of pharmacies must be conducted by means consistent with "the dignity of the profession."

Product Line. The CSM project component will primarily promote condoms, oral contraceptives and secondary methods of birth control. These two methods have been chosen because of relative ease of use, their present sale in pharmacies, and effectiveness. In addition, the promotion of condoms promotes the idea of contraception among men, an audience which has not received much attention in previous efforts. Condoms currently provided by USAID and sold under the name of "WAHA" will continue to be provided. It is likely that the Noriday 1.50 pill, currently provided by USAID and sold as OP-50, will continue to be provided. Additionally, a 1.30 pill (Wyeth) should be available. Should it be furnished by USAID, it appears that no

problems would arise in obtaining the necessary entry permit for this product. Overpacking of these products, using packaging pre-tested in focus group settings, will be done by an organization subcontracted for that purpose.

Elements of the CSM Component

a. Strengthening of the ONFP's marketing unit.

This unit, comparable to what is traditionally known as the marketing division of a private corporation, is responsible for developing program strategies and designing and managing tactics to carry out these strategies. Social marketing activities typically attempt to build this capability into existing organizations. In Tunisia, the ONFP, a "public entity of an industrial and commercial nature" has been selected to be the organization within which to build social marketing expertise. This is because within the ONFP there is already a social marketing unit and the fact that the GOT (through the ONFP) controls contraceptive distribution. The ONFP has organized itself in a manner supportive of social marketing, with the creation of a Social Marketing Section within its IEC Division. The personnel and structure of this division represent a potentially strong marketing organization, and it is already engaged in activities necessary to the introduction of a complete marketing program. The division shows strong commitment to the principles of research-based, marketing strategy development.

Strengthening of the marketing unit will involve the training of the Chief of the Social Marketing Division and his staff through technical assistance. The Chief of the Social Marketing Division will have overall responsibility and will develop strategy in coordination with other staff described below. The equivalent of the following positions will be needed. Expertise will be developed by training existing personnel or recruiting from outside the ONFP, as necessary.

- Media Director - responsibility for direction of mass media program and coordination with local advertising agency(ies) contracted for design of media campaign.
- Research Director - responsibility for design and implementation of marketing research; will also assist marketing manager in strategy development.
- Marketing Manager - responsibility for coordination with field component (délégués médicaux) and assisting research and media directors in strategy development.

These staff members will receive training in several ways:

- in-country training through work with CSM technical assistance;
- attendance at regional workshops designed to build skills of staff and suppliers of CSM programs;
- observational tours of successful social marketing activities in culturally appropriate settings; and,
- formal training in the U.S. by organization(s) with appropriate expertise, and in conjunction with advertising agencies, market research firms, or marketing divisions of pharmaceutical companies.

b. Reinforcement of the role of the private pharmacist/and sensitization of physicians.

CSM relies on sales of contraceptives in various retail outlets. In Tunisia, private pharmacies serve as points of purchase for the CSM products. Given the sensitivity and relatively conservative medical tradition prevailing in the country, USAID has determined that it is not feasible in the present project to pursue contraceptive retail sales in other outlets. However, after three years of CSM activity the issue of permitting condom sales outside pharmacies may be examined with appropriate ONFP and/or MOPH officials.

The promotion of contraceptive sales in private pharmacies can have an impact on contraceptive prevalence in Tunisia because:

- pharmacies exist in all regions of the country;
- private pharmacies already have a major market share, accounting for distribution of 80% of orals and a substantial proportion of condoms in the past 2 years; and,
- the pharmacist is looked to as an important provider of health information and services.

The CSM activity will build upon these strengths to increase private sector (pharmacy) oral and condom sales by 15% annually throughout the LOP. The primary ways through which the role of pharmacists will be reinforced are:

i) Pricing. The single most effective way to increase private sector sales of contraceptives will be establishment of a price which provides an adequate financial incentive for the pharmacist.

ii) Information and promotion among pharmacists. Prior to beginning such activities a limited amount of qualitative research will be conducted among pharmacists (e.g., two focus groups in Tunis and Sfax, and 8 to 10 in-depth interviews in smaller urban centers in other governorates). This will provide information regarding:

- pharmacists' knowledge and attitudes toward family planning in general and methods in particular;
- pharmacists' perceptions of consumer behavior regarding contraception;
- types of promotional materials which pharmacists would like to have (presentoirs, plastic bags, calendars, point of purchase displays);
- attitudes toward contraceptive prices and incentives to stock and sell; and,
- screening for oral contraceptives.

Results of this research will be used in the design of promotional materials and educational efforts directed at pharmacists. A two-day seminar to "kick-off" CSM activities will be conducted once initial materials are prepared. "Round-table" or workshop-type sessions will be held twice yearly as a part of on-going motivation of pharmacists and will also serve to identify problems with promotion, supply, and sale of CSM products. Consideration will be given to conduct of a special RAPID-type presentation on one of these occasions, to sensitize pharmacists to the problems of rapid population growth and closely-spaced pregnancies.

iii) Medical detailing to pharmacists and physicians. In the private sector, pharmaceutical companies rely heavily on "detailing" (i.e., individual promotion and education) to physicians and pharmacists to increase product sales. The CSM activity will use detailers, délégués médicaux, in much the same way. However, the role of the CSM délégués will be broader than that of encouraging sales. The délégués will be the crucial link between the ONFP Social Marketing Division and the private pharmacist and physician, and will have as objectives to:

- stimulate pharmacists' interest in providing family planning information to women and men;
- increase pharmacy sales of contraceptives;

- keep pharmacists and physicians abreast of latest research findings (regarding new methods, secondary effects, etc.) to enable them to respond accurately to clients' questions; and,
- encourage proper screening of women who desire to take the pill and provide information on other secondary methods as needed.

Currently ONFP has one medical délégué on its staff. This person (who presently has no promotional materials available for distribution) calls on physicians throughout the entire country. Although pharmacists should be visited as well, the délégué has little time remaining to carry out such visits. Under the CSM activity, a field staff of five family planning detailers will be recruited by the ONFP and trained, under subcontracts, through a private Tunisian organization which recruits, trains, and supervises detailers for private pharmaceutical companies. The ONFP Social Marketing Division (Marketing Manager) and the ONFP's staff pharmacist will assist in selection and development of training programs for these detailers. The CSM Marketing Manager will have responsibility for monitoring these délégués.

With the ONFP's field staff of six délégués, it will be possible to visit each relevant physician (generalists and gynecologists) and pharmacy throughout the country every two months. Special promotional materials (brochures, calendars, prescription pads) will be designed to be distributed, along with samples, by the délégués. At least three times a year one-day seminars will be held at which délégués will exchange ideas and receive on-going training designed to up-grade their skills.

iv) Strengthening of contraceptive distribution system. Activities ii and iii described above are designed, either directly or indirectly, to increase consumer demand for contraceptives. It is essential that growing demand be accompanied by assured access to the product desired. Thus, the system of distribution of commodities to pharmacies must operate effectively and without interruption.

There is some question as to the efficacy of the present importation and distribution system. All pharmaceuticals are imported by the Pharmacie Centrale Tunisienne (PCT). Until 1982-83, private wholesalers distributed all medications, including contraceptives, to pharmacies. At that time, the decision was made to centralize distribution of orals and condoms through the ONFP. After receiving contraceptives from the PCT, ONFP stores them in its central warehouse to await distribution, by an ONFP truck, to regional centres in each of the 23 governorates. Pharmacists are then encouraged to come to the

TABLE 2.3: Project Implementation Schedule: Component #2
Contraceptive Social Marketing

ACTIVITY	YEAR 1				YEAR 2				YEAR 3			
	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Marketing												
Research TA	X	X	X	X	X		X		X		X	
Marketing TA	X	X	X	X		X		X		X		X
Observational Tour	X	X										
Research and Media Strategy	X											
Delegates Hired		X										
Contraceptive Overpacking		X	X	X	X	X	X	X	X	X	X	X
Revised Res. and Media Strategies					X	X			X	X		
Evaluation							X					

TABLE 2.4: Project Component #2:
Contraceptive Social Marketing

Element	YEAR 1		YEAR 2		YEAR 3		TOTALS	
	AID	GOT	AID	GOT	AID	GOT	AID	GOT
	\$US 000	TD000						
Marketing T.A./ Staff								
*Person months	12.0		6.0		4.0			
Salary	72.0	45.0	36.0	45.0	24.0	45.0	132.0	135.0
Per Diem	27.0	0.0	13.8	0.0	9.2	0.0	50.0	0.0
Travel/Misc.	18.0	0.0	18.0	0.0	12.0	0.0	48.0	0.0
Overhead	117.0	0.0	60.0	0.0	40.0	0.0	217.0	0.0
Research								
*Pharmacist Survey	10.0	0.0	5.0	0.0	2.5	0.0	17.5	0.0
Training								
*Observation								
Per Diem	5.5	0.0	0.0	0.0		0.0	5.5	0.0
Travel	0.0	1.5	0.0	0.0		0.0	0.0	1.5
*Regional								
Per Diem	0.6	0.0	0.6	0.0	0.6	0.0	1.8	0.0
Travel	0.0	0.3	0.0	0.3		0.3	0.0	0.9
*US Based Fees &								
Per Diem	4.0	0.0	4.0	0.0	4.0	0.0	12.0	0.0
Travel	0.0	2.4	0.0	2.4	0.0	2.4	0.0	7.2
*Delegates Fees	20.0	0.0	15.0	0.0	10.0	0.0	45.0	0.0
*Pharmacists								
Fees	10.0	0.0	10.0	0.0	7.5	0.0	27.5	0.0
Per Diem	0.0	5.0	0.0	5.0	0.0	2.9	0.0	12.9
Transportation								
*Delegates	0.0	42.0	0.0	42.0	0.0	42.0	0.0	126.0
Message Development and Display								
*Posters								
Billboards	100.0	0.0	75.0	17.6	50.0	35.0	225.0	52.6

Subtotal								
FX	384.1		237.4		159.8		781.3	
LC		96.2		112.3		127.6		336.1
Inflation								
FX (5%)			11.9		16.4		28.2	
LC (12%)				13.5		31.2		44.7
Contingencies (10%)	38.4	9.6	24.9	12.6	17.6	15.9	81.0	38.1
Totals	422.5	105.8	274.2	138.4	193.8	174.7	890.5	418.9

center to pick up their supplies of orals and condoms, although in some cases direct delivery is made by the ONFP to pharmacies.

With this system in effect for only two years, it is not yet clear whether it operates more effectively (i.e., whether there are fewer interruptions in supply) than the previous system of distribution through private wholesalers. Opinions vary, and no systematic study has been carried out. The present system was ostensibly initiated to allow the ONFP to maintain better statistics on contraceptive distribution. Wholesalers and pharmacists are apparently reluctant to become involved in detailed reporting, given the low return on the sale of contraceptives (orals and condoms are provided free to pharmacies; when wholesalers were involved they received no more than 10 millimes for delivery of a cycle of pills or three-pack of condoms) and the failure, in many cases, of pharmacists to strictly adhere to the laws regarding distribution. The contractor will provide TA to the ONFP to study the contraceptive distribution system.

Component Number 3: Targetted and Evaluated Training

This component of the project will assist the ONFP to:

- institute and strengthen family planning training programs in the three medical schools, twelve schools of public health and one school of social work;
- reinforce the practical training program for several categories of health and social workers to respond to the information and family planning needs of different segments of the population;
- train program administrators; and,
- provide long and short-term US and 3rd country based training for population specialists and support for attendance at international conferences.

A. Academic Training

In view of the substantial and wide ranging family planning training needs for several categories of medical, para-medical and social work personnel, it has become clear that these needs cannot be satisfied without a more substantial participation of Tunisia's professional education institutions. Strengthening of family planning education in medical and public health schools and the integration of family planning education into the curricula of community development training programs is required

in order to shift theoretically-oriented pre-service training activities from the ONFP to the professional schools. In view of limited financial and human resources, the ONFP cannot continue to compensate for the lack of a comprehensive, well-designed family planning training program at these institutions, as well as develop its own capacity in the areas of program management and in-service training.

The ONFP has, in the past, made some significant contributions to the evolution of the family planning training program, but its efforts have been hampered by limited technical and financial resources. Further, its ties to medical training institutions and the professional milieu which sets the standards for such schools have also been limited. It has recently, however, begun creating linkages as a basis for shifting training responsibilities to these schools.

Given that the educational institutions are not yet offering diverse and sophisticated family planning course work in their programs, the ONFP proposes to undertake a training of trainers program to develop the potential of these institutions to train their personnel and ultimately their students in different aspects of family planning and family planning counseling.

The objectives of this training activity are:

- review of existing but limited family planning training programs in these target professional schools;
- development of the capabilities of faculty members of the target professional schools, in the conception, implementation and evaluation of family planning education;
- establishment of new or revised family planning training modules in the professional schools; and,
- development of a training evaluation plan.

In order to meet these objectives, the ONFP will conduct a series of motivational workshops for teachers which will examine implementation issues for the program. A series of curriculum development workshops will also be held to design family planning training modules for training of students at these institutions.

The ONFP plans to reinforce the present professional staff of its national training center by building up a multidisciplinary team responsible for the planning, implementation and evaluation of ONFP training activities.

In support of this program the contractor will provide funds

for short term technical assistance to the ONFP by training experts who will participate in program design and in the development of evaluation methods and instruments. the contractor will also provide a financial contribution on a diminishing basis for direct training costs, including subcontractors hired for training, materials, supplies, and direct administrative support costs (except salaries). The collaboration of U.S. cooperating agencies and training institutions will be sought to help the ONFP strengthen family planning training in the medical schools and to stimulate fruitful linkages with U.S. educational institutions.

B. In-Service Training

As academic teaching of family planning is assumed by the medical faculties and the schools of public health, the current ONFP pre-service, post-graduate training activities will be phased out. The ONFP will then focus on developing an in-service training program which will increasingly focus on practical training, particularly in the areas of counseling and service delivery. The program will address the needs of public sector service providers. With a view to making this program directly relevant to field operations and field research, the ONFP proposes to conduct this training in regional sites, each coordinating activities in several governorates and drawing upon available local technical resources. These regional education units will be under the supervision of qualified ONFP délégués, who are trained educators, and will utilize the facilities of ONFP "Centres Régionaux d'Education et de Planning Familial" (CREPF). The national training center will provide the professional technical support for the development and periodic review of practical training modules and the dissemination of training materials. It will also conduct research to improve the quality and content of the program and evaluate the effectiveness of the teaching. The decentralization of training is desirable in order to reach community level workers in surroundings and circumstances with which they are familiar and in which they work.

The U.S. contribution to this activity will be directed primarily at encouraging the development and strengthening of the program through short-term technical assistance in program design and evaluation and, to a lesser extent, to supporting the cost of audio-visual training equipment for the national training center and four peripheral training units. The equipment will consist of: overhead and slide projectors, video recorders, plastic anatomy models and photocopiers. The amount for this equipment will not exceed \$30,000 over the life of the project. In addition, the project will support training of MOPH and MSA personnel through subcontracts.

Development of a detailed framework for a systematic approach to program design, implementation and evaluation will begin in FY 86. The bulk of the in-service training activities will be carried out in FY 86 and FY 87. Training of trainers activities will be undertaken in FY 86 - 87 and will decrease thereafter. Throughout the project, the national training center will also focus on the organization and management of a countrywide in-service training program at the regional level and international training.

C. Training Program Administrators

The present management staff of the ONFP training center consists of a part-time training director, a part-time medical coordinator and a full-time administrative assistant. While this staff has experience in managing training programs, it has been unable to meet all the needs of an expanded program. The ONFP will assign in FY 85 a full-time team responsible for implementing the training program. The team will consist of a curriculum development specialist, an evaluation specialist, a supervisory midwife for the practical medical training program and a learning materials development specialist. The team will participate in training activities at the national and provincial levels. Technical assistance, short-term training and exposure to other training programs will be required to develop the skills of the new staff and maximize their inputs in the training program.

The project will provide short-term training for the professional staff of the training center which is related to improving their functioning in training areas supported by the project.

The following criteria must be met by each of the above training activities which is to be funded under the project:

- 1) The program must address one of the following areas:
 - development of efficient delivery of family planning information and services to meet the ONFP demographic objectives for a specified population group;
 - focus on further integration of family planning into regular medical and other educational programs;
 - development of increased participation of field level personnel from other institutions in family planning, IEC and service delivery;
 - shifting of basic training from the ONFP to professional schools; or,

- establishment of regular, periodic review of staff work performance.
- 2) Methods for establishing costs of the training exercise must be clearly delineated and documented.
- 3) The target audience must be clearly identified and recruitment plans must be developed; for programs aimed at staff from other agencies, formal agreement from these agencies must be obtained.
- 4) A minimum enrollment agreed upon by the USAID project officer and the ONFP Director of International Cooperation must be achieved.
- 5) A clear evaluation plan, relating training to service delivery, must be undertaken.
- 6) The training purpose and objectives must be clearly stated and a training plan aimed at achieving these objectives must be included.

A yearly training plan will be submitted by the Director of the ONFP national training center as prescribed in the PP section, Project Implementation.

The contractor will disburse its contribution for training costs after receipts for the training session have been received by the contractor. The USAID financial contribution for training costs will be for training materials, subcontractors providing training, supplies and direct administrative support costs (except salaries). Reimbursement will be:

Year I: 80% USAID, 20% GOT,
Year II: 60% USAID, 40% GOT, and,
Year III: 40% USAID, 60% GOT.

D. US and Third-Country Training

As noted in the May 1984 USAID Evaluation, there exists a need for qualified demographers and population professionals in the GOT. To increase capacity of the ONFP and the MOPH in the field of population/family planning, the project will support long-term training of ONFP and relevant MOPH staff leading to a graduate degree in management of family planning programs, demography, operations research, or other disciplines directly relevant to the Tunisian national family planning program. Also, the project will support short-term training in the U.S. and third countries which leads to skills immediately applicable in

TABLE 2.5: Project Implementation Schedule: Component #3
Training

ACTIVITY	YEAR 1				YEAR 2				YEAR 3			
	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Recruitment of Multidisciplinary Team	X											
Training of Multidisciplinary Team		X										
Training Eval. Plan Finalized		X										
Final Training Plan Developed			X									
Long-Term Trainees in US			X	X	X	X	X	X	X	X		
Training of Trainers	X	X	X	X	X	X	X					
Inservice Training			X	X	X	X	X	X	X	X	X	X
Conferences			X				X				X	
Evaluation							X					

TABLE 2.6: Project Component #3:
Training

Element	YEAR 1		YEAR 2		YEAR 3		TOTALS	
	AID \$US 000	GOT TD000						
Training of Trainers	80.0	20.0	42.0	28.0	21.0	14.0	143.0	62.0
Inservice Training	35.0	8.8	30.0	20.0	25.0	37.5	90.0	66.3
Contract Trg.	50.0	0.0	50.0	0.0	25.0	0.0	125.0	0.0
External Training								
ST U.S.	30.0	6.0	20.0	4.0	20.0	2.0	70.0	12.0
LT U.S.	60.0	3.0	60.0	3.0	60.0	3.0	180.0	9.0
A/V Equipment	10.0	0.0	10.0	0.0	10.0	0.0	30.0	0.0
Conferences	21.0	7.0	21.0	7.0	21.0	7.0	63.0	21.0
Subtotal								
FX	286.0		233.0		182.0		701.0	
LC		44.8		62.0		63.5		170.3
Inflation								
FX (5%)			11.7		18.7		30.3	
LC (12%)				7.4		15.5		23.0
Contingencies (10%)	28.6	4.5	24.5	6.9	20.1	7.9	73.1	19.3
Totals	314.6	49.3	269.1	76.4	220.7	86.9	804.4	212.6

improving the Tunisian family planning program. It is anticipated that at least three individuals will receive graduate degrees under the project's sponsorship and that at least ten will receive short-term training. All international airfares will be paid by the GOT.

Component No. 4: Demographic and Family Planning Service
Delivery Research

The research activities funded by this project will focus on obtaining data for (1) targetting of family planning service delivery resources, (2) project evaluation, and (3) strengthening Tunisian population capabilities. These activities will be primarily under the direction of the Population Division of the ONFP, but will also include the Human Resources Division of the Ministry of Plan (MOP).

Resource Targetting

Targetting of family planning resources is defined to include research and other activities with focus on:

- determinants of method-specific contraceptive acceptance by different population subgroups;
- deterrents to use of family planning services and contraceptives; and,
- alternatives to the current family planning service delivery system which the GOT could adopt as a means of improving the cost-effectiveness of family planning service delivery in urban, peri-urban and rural areas.

Cost effectiveness is an issue since the current ONFP service delivery program is expensive in light of existing parallel social service systems which could be used to provide family planning services and the ONFP's expansion of its infrastructure to create its own parallel system. There have been some attempts to coordinate systems and service delivery functions (e.g., mobile teams to rural MOPH clinics), and indeed the ONFP is committed to increasing coordination. However, the focus of ONFP/MOPH collaboration to date has primarily been the detailing and training of MOPH personnel in family planning but without any systematic identification of target audiences or content. Collaboration with other Ministries has consisted of the introduction of family planning into the curricula of training schools, apparently with limited success, and some additional training. Possible alternatives for consideration could include integrated FP/MCH service delivery, door-to-door household visits

by social workers, community-based distribution (CBD), supervisory systems and motivation, joint regional/delegation programming, etc.

Research activities will measure impact, coverage, and costs. Results from these research activities, which may involve the support of small pilot activities, will provide information of value to the GOT's programming decisions in family planning service delivery.

The criteria to be applied in the selection and design of these research activities are as follows:

- (1) The activity must clearly address a question of program-targetting in the areas listed above.
- (2) If the research proposes to examine an alternative delivery system on a pilot basis, the proposed alternative must (a) utilize part of the GOT's existing social service delivery structure, with significant collaboration of Ministry/agency personnel and financial contribution (75% of personnel, 25% of research costs. The contract will support 100% of external technical assistance). (b) contribute to inter-Ministerial/agency collaboration.
- (3) The population studied must be representative of a large segment of the population or be an important target subpopulation.
- (4) The study methodology must be appropriate to address the question:
 - (a) research questions must be clearly stated,
 - (b) hypotheses must address research questions,
 - (c) preliminary sampling plan must be included,
 - (d) respondent burden must be reasonable,
 - (e) data collection methods must be reliable and valid,
 - (f) the analysis plan must be scientifically valid and must address the research question with the data to be collected, and,
 - (g) implications of findings for programmatic decisions must be clear.

(5) Staffing must be clearly delineated.

(a) A.I.D. will not support ONFP salaries;

(b) allocation of ONFP staff to project must represent sufficient time to adequately manage project and must not conflict with other responsibilities;

(c) if necessary, the contractor will support salaries for interviewers, data entry personnel and other research personnel, but only on a temporary, contractual basis;

(d) the contractor will support external technical assistance if needed for study design or data analysis.

(6) A plan for implementation and timely dissemination of research results to program decision makers must be included.

(7) Total cost of A.I.D. contribution to activity must not exceed \$125,000. A.I.D. will support up to eight studies over the LOP.

(8) Research activity must be completed by PACD (June 30, 1989).

(9) GOT contribution for each activity must be at least 25%.

Adherence of proposals to these criteria will be jointly assessed by the contractor and the Director of the ONFP Population Division. Funds for research in resource targetting will be disbursed only after it has been so determined that the activities meet the above criteria.

In addition to funding the above new research activities, the project will support the analysis of data obtained from centrally-funded research activities. In each case, however, the data must meet the criteria above for new activities to insure the scientific validity of findings. At least half of all project funding for resource targetting must include activities in which the MOPH or other non-ONFP service providers play a key role.

In addition, the project will fund other activities which aim at cost effectiveness, broader coverage, and use of other GOT organizations (e.g., the MOPH) in delivering services.

Project Evaluation

Research activities aimed at project evaluation will include a contraceptive prevalence survey to be performed late in 1987 and will provide data for assessing the overall success of the project, including demographic growth rate, crude birth rate and the contraceptive prevalence rate, by method and geographic

TABLE 2.7: Project Implementation Schedule: Component #4
Resource Targetting and Demographic Research

ACTIVITY	YEAR 1				YEAR 2				YEAR 3			
	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Demographic Study Proposal:		X										
Demographic Study					X	X	X		X	X		
Resource Targetting	X	X	X	X	X	X	X	X	X	X	X	X
Cost-benefit Study			X	X	X	X	X	X				
NFP Activities:					X	X	X	X	X	X	X	X
Evaluation						X						

TABLE 2.8: Project Component #4:
Demographic and Service Delivery Research

Activity	YEAR 1		YEAR 2		YEAR 3		Totals	
	AID	GOT	AID	GOT	AID	GOT	AID	GOT
	\$US 000	TD000						
Short-term T.A.								
*Person-months	4.0		4.0		4.0			
Salary	24.0	60.0	24.0	60.0	24.0	60.0	72.0	180.0
Per Diem	9.2	0.0	9.2	0.0	9.2	0.0	27.6	0.0
Travel/Misc.	12.0	0.0	12.0	0.0	12.0	0.0	36.0	0.0
Overhead	40.0		40.0		40.0		120.0	0.0
Resource Targetting								
*8 Activities	402.0	167.0	500.0	85.0	250.0	85.0	1,152.0	337.0
NFP Contract	0.0	0.0	30.0	0.0	30.0	0.0	60.0	0.0
Project Evaluation								
*Prevalence Study	0.0	0.0	125.0	0.0	125.0	0.0	250.0	0.0
Conferences								
Fee	1.0	0.0	1.0	0.0	1.0	0.0	3.0	0.0
Per Diem	1.0	0.0	1.0	0.0	1.0	0.0	3.0	0.0
Salary	0.0	0.4	0.0	0.4	0.0	0.4	0.0	1.2
Travel	3.0	0.0	3.0	0.0	3.0	0.0	9.0	0.0
Subtotal								
FX	492.2		745.2		495.2		1,732.6	
LC		227.4		145.4		145.4		518.2
Inflation								
FX (5%)			37.3		50.8		88.0	
LC (12%)				17.4		35.5		53.0
Contingencies (10%)	49.2	22.7	78.2	16.3	54.6	18.1	182.1	57.1
Totals	541.4	250.1	860.7	179.1	600.6	199.0	2,002.7	628.3

region. This will ensure an independent assessment of contraceptive prevalence in Tunisia.

Other activities aimed at improving local research capacity will include support costs for Population Division staff and other appropriate individuals to attend international population conferences, with priority toward support of those staff members who will be presenting results of research activities in Tunisia. Up to three such attendances will be supported each year of the project. Approval for attendance will be by the USAID project officer on the request of the Director of International Cooperation of the ONFP.

Natural Family Planning Activities

Finally, the project will provide modest support to a Tunisian nongovernmental organization, L'Action Familiale de Tunisie, under the resource targetting, to continue ongoing natural family planning activities. L'Action Familiale has for several years been engaged in education activities furthering natural family planning in Tunisia. This organization has been centrally-funded by A.I.D., but to increase its activities and ensure its continuing activity, this project will direct minimal resources to it in FY 86 and FY 87.

L'Action Familiale is unique in Tunisia, since it has ongoing programs in natural family planning and is the only organization in Tunisia which focuses its activities in this area. Its program is directed at training professionals, paraprofessionals and married women in methods of natural family planning. L'Action Familiale is associated with the Prelature of Tunis and is affiliated with the IFFLP.

L'Action Familiale will work under the technical and administrative guidance of the prime contractor for this project.

Project Administration

The project budget also covers costs of administration of the prime contractor and costs of administering and coordinating activities of involved cooperating agencies, NGOs and subcontractors. This budget supports a full-time project manager and a half-time secretary. It also provides logistic support, office equipment, travel and communications.

Contraceptives

The project provides centrally-procured contraceptives to

TABLE 2.9: Contraceptive Budget

Activity	YEAR 1		YEAR 2		YEAR 3		Totals	
	Quantity	US \$000	Quantity	US \$000	Quantity	US \$000	\$US 000 AID	\$US 000 GOT
Public Sector (AID)								
*Orals (cycle)	90.0	9.9	90.0	9.9	90.0	9.9		
*Condoms (units)	75.0	3.2	75.0	3.2	75.0	3.2	29.7	
*Cu-T (units)	41.0	35.0	41.0	35.0	41.0	41.0	9.6	
*Foam (cans)	10.5	12.0	10.5	12.0	10.5	12.0	111.0	
*Conceptrol (tabs)	37.5	2.7	37.5	2.7	37.5	2.7	36.0	
Subtotal		62.8		62.8		68.8	8.1	194.4
Public Sector (GOT & UNFPA)								
*Orals								
*Condoms								
*Cu-T								
Lippes								
*Foam	62.0		66.0		68.0			
*Conceptrol								0.0
*Crema/Gels								
Private Sector (AID)								
*Orals (cycle)								
*Condoms	1,623.0	173.5	1,494.0	164.4	1,388.5	141.7	479.6	
Subtotal	2,040.0	86.7	1,876.5	79.8	1,618.5	68.8	235.3	
*Overpacking		13.2		12.1		10.5	714.9	
Private Sector (GOT)								
*Orals (cycle)								
*Condoms (unit)	0.0	0.0	248.6	49.7	572.3	114.5		164.2
Subtotal	0.0	0.0	312.7	13.3	719.2	30.6		43.9
Overpacking		0.0		3.2		7.3		208.1
Shipping (AID)								
10% of cost		32.3		30.7		27.9	90.9	

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Subtotal								
FX		368.5		349.8		317.7	1,036.0	
LC	0.0		66.2		152.4			218.6
Inflation								
FX (5%) - AID				17.5		32.6	50.1	
FX (5%) - GOT			3.3		15.6			18.9
Contingencies								
(10%)	0.0	36.9	7.0	36.7	16.8	35.0	108.6	23.8
Totals	0.0	405.4	76.5	404.0	184.8	385.3	1,194.7	261.3

TABLE 2.10: Project Administration Budget

Element	YEAR 1	YEAR 2	YEAR 3	Totals
Project Manager	50.0	50.0	50.0	150.0
Secretary	5.5	5.5	5.5	16.5
Logistics	7.2	7.2	7.2	21.6
Office Equipment	2.5	0.0	0.0	2.5
Office Supplies	0.5	0.5	0.5	1.5
Communications	1.0	1.0	1.0	3.0
Miscellaneous	0.5	0.5	0.5	1.5
Travel	2.4	3.6	2.4	8.4
Overhead	69.6	68.3	67.1	205.0
External Audit	0.0	30.0	0.0	30.0
Evaluation	0.0	100.0	0.0	100.0
Subtotal FX	139.2	266.6	134.2	540.0
Inflation (5%)		13.3	13.8	27.1
Contingencies (10%)	13.9	28.0	14.8	56.7
Totals	153.1	307.9	162.8	623.8

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nsure supplies in the private and public sectors over the course of the project. These contraceptives will be procured through ID/W under PIO/Cs. In addition, overpacking of these contraceptives for the private sector component will be covered by the project. The source and origin of all contraceptives will be the United States.

III. IMPLEMENTATION PLAN

Implementation of the overall project will begin with the signing of a Project Agreement with the Ministry of Foreign Affairs in September, 1985. This ProAg will describe the purpose of the project, its major inputs and planned outputs. An initial obligation of \$_____ will be made at this time plus an in-kind contribution of contraceptives valued at \$_____. Implementing documents (PIO's, PIL's, etc.) will be prepared within three months after project agreement.

The major implementation actions of each of the four components are shown in tables 2.1, 2.3, 2.5, 2.7 in Section II of this Project Paper.

Project Management Plan

a. Within the GOT

The ONFP will be the primary recipient of U.S. assistance under this project. The ONFP has financial autonomy (authority to disburse without prior approval from other agencies) and, under the tutelage of the MFPF, relative management autonomy. The ONFP has authority to recruit and contract.

The President Director General (PDG) of the ONFP maintains final authority on technical matters and project activities in accordance with general GOT, ONFP, and "Conseil d'Administration" policies. The PDG is the ONFP's signatory and the direct counterpart of the USAID project manager for the bulk of the activities under this project.

The ONFP has maintained close and open contact with USAID throughout project design. Major project activities will be elaborated with ONFP technical staff during implementation. Field activities will be implemented in collaboration with ONFP regional délégués and staff.

Other GOT ministries and/or Tunisian organizations participating in the project will include the MOPH, MSA, and PVOs. This project will encourage the assumption by these groups of a more active service delivery role. The ONFP has initiated this process via its Commission de Programmation with respective groups. USAID will promote these actions by setting aside funds for use only with participating organizations.

b. In the Private Sector

The contraceptive social marketing activities will engage local Tunisian organizations in the private sector as needed to

execute specific activities. This will be done through subcontracting with such organizations as:

- a private research organization to conduct qualitative research prior to message development and in testing product packaging;
- an advertising agency to produce media materials, promotional materials and packaging for the CSM products; and
- an organization to recruit, train and supervise detailers and develop the medical detailing system.

c. Contractors

Under a competitively awarded contract, research and training TA and public sector IEC will be carried out. This contractor will hire a part-time, long term (30 pm) coordinator/management advisor. This individual will work directly with the ONFP to handle administrative details for the project and also to provide technical assistance related programming, management and budget structure, training, IEC and TA needs. The contractor will be required to support most aspects of project implementation, identification and scheduling of short-term consultants and scopes of work, identification of training candidates and programs, etc. In addition, the contractor will coordinate work of all subcontractors, under supervision of the A.I.D. project monitor.

The contractor will be responsible for working with the ONFP IEC Division in establishing the Social Marketing unit and operations. This will include training (on-the-job and formal), establishing contacts with private sector marketing and advertising companies, assisting in market and audience research design and implementation, assisting in establishing a contraceptive distribution system, overseeing the design of IEC materials, etc; and for identifying and scheduling short term consultants in CSM activities.

Westinghouse Public Applied Systems, under its Cooperative Agreement with A.I.D. will be used to conduct the contraceptive prevalence study under the project. Their work will be coordinated by the prime contractor, under the supervision of the USAID monitor for the project.

Finally, a subcontract will be executed with L'Action Familiale de Tunisie, of the Prelature of Tunis to continue natural family planning activities presently underway. This contract will be supervised directly by the prime contractor

under the guidance of the Mission's project monitor. L'Action Familiale is unique in Tunisia, since it has ongoing programs in natural family planning and is the only organization in Tunisia which focuses its activities in this area. Its program is directed at training professionals, paraprofessionals and married women in methods of natural family planning. L'Action Familiale is associated with the Prelature of Tunis and is affiliated with the IFFLP. L'Action Familiale will work under the technical and administrative guidance of the prime contractor for this project.

d. Within USAID

The USAID/Tunis Population portfolio will be monitored in the Mission's Program Office. USAID will assume administrative, documentary and coordinative responsibilities of the project.

f. A.I.D. Grantee/Contractor Organizations

Other technical assistance will be provided under A.I.D./W-funded agreements, complementary to project activities, in such areas as IEC materials development; operations research; family planning records and data management; private sector project design; and management, analysis and evaluation. USAID will also draw on personnel from these and other organizations to assist in project evaluations, as described in the Evaluation Plan (Section VII).

Contracting Plan

Contracting under the project will include procurement both within Tunisia and in the United States. Most project activities will be under a competitively awarded Direct A.I.D. contract. This contractor will be responsible for all training and research activities as well as CSM and IEC activities. In addition, the contractor will coordinate the contraceptive prevalence study, which will be conducted by Westinghouse Public Applied Systems under its A.I.D. Cooperative Agreement. Subcontracts will be issued for production of IEC materials, for training of délégués in the CSM activity, for overpacking of contraceptives, for in-country qualitative research, and for some training activities covered by the project, but these will be negotiated by the ONFP with the guidance of the contractor. PIO/Ts will be issued for technical assistance not covered by these contracts (such as the project evaluations); PIO/Ps will be issued for all training and observational visits outside of Tunisia. Commodities, including contraceptives, will be purchased through PIO/Cs by AID/W.

The contraceptive prevalence survey to be conducted in 1987 will be conducted by Westinghouse Public Applied Systems under their existing cooperative agreement with A.I.D.. This contract will provide all technical assistance necessary for this activity and will provide analysis of data and reporting prior to December, 1988.

The contracting process will require that either the prime contractor be a minority firm or that the subcontracting plan of the prime contractor include subcontracts to minority firms.

The contracting plan for the project is given in Table 3.1.

TABLE 3.1: Contracting Plan

<u>Component/Activity</u>	<u>Method of Implementation</u>	<u>Approximate A.I.D. Amount</u>
<u>1. IEC</u>		
Technical Assistance	Direct AID	
	Contract (A)	203.7
Research-Focus Groups	Subcontract	36.0
KAP	Direct AID	600.0
	Contract (A)	
Media Materials Prod.	Subcontract	674.0
Print Materials	Subcontract	180.0
A-V Equipment	Direct AID	
	Contract (A)	30.0
<u>2. Contraceptive Social Mktg.</u>		
Technical Assistance	Direct AID	
	Contract (A)	447.0
Research-Pharmacists' Survey	Direct AID	
	Contract (A)	17.5
Training-Observation	PIO/P	5.5
-Regional	PIO/P	1.8
-U.S. Based	PIO/P	12.0
-Pharmacist	Subcontract	27.5
-Délégués	Subcontract	45.0
Overpacking	Subcontract	35.8
Message Development	Direct AID	225.0
	Contract (A)	
<u>3. Training</u>		
Technical Assistance (including Training of Trainers and Inservice)	Direct AID	296.0
	Contract (A)	
In-Country Training	Subcontract	125.0
U.S. Based Training	PIO/P	250.0
A.V. Equipment	Direct AID	30.0
	Contract (A)	

4. Demographic and Service Delivery Research

Technical Assistance	Direct AID	255.6
Research - Resource	Contract (A)	
Targetting	Subcontract	1152.0
NFP activities	Subcontract	60.0
	(Action Familiale)	
Prevalence Studies	Westinghouse	250.0
	Coop. Agreement	
Conferences	PIO/P	15.0

5. Project Administration

Project Management	Direct AID	410.0
	Contract (A)	
Audit	PIO/T	30.0
Mid-term & Final		
Evaluations	PIO/T	100.0

6. Contraceptives	PIO/C	1194.7
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IV. MONITORING PLAN

All project activities, including those funded by A.I.D./w grantees-contractors, will be monitored by USAID/Tunisia. Direct monitoring will be the responsibility of the project manager in the USAID Program Office. USAID will follow project progress in accordance with the implementation plan and/or detailed work plans established for individual activities; and will ensure sufficient project documentation (PIL's, PIO's, semi-annual progress performance reports from long term contractors) for reference during evaluation).

The ONFP will submit yearly, by January 15th, a report of activities conducted under the project for the previous year and a program of activities for the subsequent year.

The USAID project manager will participate in all project evaluation activities, and will ensure that evaluation findings and recommendations are reflected in revisions, as appropriate, in project design or execution.

V. SUMMARY OF ANALYSES

A. Technical Feasibility Analysis

The IEC and CSM activities under the project will build on an existing infrastructure. IEC activities will take place in

the mass media under agreement with GOT officials responsible for these organizations. In addition, production of messages will be based on empirical findings and will be conducted under subcontracts with local firms specializing in this area with technical assistance under the direct A.I.D. contract. The CSM activities will be through the existing network of pharmacies. Both the mass media and pharmacies are available widely in Tunisia and these activities are likely to reach the target population.

Problems which must be addressed during the project relate, however, to pricing of contraceptives in the private sector and distribution to the private sector. In addition, there are contextual constraints which must be heeded in developing messages to ensure that the messages will not cause a backlash and possible termination of project activities. The IEC and CSM project components will address all of the governorates in Tunisia.

With respect to proposed training activities, contacts between the ONFP and the professional schools are presently being developed. The project aims to turn over basic education to these institutions, but there will be a need to closely monitor the proper assumption of this role by these schools. With respect to inservice training activities, the ONFP has set up regional training centers which will provide the basis for identifying training needs and for developing programs to meet these needs.

The research program is built on an existing cadre of professionals in the field of demography. There is a need for adequate computer equipment and training as a prerequisite to conducting meaningful research. Also, as noted in the May 1984 evaluation, there is a continuing need for training of the research staff at the ONFP. The staff are presently over-extended in their responsibilities and there will be a need to prioritize activities in this area. In addition, there is a need to contract out activities so as not to enlarge the ONFP staff at a time when GOT budget constraints are prohibitive. Finally, since no comprehensive cost-effectiveness evaluation has been conducted of the Tunisian family planning program, this should receive highest priority under the project.

B. Financial Analysis

In spite of a general deterioration in the Tunisian macro-economic situation during the early 1980s, GOT allocations to the ONFP increased in real terms by 142 percent, and as of 1984 comprised 59 percent of total funding for the

ONFP. If the trends established during the 1980s continue, the GOT will support approximately 70 percent of the ONFP budget by 1986. Although the GOT has demonstrated its commitment to pick up the costs associated with their family planning program, donor support will be required after 1986 to maintain current ONFP programs until transfer of financial responsibility for these programs to the GOT is complete.

The proposed AID project will continue to support activities started under the centrally-funded project, as well as support relatively new ONFP initiatives in social marketing and private sector contraceptive distribution. However, the new project will not pick up many of the recurrent expenditures currently supported by the intermediary agencies. It is strongly recommended that AID offer support to the ONFP to identify ways that the transition between the funding support of the two projects can be made smoothly. In addition to this transitional support, several activities of the proposed project will assist the ONFP in matching future program activities to anticipated recurrent budgetary funds.

The annual local currency recurrent costs implied by the proposed project are estimated to equal 4.5 percent of the projected GOT contribution to the ONFP in 1991. In view of anticipated pressures on the GOT to reduce the growth of public expenditures, the ability of the GOT to pick up these additional recurrent costs will depend to a great extent on the strength and level of political support for family planning in Tunisia.

The annual foreign exchange recurrent costs implied by the project are estimated to equal 10.3 percent of the projected GOT contribution to the ONFP in 1991. It is expected that the additional revenue generated as a consequence of altering GOT contraceptive pricing policy will cover at least the local currency equivalent cost of the pills and condoms distributed to the private sector, and thus a large percentage of the above recurrent costs. Further, the estimated additional FX requirement of project activities is equivalent to only 0.03 percent of Tunisia's total import (fob) bill in 1983. Contraceptives, the largest component of these costs, are estimated to equal only 1.2 percent of total Tunisian 1983 pharmaceutical imports. These FX requirements seem insignificant in light of total Tunisian pharmaceutical and import bills, and it is not expected that the GOT will have difficulty allocating sufficient FX to finance these requirements in 1990. Nevertheless, the adequacy of planned AID post-project support (in the form of contraceptives for the GOT public sector family planning programs), will be an important issue for consideration during the mid-term project

evaluation.

Finally, the contraceptive cost-recovery objectives proposed by the project imply at least 6-fold increases in the prices of pills and condoms sold in the private sector. Anecdotal information for Tunisia, and from studies in other developing countries, is reassuring that such price increases will not result in permanent declines in private sector contraceptive sales, especially in light of the absolute amount of increase desired. Nevertheless, the introduction of proposed price increases should occur slowly, in order that the actual response of Tunisians (particularly low income households) to the price changes, can be taken in to account in determining a final pricing strategy for the country. The GOT's contribution to the ONFP budget has increased from 31% in 1980 to 59% in 1984. However, donors are still an important source of revenue for the ONFP. The annual rate of increase of the GOT contribution (in 1980 TD) has fallen from 43% from 1982 to 1983 to 5% from 1984 to 1985. Considering both the GOT and donor contributions to the ONFP's budget (in 1980 TD), the annual rate of increase of the ONFP budget has declined from +10% from 1981 to 1982 to -5% from 1983 to 1984.

C. Economic Analysis

An economic analysis examines the cost-benefit and the cost-effectiveness of a program to determine whether it is a sound investment. It is difficult to use traditional methods of cost-benefit analysis for family planning programs since it is hard to assign a value to a life saved or a birth averted. Approaches which are usually used either evaluate the effects of reduced population growth rates on per capita income or the difference between an individual's projected consumption (including social services) and the individual's production over a lifetime. Both approaches have shown family planning programs to have a high return.

Examining the cost-effectiveness of this program is difficult since there are several new components which have not been tried in Tunisia and since it is difficult to determine the effectiveness of existing programs in increasing prevalence and reducing birth rates.

D. Social Soundness Analysis

Tunisia is a society which is predominantly Islamic. While there are conservative religious interpretations regarding family planning, it is not per se prohibited in the teachings of the prophet. In fact, there are several interpretations which support family planning activities, especially as related

to the health of the mother and children. The GOT has strongly supported family planning since shortly after independence, however the decrease in the crude birth rate (from 45 in the early 1960s to 35 in the early 1980s) may be attributable to the increased age at marriage, better education, and the GOT's limit in family allowances for large families. The 1978 World Fertility Survey found that the average number of children desired in Tunisia stands at 4.2.

The economic basis for a family planning program is clearly evident. The growth of the young labor force, while slower than in many developing countries, is more than double that of the developed countries. This is especially problematic given the scarcity of existing jobs and the slow creation of new employment.

This project builds on twenty years of A.I.D. support for family planning activities in Tunisia. There are clear lessons to be learned from previous experience, both positive and negative. In particular, attention must be paid to the cultural context in which the project takes place. For example, the SYNTEX project in 1977-78 failed because project designers failed to take into account that mass-media advertising is very limited in Tunisia; advertising of contraceptives on television before advertising of other commercial products was sought and ultimately led to the cancellation of the project. Also, considerable operations research has been conducted in Tunisia. The results of this research should be examined to determine adequate ways to implement project activities.

E. Administrative Analysis

The project will work primarily with the ONFP and secondarily with the MOPH. The focus will need to be on accentuating the coordination role of the ONFP and the service delivery role of the MOPH. At the same time, the assumption of activities formerly conducted under the auspices of the ONFP by other organizations will need to be carefully monitored.

The project will increase the staff of the social marketing unit within the IEC Division of the ONFP by five. This is necessary given demands of reaching private sector service providers. Recurrent costs of this staff increase will be met by increased revenues generated by increased contraceptive prices in the private sector. In addition, eligible staff might be transferred from other redundant ONFP positions into these positions.

Monitoring of the program will be within the program office of USAID.

Programs aimed at service providers assume that they will be motivated to perform family planning functions. Likewise, the shifting of basic training to professional schools assumes that staff in these schools will be motivated and qualified to teach new family planning content. These assumptions will need to be verified over the course of the project.

VI. POLICY ISSUES, CONDITIONS, COVENANTS AND NEGOTIATING STATUS

Policy Issues

Policy adjustments which are crucial to the success of this project and, more importantly, to Tunisia's ultimate realization of a valued national growth rate, fall into two major categories: liberalization of regulations regarding promotion, pricing and distribution policies; and the inclusion of focused demographic projections reflected in the VIIth National Development Plan (to begin January 1, 1987).

As of May, 1985 contraceptives - which in Tunisia fall under the realm of pharmaceuticals - are not promoted in the media or at points of sale/distribution. Legal authority to allow advertising of pharmaceuticals (including contraceptives) rests with the MOPH which has not to date taken steps to issue the required enabling regulations for (pharmaceuticals) contraceptives to be advertised by brand name or display. (See Section No. II.B on Social Marketing) In order to permit brand specific advertising of contraceptives a policy decision by the MOPH would be required to issue regulations governing contraceptive advertising. While brand specific advertising is not mandatory for this project, long-range gains could be made in contraceptive prevalence if brand-specific advertising were permitted. During the project USAID will continue policy dialogue in this area.

Method-specific promotion of contraception will be required, at least in pharmacies and ideally in the mass-media, during this project.

Closely related to the issue of promotion is that of pricing policy. Officially established prices bear no relation to the cost of production. Prices for contraceptives have not been changed since 1976. It is clear that the current contraceptive price structure might need to be revised with an increase to a level which will more realistically relate to the actual costs involved in making contraceptives available in the private sector. Even with the substantial subsidy envisioned during the planned social marketing experiment, the present

permitted price for contraceptives seems far too low to allow for any cost recovery which is necessary if social marketing is to be at all viable in the Tunisian context. Therefore, the GOT needs to examine whether there is a need for the establishment of a more realistic and equitable contraceptive pricing structure in the private sector.

Coordination of family planning activities among public service providers (ONFP, MOPH, MOSA) has been weak; indeed coordination between the ONFP and the MOPH has been discouraged during the course of Cooperating Agency activity in Tunisia. This project sets aside money to support only activities aimed at coordination among agencies, particularly the ONFP and the MOPH.

Distribution of contraceptives was taken from the private sector and placed in the hands of the ONFP during 1982 and 1983. Since this time supply problems appear to have developed in pharmacies. USAID will encourage a return of distribution to the private sector during the project.

Dispensing of contraceptives has become conservative over the past four years; pills can be dispensed only by physicians or by pharmacists or midwives under a physicians prescription (except for resupply of pills which is now permitted by nurses, social workers and family aides - as a result of USAID policy dialogue). Also, in the public sector, first cycle pills are provided to an acceptor only during her menses; no secondary method is provided in the interim. USAID will seek a liberalization of medical protocols regarding contraceptive distribution.

Recommended Covenants and Condition Precedent

Based on the above policy considerations, the following Condition Precedent and Covenants are recommended for inclusion in the project agreement:

Except as the Parties may otherwise agree in writing, the following condition precedent, which must be satisfied in form and substance satisfactory to A.I.D., is applicable to the project:

Prior to any disbursements after the publication of the VIIth Development Plan, there must be evidence that subsidies on contraceptives on sale in pharmacies have been substantially diminished and prices increased to a level which provides adequate incentive for pharmacists and wholesalers and helps to meet recurring costs of the ONFP.

Special Covenants

(1) The Parties agree to establish a Project Evaluation program. Except as the Parties otherwise agree in writing, the program will include, during the implementation of the Project and at one or more points thereafter: (a) evaluation of progress toward attainment of the objectives of the Project; (b) identification and evaluation of problem areas or constraints which may inhibit such attainments; (c) recommendations as to how such problems or constraints should be addressed; and (d) evaluation, to the degree feasible of the overall development impact of the Project. The ONFP, in collaboration with the institutions responsible for technical assistance under the Project, will develop an information system which will satisfy A.I.D. project evaluation requirements. The periodic evaluations required by this Section will be carried out by teams composed of representatives of A.I.D. and Government officials appointed by the ONFP.

(2) The GOT/ONFP agrees to study and implement management and administrative changes that will assist the ONFP achieve its mandate more efficiently and effectively. The study will address the role of the ONFP in relation to the role of the MOPH, the private sector, pharmacies, and medical schools. This study will be completed by December, 1986; this project will provide technical assistance to the ONFP as needed for this study.

(3) The GOT/ONFP agrees to require method-specific promotion of contraception in pharmacies within 120 days of the effective date of this agreement and to allow method-specific promotion of contraception in the mass-media by the second year of the project.

(4) The GOT agrees to increase the contribution of the Ministry of Public Health as a provider of family planning services, particularly in the areas of providing tubal ligations, distribution of IUDs and pills, pre- and post-partum family planning counseling, and rural service delivery and to develop a stronger coordination between the MOPH and the ONFP with respect to family planning service delivery. Within six months of the signing of the project agreement, the ONFP and the MOPH will develop a plan and a timetable for actions leading to an increased contribution of the MOPH in these areas.

(5) Except as agreed to in writing:

(a) The equipment provided under the Project shall be restricted to the purposes provided the this Agreement.

(b) The ONFP will be responsible for logistical support of A.I.D.-financed contract personnel within the project area, including office space, clerical support and transportation outside of the Tunis area.

(6) Section 6.2: Prohibition of Abortion-Related Activities: None of the funds made available under this grant may be used to finance any costs relating to (a) performance of abortion as a method of family planning, (b) motivation or coercion of any person to undergo abortion, (c) biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion as a method of family planning, or (d) active promotion of abortion as a method of family planning.

(7) Article 8: Disbursements for Family Planning Projects: Section 8.1: Disbursements for Foreign Exchange Costs: (A) After satisfaction of conditions precedent, the grantee may obtain disbursements of funds under the grant for the foreign exchange costs of goods or services required for the project in accordance with the terms of this agreement by such of the following methods as may be mutually agreed upon: (i) by submitting to A.I.D. with necessary supporting documentation as prescribed in implementation letters (a) requests for reimbursement for such goods or services or (b) requests for A.I.D. to procure commodities or services on grantee's behalf for the project or (c) requests for A.I.D. to issue letters of commitment for specified amounts directly to one or more contractors or suppliers committing A.I.D. to pay such contractors or suppliers for such goods or services.

(8) Section 8.2: Disbursements for Local Currency Costs: (A) After satisfaction of conditions precedent, the grantee may obtain disbursements of funds under the grant for local currency costs required for the project in accordance with the terms of this agreement by submitting to A.I.D., with necessary supporting documentation as prescribed in project implementation letters, requests to finance such costs. Disbursements by A.I.D. shall be in reimbursement for goods or services required for the project or, if advances of local currency are mutually agreed upon, disbursements shall be made into a special account to ensure, inter alia, that none of the funds provided by A.I.D. may be used to finance any of the costs prohibited under Section 6.2 of this agreement. (B) Local currency advanced by A.I.D. to the grantee may thereafter be advanced by the grantee to any other entity for the purposes of the project with the agreement of A.I.D. only if such advances are also made into a segregated account or accounts to ensure that such funds may not be used to finance any costs prohibited under Section 6.2 of this agreement.

VII. EVALUATION PLAN

Evaluations will be critical to ensure that activities are selected and implemented in light of what the project has been designed to achieve. As such, scopes of work must be designed to identify special or on-going problems impeding execution of output activities and to determine if implementation plans and/or strategies need to be modified.

Several evaluative procedures have been built into this project. These procedures are both specific to the project components and to evaluation of overall progress toward the project purpose.

Baseline contraceptive prevalence and demographic data will be available early in LOP, from the 1983 CPS and 1984 census. A KAP survey will be conducted early in the project, and will include consumer groups, pharmacists, physicians and decision-makers. This information will be used for planning/targetting as well as for later assessment of project impact.

Training activities will be evaluated on the basis of their effectiveness in contributing to an ONFP programming and planning, supervision and evaluation function; improved IEC programs; and increased collaboration with other Ministries/agencies. As the training component is necessary to all project elements, an assessment of its effectiveness will be made by category.

Operations research activities, by their nature, have an evaluative mechanism built into their function. Beyond this level, project evaluations will need to show how OR results contribute to the project's purposes of designing demographically focussed, affordable and effective programs.

An external evaluation will be undertaken in mid-project. It will review the earlier PES and assess subsequent actions taken. A major focus of this evaluation will be on policy changes, important assumptions affecting achievement of the project purposes, and the general socio-political-economic setting. Recommendations pertaining to continued A.I.D. support, at what level, for how long and under what conditions will be made for all project components. It is assumed that a project-funded contraceptive prevalence survey will be conducted in 1987 will be available to determine demographic impact and contraceptive usage. Other project components will be evaluated against EOPS conditions. The evaluation will use external consultants (contractors/IQC's).

A total of \$100,000.00 has been budgeted for evaluations.

Best Available Document

TO: DIRECTOR, USAID
 FROM: NEAC
 SUBJECT: REVISION OF TUNISIAN FAMILY PLANNING AND POPULATION DEVELOPMENT PID (614-3331)

TO: DIRECTOR, USAID
 DATE: JAN 15 1971
 FROM: NEAC
 SUBJECT: PID
 DIST: AID

ATTN: [illegible]
 [illegible]

NEAC HAS REVIEWED THE PID ON DECEMBER 23 WITH DEBOUT
 AND [illegible] PRESIDING. THE USAID/TUNIS
 ADVISOR, JIM VERRILLION, AND EMILY LEONARD
 WERE PRESENT VIA TELEVISION.

1. THE PID OPENED WITH A SUMMARY OF THE REVISIONS MADE
 TO THE SUBMITTED PID (ORIGINAL WAS REVIEWED BY NEAC
 ON [illegible]). THESE INCLUDED:

2. THE PID OPENED WITH A SUMMARY OF THE REVISIONS MADE
 TO THE SUBMITTED PID (ORIGINAL WAS REVIEWED BY NEAC
 ON [illegible]). THESE INCLUDED:

- [illegible] TO CORRESPOND WITH [illegible]
- [illegible] OF INTENDED CHANGES IN POLICIES
 INCLUDING PROMOTION OF SOCIAL MARKETING INCLUDING
 EXTENSION OF DISTRIBUTION NETWORKS VIA
 PROMOTION OF CONTRACEPTIVE
 AND REMOVAL OF COMMODITIES

THE PRIVATE SECTOR ROLE IN FAMILY

CONCERNED WITH FAMILY PLANNING

CONCERNED WITH FAMILY PLANNING

PROJECT BUILDS ON CONTINUATION OF THE
 ELEMENTS OF THE CURRENT PROGRAM
 WILL CONTINUE SUPPORTING
 HAVE BEEN SUCCESSFUL (JUDGMENT, HAVE) A
 ELEMENTS WHICH HAVE BEEN SEPARATE BUT
 FOR GREATER IMPACT (E.G. IFC, SOCIAL
 PROJECT WILL NOT FUND THOSE CENTRALLY
 WHICH HAVE NOT BEEN AS SUCCESSFUL (E.G.
 A COMPLEMENTARY FOCUS OF THE PROJECT IS

... FOR ALL ASPECTS OF SERVICES AND DELIVERY.

3. RECOMMENDATIONS AND DECISIONS

A. DECISIONS BY THE NEAC:

1) MOPS: THE NEAC RECOMMENDED THAT PID BE APPROVED FOR DEVELOPMENT INTO A PP AND THAT THE FINAL PP BE APPROVED BY THE MISSION. THE NEAC NOTED THAT THE PP SHOULD PROVIDE SPECIFICS ON SUCH ISSUES AS; SOCIAL SERVICES, PRIVATE SECTOR ROLE, AND POLICY DIALOGUE STRATEGIES AND BENCHMARKS.

2) FUNDING LEVEL: THERE WAS SOME DISCUSSION THAT PP LEVELS COULD REACH US\$ 12 MILLION. THE NEAC ENCOURAGED USAID TO ESTABLISH A BUDGET WHICH CORRESPONDS TO PROJECT NEEDS; AND REQUESTED THAT MORE PRECISE BUDGET FIGURES BE COMMUNICATED TO AID/4 AS SOON AS AVAILABLE TO FACILITATE PLANNING.

B. ISSUES CONSIDERED CRITICAL TO APPROVAL/AS A CONDITION OF DISBURSAL PP APPROVAL:

IN ORDER TO IMPLEMENT THE AGENCY'S POLICY REGARDING AERATION ACTIVITIES, A PROVISION READING AS FOLLOWS MUST BE INCLUDED IN THE GRANT AGREEMENT BETWEEN A.I.D. AND THE BOT:

"THE BORROWER/GRANTEE AGREES THAT FUNDING PROVIDED BY A.I.D. FOR THIS PROJECT SHALL BE DISBURSED IN REIMBURSEMENT FOR COSTS INCURRED, OR IN ADVANCE TO SEPARATE ACCOUNTS, TO ENSURE THAT NONE OF THE FUNDS PROVIDED BY A.I.D. FOR THE PROJECT CAN BE USED TO SUPPORT AERATION."

THE GRANT AGREEMENT SHOULD ALSO MAKE IT CLEAR THAT AERATION SHOULD BE INCLUDED IN ALL SUBGRANT AGREEMENTS.

C. RECOMMENDATION OF THE MISSION TO RESOLVE THE DISCREPANCY IN FERTILITY LEVELS:

THE MISSION EXPRESSED CONCERN THAT THE PROJECT GOAL (AND PROJECT GOAL) IS NOT WELL DEFINED. THE FIGURES USED FOR THE PROJECT GOAL ARE, THEREFORE, UNAMBITIOUS FOR A PROGRAM OF THIS TYPE. IT IS RECOMMENDED THAT THESE FIGURES BE REASSESSED TO REFLECT REAL WORLD CONDITIONS IN FERTILITY.

UNCLASSIFIED

STATE 00653/31

AC: AID ... PLANS FOR ECON CHRON

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TO ... PRIORITY 3331
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LOC: INCC...
30 JAN 85
CN: ...
CHRG: AID
DIST: AID

UNCLAS SECTION 02 OF 32 STATE 006533

2) MOBILE CLINICS/ALTERNATIVES TO SERVICE
OUTREACH: THE NEAC PROPOSED THAT THE COST-EFFECTIVENESS
OF THE MOBILE CLINICS BE REVIEWED WITH THE INTENT OF
PHASING OUT THIS CENTRALLY FUNDED ACTIVITY TO OTHER
ALTERNATIVES AS SOON AS FEASIBLE (E.G. EARLY IN FY '86).
ALTERNATIVE MODES OF SERVICE DELIVERY AND RELATED ACTIONS
SHOULD BE CAREFULLY CONSIDERED, AND A DETERMINATION OF
WHERE TO CHANNEL PROJECT RESOURCES FOR MAXIMUM COST
EFFECTIVE SERVICE DELIVERY, MADE. SOME QUESTIONS RELATED
TO THIS WHICH DESIGN AND PP DESIGN TEAM SHOULD CONSIDER
ARE:

- WHAT CAN THE PRIVATE SECTOR REALISTICALLY COVER?
- WHAT ARE COST-EFFECTIVE APPROACHES (E.G. CBD, UNTAPPED RESOURCES, AND INFRASTRUCTURES OF OTHER MINISTRIES/AGENCIES)?
- WHAT IS THE POTENTIAL EFFECT OF CHANGES IN MEDICAL PROTOCOLS, ETC. ON COVERAGE/CONTRACEPTIVE PREVALENCE?

3) SOCIAL MARKETING: THE NEAC CONCLUDED THAT SOCIAL MARKETING WOULD BE APPROPRIATE FOR THE TUNISIA CONTEXT, BUT NOT TO THE EXCLUSION OF OTHER APPROACHES. AN APPROPRIATE "MIX" OF PROJECT COMPONENTS SHOULD INCLUDE ACCORDINGLY SOCIAL MARKETING ELEMENTS; AND THE LATTER

SHOULD PROVIDE AN INDICATION OF COST BASIS FOR SERVICES AND PRICING LEVELS.

4) TUNISIA'S LEVEL OF SOPHISTICATION (I.E. ECONOMIC DEVELOPMENT ISSUES IN FP/POPULATION) WOULD ...
... OF THE "STANDARD" ...
... COULD BE TARGETED TO LOOK AT SUCH FUNCTIONS AS ...
... CHANGES IN MEDICAL PROTOCOLS OR THE EFFECT ...
... ON CONTRACEPTIVE PREVALENCE (CP). AS ...
... RAPID PROJECT WOULD NOT BE ...
... (STANDARD MODEL), AID IS ALREADY OVER ...
... THE DESIGN SHOULD CONSIDER CONTRACTING ...
... FOR A RAPID-TYPE COMPONENT FOR ...

5) PROJECT TRAINING COMPONENT: THE PP DESIGN SHOULD CONSIDER A TRAINING STRATEGY THAT WILL INCREASE EMPLOYMENT ON TRAINING AT ALL LEVELS, E.G. MEDICAL AND

PARAMEDICAL STUDENTS AND, PARTICULARLY, LOWER LEVEL NO. AND OTHER OUTREACH PERSONNEL. THE INTENT IS TO ESTABLISH AND INSURE A MECHANISM FOR FAMILY PLANNING THROUGH ALT.

6) GOT ASSUMPTION OF COST: THE PP DEVELOPMENT PROCESS SHOULD CAREFULLY REVIEW THE GOT'S ABILITY TO INCREASINGLY ASSUME COSTS.

7) COORDINATION: THE PP SHOULD ANALYZE AND DESCRIBE HOW THE PROJECT ACTIVITIES AND OTHER DONOR'S ACTIVITIES WILL BE COORDINATED, INCLUDING THE IDEA OF A COORDINATING BOARD.

8) PP DESIGN STRATEGY: AS DISCUSSED WITH JIM VERMILLION; IT IS PROPOSED THAT THE PP DESIGN PROCEED IN 2 STAGES, I.E.

- A) PRELIMINARY COUNDTWORK AND ANALYSIS IN 1) CONTRACEPTIVE SOCIAL MARKETING/IEC COUNTRY ASSESSMENT INCLUDING PROBLEMS AND LESSONS LEARNED FROM PREVIOUS CONTRACEPTIVE SOCIAL MARKETING ACTIVITIES (SYNTEX) IN TUNISIA; 2) CONTINUED PROJECT-SPECIFIC POLICY DIALOGUE AND ASSESSMENT OF GOT'S REAL COMMITMENT TO RELEVANT PROJECT POLICY ISSUES; 3) INVENTORY OF OTHER DONOR ACTIVITIES, AND INITIAL DISCUSSIONS ON COORDINATION; 4) IDENTIFICATION OF INSTITUTIONAL ANALYSES; 5) REVIEW OF DEMOGRAPHIC DATA AND OPTIMAL TARGETS; AND 6) INTERNAL REVIEW OF HOW PROJECT MONITORING RESPONSIBILITIES AND CAPABILITIES AND

1) FULL PROJECT PAPER DEVELOPMENT

PHASE (A) SHOULD BE UNDERTAKEN WITH THE ASSISTANCE OF THE TWO LOCAL HIR PP DESIGN TEAM MEMBERS. PHASE (B) SHOULD INCLUDE WORKSHOPS IN FINANCIAL AND ECONOMIC ANALYSES.

**PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK**

Annex II

From FY 86 to FY 88

Total U. S. Funding 7,500,000

Date Prepared: 7/2/85

Project Title & Number: 664-0331 Family Planning and Population Development

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS														
<p>Program or Sector Goal: The broader objective to which this project contributes: To reduce Tunisia's fertility rate by 1988, and thereby enhance potential for achievement of the country's economic and social development objectives.</p>	<p>Measures of Goal Achievement: - Population growth rate reduced - Age-specific fertility reduced</p>	<p>Demographic data CPS 1987-88</p>	<p>Assumptions for achieving goal targets:</p>														
<p>Project Purpose: To increase contraceptive prevalence by 9% through:</p> <ul style="list-style-type: none"> - targetted and evaluated IEC activities - contraceptive social marketing - targetted and evaluated training - program focussing, including demographic and operations research - identification of alternative public sector delivery mechanisms 	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <ol style="list-style-type: none"> 1. 42.7% of MWRA practicing a modern method of family planning in governorates covered under this project 2. Contraceptive purchases through pharmacists increased by 52%. 3. Systems for programming, implementing and evaluating FP services, research, training, IEC based on needs, cost-effectiveness and resources available in place. 	<ul style="list-style-type: none"> - CPS, 1981; FY 87-88 - ONFP marketing organization unit and network - Pharmacists' display and stocks - Sales Statistics - Pharmacist and consumer interviews - KAP studies - Field visits; observation/interviewing 	<p>Assumptions for achieving purpose:</p> <ul style="list-style-type: none"> - 1985 CP is correctly reported at 34% - Significant unmet need/demand for FP services exists - GOT and ONFP will implement organizational changes based on program objectives - Pharmacists will have an interest in and commitment to serving as informed providers of health education and services - GOT will continue to provide budget support for FP program - MOPH personnel and service outlets will continue to collaborate on ONFP programs - Contraceptive social marketing is socially, politically and administratively acceptable. 														
<p>Outputs:</p> <ol style="list-style-type: none"> 1. Program-based demographic and operations research conducted. 2. IEC activities targetted and evaluated. 3. Training plans by category of personnel and by region established, completed and evaluated. 4. Contraceptive social marketing program 5. Alternative service delivery mechanisms identified (public and private sector). 6. Policy adjustments in FP service/commodity delivery and population policy development. 	<p>Magnitude of Outputs:</p> <ol style="list-style-type: none"> 1. OR designed and/or used for supervision, programming and budgeting, and cost-effectiveness (7-8 studies). 2. Audience-and-method-specific FP information regularly (1-2 times/week) presented via TV/radio, movie message and service delivery. 3. Performance-based training and evaluation established for all FP-related personnel. 4. Contraceptive social marketing in pharmacies accessible to 80% of target population. 5. Family planning activities in Public Health Structures. 6. Contraceptive pricing, promotion and distribution policies liberalized; demographic projections reflected in VII Development Plan. 	<ul style="list-style-type: none"> - observation; site-visits - contraceptive stock flow (records; observation) - marketing research results; media strategy objectives and outputs - monitoring of radio, TV, movie, and service presentations - MOPH, HSA, and MYD, MCA unions networks and reports - review/observation of ONFP's training plans, evaluation and supervision - seminars/workshops - research design - on-site verification of project activities - monitoring of program and Development Plan 	<p>Assumptions for achieving outputs:</p> <ul style="list-style-type: none"> - Coordinated MCH/PIC/FP service will continue to be a GOT priority - Method-specific promotion will be permitted at least in pharmacies - Realistic pricing structure for contraceptives will be established (private sector) - Pharmacists will be sufficiently motivated to maintain adequate supplies of contraceptives - ONFP and MOPH will endorse/permit public service messages - Policy changes will have a favorable impact on CP 														
<p>Inputs:</p> <table border="0"> <tr> <td>TA</td> <td>3298.7</td> </tr> <tr> <td>TRAINING</td> <td>777.8</td> </tr> <tr> <td>COMMODITIES</td> <td>969.1</td> </tr> <tr> <td>Other costs</td> <td>1338.7</td> </tr> <tr> <td>Evaluation/Audit</td> <td>130.0</td> </tr> <tr> <td>Contingencies</td> <td>681.9</td> </tr> <tr> <td>Inflation</td> <td>803.6</td> </tr> </table>	TA	3298.7	TRAINING	777.8	COMMODITIES	969.1	Other costs	1338.7	Evaluation/Audit	130.0	Contingencies	681.9	Inflation	803.6			
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Contingencies	681.9																
Inflation	803.6																

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ANNEX III. STATUTORY CHECKLIST

1. COUNTRY CHECKLIST

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FAA Sec. 481; FY 1985 Continuing Resolution. Has it been determined or certified to the Congress by the President that the government of recipient country has failed to take adequate measures or steps to prevent narcotic and psycnotropic drugs or other controlled substances (as listed in the schedules in section 202 of the Comprehensive Drug Abuse and Prevention Control Act of 1971) which are cultivated produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States government personnel or their dependents or from entering the United States unlawfully? No

2. FAA Sec. 620(c). If assistance is to a government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) the debt is not denied or contested by such government? No

3. FAA Sec. 620(e)(1). If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? No

4. FAA Sec. 620(a), 620(f), 620D; FY 1985 Continuing Resolution Secs. 512 and 513. Is recipient country a Communist country? Will assistance be provided to No

Angola, Cambodia, Cuba, Laos, Vietnam, Syria, Libya, Iraq or South Yemen? Will assistance be provided to Afghanistan or Mozambique without a waiver?

5. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction by mob action of U. S. property? No
6. FAA Sec. 620(l). Has the country failed to enter into an agreement with OPIC? No
7. FAA Sec. 620(o); Fishermen's Protective Act of 1967, as amended, Sec. 5. (a) Has the country seized or imposed any penalty or sanction against, any U.S. fishing activities in international waters? (b) If so, has any deduction N/A required by the Fishermen's Protective Act been made? No
8. FAA Sec. 620(q); FY 1985 Continuing Resolution Sec. 518. (a) Has the government of the recipient country been in default for more than six months on interest or principal of any A.I.D. loan to the country? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the appropriation bill appropriates funds? No
9. FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the amount of foreign exchange or other resources which the country has spent on military equipment? (Reference may be made to the annual "Taking into Consideration" memo: "Yes taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.) Yes
Taken into account by the Administrator at time of approval of Agency OYB.

10. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption? No
11. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the Taking into Consideration memo.) Current
12. FAA Sec. 620A; FY 1985 Continuing Resolution Sec. 521. Has the country aided or abetted, by granting sanctuary from prosecution to, any individual or group which has committed an act of international terrorism? Has the country aided or abetted, by granting sanctuary from prosecution to, any individual or group which has committed a war crime? No
13. FAA Sec. 666. Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA? No
14. FAA Sec. 669, 670. Has the country after August 3, 1977, delivered or received nuclear enrichment or reprocessing equipment, materials or technology without specified arrangements or safeguards? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device, after August 3, 1977? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.) No
15. ISDCA of 1981 Sec. 720. Was the No

country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Session of the General Assembly of the U.N. of Sept. 25 and 28, 1981, and failed to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the Taking into Consideration memo.)

16. FY 1985 Continuing Resolution. If assistance is from population functional account, does the country (or organization) include as a part of its population planning program involuntary abortion? No.
17. FY 1985 Continuing Resolution Sec. 530. Has the recipient country been determined by the President to have engaged in a consistent pattern of opposition to the foreign policy of the United States? No

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy? N/A

2. Economic Support Fund Country Criteria

- a. FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the country made such significant improvements in its human rights record that furnishing such assistance is in the national interest? No

2. PROJECT CHECKLIST

A. GENERAL CRITERIA FOR PROJECT

1. FY 1985 Continuing Resolution Sec. 525;
FAA Sec. 634A; Sec. 653(b).

(a) Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project; (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that amount)?

Congressional
Notification

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?
- a. Yes
b. Yes

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?
- N/A

4. FAA Sec. 611(b); FY 1985 Continuing Resolution Sec. 501. If for water or water-related land resource construction, has project met the standards and criteria as set forth in the Principles and Standards for Planning Water and Related Land Resources dated October 25, 1973, or the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for new guidelines.)
- N/A

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?
- N/A

6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. No. Project will complement regional planning activities
7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions. By design, the project will enhance private enterprise in Tunisia
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). Prime Contract will be competitively awarded to U.S. firm under the project
9. FAA Sec. 612(b), 636(n); FY 1985 Continuing Resolution Sec. 507. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. Yearly Reports of the GOT contribution will be required
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No

11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes
12. FY 1985 Continuing Resolution Sec. 522. If assistance is for the production of any commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A
13. FAA 118(c) and (d). Does the project comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the project or program take into consideration the problem of the destruction of tropical forests? Yes
14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)? N/A
15. FY 1985 Continuing Resolution Sec. 536 Is disbursement of the assistance conditional solely on the basis of the policies of any multilateral institution? No

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

- a. FAA Sec. 102(b), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and ensuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical N/A

assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

- b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used? N/A

- c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? N/A

- d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)? N/A

- e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"? (M.O. 1232.1 defined a capital project as the "construction", expansion, equipping or alteration of a physical facility or facilities financed by A.I.D. dollar assistance of not less than \$100,000, including related advisory, managerial and training services, and not undertaken as part of a project of a predominantly technical assistance character.) N/A

- f. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth? N/A
- g. FAA Sec. 281(p). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country, utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government. N/A
2. Development Assistance Project Criteria (Loans Only)
- a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan, at a reasonable rate of interest. N/A
- o. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan? N/A
3. Economic Support Fund Project Criteria
- a. FAA Sec. 531(a). Will this assistance promote economic or political stability? To the extent possible, does it reflect the policy directions of FAA Section 102? Yes
- b. FAA Sec. 531(c). Will assistance under this chapter be used for military, or paramilitary activities? No
- c. FAA Sec. 534. Will ESF funds be used to finance the construction of the operation or maintenance of, or the supplying of fuel for, a nuclear facility? If so, has the President certified that such use of funds is indispensable to nonproliferation objectives? No

- d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? No

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304118

Monsieur le Directeur de la Mission Spéciale
Américaine de Coopération Economique et Technique
en Tunisie

T U N I SO B J E T : Coopération Tuniso-Américaine

Programmation des Fonds de Soutien Economique
de l'année fiscale 1985.

REFERENCE : Nos lettres du 5 et 7 novembre 1984
et du 7 décembre 1984
Votre lettre du 9 Janvier 1985.

Monsieur le Directeur,

Me référant aux correspondances sus-visées et suite aux
divers entretiens avec les responsables de la Mission US/AID-Tunis,
j'ai l'honneur de porter à votre connaissance que le Gouvernement
tunisien propose que le reliquat des 11,2 Millions de \$ ESF accordés
à la Tunisie dans le cadre de l'année budgétaire 1985 soit affecté à
des projets de développement comme suit :

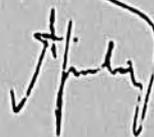
- 1 - Transfert de Technologie (664-0315) = 5,2 Millions de \$ US, consis-
tant en une avance pour le Programme de l'année 1986
- 2 - Planification familiale (664-0331) = 1 Million de \$ US pour un projet
dont le coût total est évalué à 7,5 Millions de \$ US.

Le Financement global du dit projet serait assuré par une dotation supplémentaire de 4 Millions de \$ E.S.F. de l'année 1986 et 2,5 Millions de \$ sur les Fonds Américains d'Aide au Développement de 1985 (AID/Washington).

- 3 - Transfert de Technologie Agricole (664-0304) = 1,5 Million de \$ US.
Un montant de 1,2 Million de \$ US des Fonds E.S.F. 1986 permettrait de compléter le schéma de financement du projet dont le coût total est évalué à 2,7 Millions de \$ US.
- 4 - Technologie de l'Informatique (664-0334) = 3,5 Millions de \$ US.
Ce projet devant être préparé, dans les meilleurs délais, par les experts tunisiens et leurs homologues américains.

Aussi vous saurais je gré de bien vouloir porter ce qui précède à la connaissance de vos Hautes Autorités afin de pouvoir procéder à la signature des Accords de Coopération se rapportants aux projets de développement sus-mentionnés.

En la Présidence de l'Etat-major du
Ministre des Affaires Étrangères et des
Coopération Internationale



M. [Nom]

ANNEX V: TECHNICAL FEASIBILITY ANALYSIS

Contraceptive Social Marketing and Information, Education and Communication

Given the levelling off of progress in increasing contraceptive prevalence in Tunisia over the past several years, it is important that various means of revitalizing the country's family planning program be sought. Social marketing, enhanced IEC, and building of local capacity provide a means of increasing contraceptive prevalence through stimulating family planning activity in the public and private sectors. By employing techniques used effectively in the promotion of goods in the commercial sector, social marketing has enabled many developing countries to encourage correct contraceptive use by couples of reproductive age.

Tunisia presents an appropriate setting for continuation of assistance with emphasis on cost containment and increased contraceptive prevalence and for the implementation of a social marketing program, bearing in mind the need to adapt techniques to the country's cultural context. The Tunisian economy is largely state controlled, with the lines between public and private sectors blurred. Family planning commodities and services have been available for at least two decades through both the public and the private sectors, and it is the latter that has been flourishing during the 1980s. For 1983 and 1984, approximately 80% of oral contraceptives (902,640 and 844,080 cycles, respectively) used by Tunisian women were purchased in the private sector (i.e., in pharmacies, the only point of sale). Condom sales in pharmacies also account for a far greater proportion of total distributed than in the public sector. At the same time, the public sector operates a free, parallel service delivery system. Increased distribution of pills and condoms in the private sector can be attributed to a reluctance to prescribe methods of birth control which require specific action on the part of the user in the public sector. Methods of preference to health care providers are the IUD, tubal ligations, and injections since these do not require any specific actions on the part of the user after the initial procedure.

The high rate of sales in the private sector occurs even in the absence of targetted media campaigns to encourage purchase of pills and condoms. Should such campaigns occur, the number of contraceptives sold would presumably increase by several fold. Likewise, building the capacity of service providers in various GOT Ministries should increase consumer knowledge.

The chances for success in a CSM effort in Tunisia are increased in particular by two factors: 1) the large and growing

number of pharmacies throughout the country and 2) the exceptionally wide reach of the mass media, combined with relatively high literacy rates (62% overall, with female literacy lower than male).

Pharmacies: As of the beginning of 1985 there were approximately 740 private pharmacies in Tunisia (up from 539 in 1980). Each is staffed by a licensed pharmacien, assisted by a preparateur (a "para-pharmacien" who has followed an 18 month training program) and possibly one or more sales persons. While the average number of inhabitants per pharmacy is now over 9000, the Government of Tunisia wishes to decrease this number to 5000 in the coming decade. Pharmacies, while existing in each of the country's 23 governorates, are not evenly distributed. The city of Tunis and its metropolitan area have 160, or about 20% of the country's pharmacies. The governorate which includes the second largest city, Sfax, has 77 and the two other more densely populated governorates of Sousse and Monastir have 49 and 35 pharmacies respectively. In spite of this concentration, there remain 419 pharmacies to serve the remaining population, and it appears that the large majority of Tunisians, even in rural areas, have access to pharmacies. These are looked to as sources not only of medications but of medical and health advice, and the rural pharmacist in particular is regarded as "the doctor of the poor."

Media reach. Although official figures indicate somewhat under 600,000 television sets in 1984, and several thousand fewer radios, in Tunisia, these figures are felt by directors of the national radio and television stations, as well as by others knowledgeable in the field, to be substantial underestimations. It is widely believed that approximately 90% of Tunisians have access to television. Unlike many developing countries, a majority of these are owned by individual households, and include many battery-operated sets for use in areas not served by electricity. Stations are state owned and include two television and two radio stations (Arabic and "international," mostly French). Radio broadcasts occur approximately 18 hours per day, and each television station broadcasts in the evening hours. (Italian television is also received directly). Radio and television are frequently and effectively used for public service messages by various government agencies. Commercial advertising does not exist on either radio or television in Tunisia. However, directors of both radio and television indicated strong interest in broadcasting "tasteful" family planning messages at the request of the Ministry of Health and/or ONFP.

Print media also present an excellent opportunity to reach certain segments of the population. There are several daily Arabic and French newspapers as well as weekly and monthly

periodicals in which family planning messages could be carried. Outdoor advertising (billboards and panels) is also widespread and is one of the media most frequently used by commercial advertisers.

An evaluation of the potential for conducting a social marketing activity in Tunisia and for enhancing an IEC program for target-audiences found the situation favorable largely due to the above factors. Other facilitating conditions were felt to be the high level of awareness (90%, according to preliminary results of the 1983 Contraceptive Prevalence Survey) of contraceptive methods among Tunisian women. Yet another positive factor is the Tunisian Government's strong commitment to reducing population growth and, more important, the ONFP's interest in applying techniques of sound training, demographically determined IEC and programming and social marketing, toward the attainment of this goal.

In spite of this generally favorable environment, implementation of social marketing in Tunisia will need to address several constraints which could determine such an activity's success or failure. In the pharmaceutical area the state controls importation of all products through the Pharmacie Centrale Tunisienne. Furthermore, distribution of all contraceptives was recently (1983) taken out of the hands of wholesalers and became the responsibility of the ONFP. The efficacy of this system relative to the former is not clear. Contraceptive pricing has also discouraged financial incentive for pharmacists to stock and sell. A price increase might be necessary to stimulate sales and to avoid a growing tendency of women to be suspicious of a medication that is purchased at far below the price of other medical products.

The above problems must be addressed early in dialogue with policy makers at an appropriate level. Other constraining factors may be dealt with by proceeding with prudence in project implementation. In particular, the lack of a strong tradition of commercial advertising, and cultural sensitivity regarding overt discussion of sexual practices, must be considered in the design of media campaigns and education programs. As a final point, the conservative and French tradition reflected in the Tunisian medical community must be noted. This has resulted in a bias toward use of clinical methods of contraception (IUD and female sterilization) and a tendency for physicians to resist liberalization of distribution laws and practices regarding the pill.

The above has described the context within which this family planning project for Tunisia will be implemented. These factors may have been largely responsible for the levelling off of

contraceptive prevalence and the failure of an earlier effort to carry out social marketing in Tunisia. These factors were taken into account in the design of the present project and must remain in focus throughout its implementation.

If the GOT will not permit method-specific promotion in pharmacies, then the social marketing component of the project should not be undertaken. In addition, the GOT should examine contraceptive pricing and distribution of contraceptives in the private sector, given the cost implications of present policies in these two areas. Although early IEC and CSM activities can be conducted in the absence of changes in these areas, success in later stages will be contingent upon progress in addressing pricing and distribution method issues.

The IEC and CSM activities will be launched in all 23 governorates simultaneously. This is feasible given:

- The relatively small land surface of Tunisia.
- The extensive reach of mass media.
- The wide distribution of pharmacies throughout the governorates and relatively even distribution of the population (with the exception of the Tunis area).

The approximately 64% of MWRA who do not currently practice modern methods of contraception constitute one potential set of target beneficiaries. Results of the 1983 Contraceptive Prevalence Survey will provide information regarding the demographic profile of this group, which will then be segmented for programming purposes based on results of the qualitative, and later, quantitative research conducted early in the project.

The objective of the CSM activity is to increase the number of persons obtaining contraceptives through retail sales by 15% per year throughout the LOP (yielding a 52% increase over the life of the project).

The overall goal of the A.I.D. population program is to increase contraceptive prevalence from the current 35% to 42.7% by 1988. 2/3 of the increase is to be attributable to sales in pharmacies. If this is to occur, a total increase in retail sales of contraceptives of 52% would need to occur by the end of the project to account for 150,000 CYP of pills (1,950,000 cycles) and 22,000 CYP of condoms (2,200,000).

The other 1/3 of the increase in contraceptive prevalence is expected to occur in the public sector. Project activities in this sector include demographically targeted service delivery and capacity building of public health and social service workers to broaden delivery of family planning information and services.

Training Activities

The training program in this project builds upon a history of successful training of family planning workers in Tunisia. The focus of training will be to shift basic training to the professional schools and to undertake continuing education, primarily at the local level. Emphasis will be placed on training of trainers in the professional schools and evaluation of their training to conduct basic training. Continuing education efforts will include identification of educational needs, participant-focussed training and evaluation of training on the job.

Recent establishment of regional training centers serves as a sound basis for developing a needs-oriented continuing education program within the ONFP. Technical assistance can build upon this structure to insure impact on field practices. Likewise, recent communication with the faculties of medicine, nursing and pharmacy opens the doors for successful training of their staff for teaching their students about family planning. Clearly, however, inputs into the curricula of these schools will need to be assessed in terms of family planning content adequacy and quality.

Research

Future directions will require attention on cost of activities and cost containment opportunities. Long range programming will need to be initiated, based on demographic need and cost. Personnel will have to be allocated according to programmatic need and will need to be held accountable for their assigned functions. In addition, many family planning services will need to be assumed by the MOPH and the MSA. These organizations are building the needed infrastructure throughout Tunisia to provide these services (e.g., primary health care centers, maternal child health centers, hospitals). In addition, their personnel will be better trained to assume these roles as a result of project activities.

The proposed research activities under the project will address these cost containment and coverage concerns. It will take place primarily within the Population Division of the ONFP. This division has received training in demographic research over the course of A.I.D. intervention in Tunisia's family planning program and now has considerable experience in this field. In addition, the division will soon receive enhanced computer capacity which is a necessary precedent to activities proposed under the project.

The division is staffed, however, by only eight professionals. While these professionals have received some training, there is still a need for further training among this cadre, as noted in A.I.D.'s May 1984 evaluation. Also, given the demands on this division, there is the possibility that its staff might become overextended. Thus, the project focusses support in this area for temporary contractual staff and technical assistance, since these seem appropriate to maintain and supplement capacity.

While activities in his division have in the past focussed on research questions of general interest in the area of population, given this project's foci and financial constraints of the ONFP, it is necessary that support under this project be for only those activities related to cost-containment, increased coverage, and project/program evaluation.

ANNEX VI: FINANCIAL ANALYSIS

The purpose of this annex is to provide an assessment of the GOT's ability to finance their contribution to the project and post-project recurrent costs. The following subjects are covered:

- A. Discussion of the Tunisian macroeconomic situation and its expected influence on GOT financing for the ONFP.
- B. Analysis of the financial contributions of the GOT, AID, UNFPA, and other donors, to the ONFP over the period 1980-1984. Estimation of the GOT contribution to the ONFP at the end of the current AID-supported project in FY 1986. Discussion of the estimated shortfall between this GOT allocation and the recurrent costs of the ONFP, and the proposed AID response.
- C. Estimation of the recurrent costs (FX, LC) of the proposed bilateral project. Discussion of the GOT's ability to finance these recurrent costs.
- D. Discussion of issues related to cost recovery for contraceptives sold in the private sector.
- E. Summary of findings.

A. The Tunisian Macro-economic Situation

The economic situation in Tunisia deteriorated during the early 1980's from that experienced during the 1970's.³ The

current macroeconomic situation and anticipated future developments will constrain the GOT's ability to finance the recurrent costs of the ONFP and its programs.

Economic Growth: Tunisian GDP growth over the 1970's averaged 6.3 percent per annum, with annual rates of growth of 7.7 percent from 1977 to 1980. However, GDP growth was only 3.5 percent from 1980-1982, rising to 4.5 percent in 1983 and 5.5 percent in 1984. It is expected to average below 5 percent for the decade.

Public Finance: Central government revenue increased by 8 percent per annum from 1978 to 1984, exceeding GDP growth over the same period. Government expenditure increased at a rate of 9 percent per year, and increased from 26 percent of GDP in 1971 to 43 percent in 1984. The government budgetary deficit increased rapidly from 2.6 percent of GDP in 1981 to 8.0 percent of GDP in 1984. In an effort to minimize foreign debt, this deficit has been largely (70%) financed from domestic sources. In view of the decline in hydrocarbon export earnings (see "External Balance" discussion below), increases in public revenues are unlikely. Efforts to reduce public investment, government subsidies, and rates of increase in civil service salaries, are expected.

Inflation and Interest Rates: Inflation rates during the 1980s have ranged between 9 and 14 percent. However, domestic nominal interest rates, frozen in 1981, range between 3 and 14 percent, resulting in negative real rates of interest. This has encouraged investment which is overly capital-intensive, speculative investment in real estate, and discouraged private savings.

External Balance: Tunisia's current account balance has become increasingly negative, and in 1982 increased from 5.8 percent to 8.4 percent of GDP, and further increased to almost 10 percent of GDP for 1984. Factors which contributed to this trend include: 1) the declining world price for oil, 2) declining Tunisian oil reserves for exports, 3) the impact of the European depression on markets for Tunisian exports, earnings from tourism, and remittances from emigrated labor, and 4) adverse weather conditions and decreased agricultural production, exports, and increased requirements for food imports. A recent decision by the World Court concerning an offshore oil find in favor of Libya, coupled with Tunisia's increasing demand for energy, has led analysts to project that Tunisia will be a net oil importer by 1990. Since 40 percent of Tunisia's export earnings in 1984 came from oil and gas exports, this shift from a net exporter to a net importer will have profound impacts on the availability of foreign exchange

in Tunisia by the end of the decade and beyond.

Foreign Debt: The first oil price shock in 1973 led to a rapid increase in investment expenditures in Tunisia which required considerable external financing. However, increasing interest rates on foreign capital in the mid to late 1970's, and the appreciation of the dollar in the early 1980's, have resulted in worsening terms for foreign borrowing. Although Tunisia's debt service ratio declined during the 1970's, it increased from 12 percent of GDP in 1980 to 22 percent in 1983.

Implications for ONFP Financing: These recent macro-economic trends point toward: 1) pressures to reduce the rate of increase, and possibly the level, of government expenditures, and 2) competition for decreasing supplies of foreign exchange. The extent to which these pressures affect GOT funding for the ONFP will depend to a great extent on the political support for family planning in Tunisia.

B. ONFP Financing, 1980-1986

GOT-financed population and family planning activities include the programs of the ONFP, contributions of personnel and facilities of other government ministries (e.g. Ministère de la Santé Publique) and subsidization of contraceptives sold in the private sector. Although the proposed project will require limited inputs from other GOT ministries, this analysis focuses on the ability of the GOT to finance the current and anticipated program of the ONFP.⁴

Since 1982, AID support to the ONFP has been through the following centrally-funded intermediary agencies: Population Council, JHPIEGO, INTRAH, IPAVS, Westinghouse, and RTI. At that time that this project was designed, it was assumed that this intermediary form of assistance would smooth the transition from the previous bilateral family planning project to a program financed entirely by the GOT.

The contributions of the GOT, AID, UNFPA and other donors to the ONFP budget from 1980 to 1984 are given in Table A6.1. The GOT's contributions have increased from 31 to 59 percent of the total ONFP budget from 1980 to 1984, and donors' contributions have declined from 69 to 41 percent.⁵ Although this trend demonstrates the commitment of the GOT to pick up an increasing percentage of the costs associated with the family planning program, donors continue to be an important source of financing for the ONFP.

Additional insight into the GOT's support for the ONFP's recurrent budget can be gained by examining trends in GOT

TABLE A6.1: Sources of Finance for the ONFP,
1980 - 1985

SOURCE	Year					(Current	TD)
	1980	1981	1982	1983	1983	1985	
<u>Government of Tunisia</u>							
- Budget de Fonctionnement	594.000	739.663	1.138.337	1.574.000	1.774.000	2.010.000	
- Budget des Activités	60.000	140.000	109.435	177.000	250.000	260.000 ⁶	
- Budget d'Investissement	106.000	45.000	200.000	170.000	165.000	420.000	
Sub-total GOT	760.000	924.663	1.447.772	1.921.000	2.189.000	2.690.000	
% of Total	31%	34%	45%	53%	59%	-	
<u>Donors</u>							
- A.I.D. ⁷	1.003.132	1.223.651	1.451.796	1.597.902	1.171.203	-	
- UNFPA	590.000	564.449	313.250	322.888	327.972	-	
- Others	67.845	31.960	34.079	-0-	42.634	-	
Sub-total Donors	1.660.977	1.820.060	1.799.125	1.720.790	1.541.809	-	
% of Total	69%	66%	55%	47%	41%	-	
<u>GRAND TOTAL</u>	-	2.744.723	3.246.897	3.641.790	3.730.809	-	

6. Estimated.

7. Includes total IPAVS contribution.

SOURCE: Projet du Budget des Activités, 1980-1984, Tunis: Office National du Planning Familial et de la Population.

expenditures converted to constant 1980 dinar (see Table A6.2). This information shows:

- GOT expenditures for the recurrent budget have increased in real terms by 138 percent since 1980. However, the annual rate of increase has fallen from 32 percent between 1982 and 1983 to 5 percent between 1984 and 1985.
- GOT expenditures for the Budget d'Investissement have fluctuated in real terms since 1980, with the annual rate of change fluctuating between -61 and 313 percent.
- GOT expenditures for the total ONFP budget have increased in real terms since 1980 by 142 percent. The annual rate of increase declined from 46 percent in 1982 to 6 percent in 1984, but increased by 15 percent between 1984 and 1985.
- Considering both GOT and donor contributions, the annual rate of increase in the ONFP budget has declined from 10 percent between 1981 and 1982, to -5 percent between 1983 and 1984.

In summary, GOT expenditures in support of the ONFP total and recurrent budgets have increased in real terms over the period 1980 and 1985, although the annual rate of increase has declined since 1982. Donor contributions have also declined in real terms over this period. If the trends established between 1980 and 1985 continue (e.g. 5 percent per annum increases in the total ONFP budget, 10 percent real increases in GOT contributions) then the GOT will be supporting approximately 70 percent of the budget of the ONFP by 1986.

Thus, it is clear that continued donor financial support will be required after 1986 to maintain current ONFP programs until transfer of financial responsibility for these programs is complete. The proposed AID bilateral project will continue to support activities started under the centrally-funded projects, as well as support relatively new ONFP initiatives in social marketing and private sector contraceptive distribution. However, the new project will not pick-up many of the recurrent expenditures (e.g. local salaries, petrol and vehicle spare parts) currently supported by the centrally-funded intermediary efforts. The GOT appears to have been preparing for the end of this type of recurrent budget support by allocating the largest proportions of its budgetary increases to the Budget de Fonctionnement. However, it is strongly recommended that AID offer support to the ONFP to assist in more precise identification of: 1) budgetary shortfalls which will occur when AID funding shifts from the

TABLE A6.2: GOF Contribution to the Budget of the ONFP,
1980 - 1985

SOURCE	(Constant 1980 TD)					
	1980	1981	1982	Year 1983	1984	1985
Budget de Fonctionnement % Annual Change	594.000 -	681.089 15%	973.770 43%	1.248.216 28%	1.304.412 5%	1.376.712 6%
Budget des Activites % Annual Change Total	60.000 -	128.913 115%	93.614 -27%	140.365 50%	183.823 31%	178.082 -3%
TOTAL GOF RECURRENT	-	24%	32%	30%	7%	5%
Budget d'Investissement % Annual Change	106.000 -	41.437 -61%	171.086 313%	134.814 -21%	121.324 -10%	287.671 137%
TOTAL GOF % Annual Change	760.000 -	851.439 12%	1.238.470 46%	1.523.395 23%	1.609.589 6%	1,842.466 15%
Total GOF & Donors % Annual Change	2.420.977 -	2.527.369 4%	2.777.500 10%	2.888.017 4%	2.743.242 -5%	NA -

SOURCE: GDP deflater for 1981 - 1983 from International Financial Statistics Yearbook, 1984, Washington, D.C.: IMF, pg. 579. Estimated GDP deflater for 1984 1.36, 1985 1.46.

old to new project, and 2) options as to what changes (personnel, programmatic and budgetary) the ONFP could adopt to smooth the transition between the two projects.

In addition to this transitional support, it is recognized that several of the activities of the proposed project will assist the GOT in reviewing future program activities and administration in light of anticipated recurrent budgetary funds.

C. RECURRENT COSTS OF PROPOSED, BILATERAL PROJECT:

Given the preceding discussion of the recurrent costs of the ONFP's portfolio under the current AID-financed project, the discussion below will focus on estimation of the additional recurrent costs, associated with the new project, which will require GOT financing. The discussion first considers project inputs that will require local currency (LC), then those requiring foreign exchange (FX).

Local Currency: The project inputs which are to be financed by the GOT from the outset of the project consist of salaries for the Contraceptive Social Marketing (CSM) staff (4 managerial level, 6 délégués), training unit staff (4 professionals), research unit staff (8 professionals), and other person-months or ONFP staff time to participate in project training and research activities. A minimum of 11 of the above staff are currently holding the position that they will have over the LOP, and it is expected that the ONFP will recruit staff for the other positions from within current personnel ranks. Thus it is anticipated that the ONFP will not face additional recurrent salary costs as a result of this project.

A second group of project inputs will require GOT-financing during the LOP, but are not expected to continue after the project, and thus will not involve on-going, additional recurrent costs. These inputs are: 1) support for international travel associated with training activities (TD 15,300), 2) per diem for délégué and pharmacist training (TD 36,400), and various inputs (personnel, transport, etc.) into the KAP and operations research projects (TD 396,000).⁸ The average additional annual recurrent cost of TD 89,540 equals 3.0 percent of the expected GOT allocation to the ONFP in 1986.

A third group of project inputs will not require GOT financing in FY 1986, but responsibility for their financing will be gradually shifted from USAID/T to the GOT over the LOP, and will continue to require financing after the end of the project. These inputs are listed below with their estimated GOT contribution over the LOP and annually after EOP.

LOCAL CURRENCY RECURRENT COSTS		
	<u>Total LOP</u> (1985 TD)	<u>Annual After EOP</u> (1985 TD)
Research		
IEC-Focus Group	35.000	15.000
Pharmacist	6.000	3.000
Mass Media Message Develmt.	168.400	125.000
Educational Materials		
Posters, Billboards	122.600	35.000
Print Materials	70.600	35.000
TOTAL	402.600	213.000

The average annual additional recurrent cost over the LOP of TD 80,520 is 2.7 percent of the expected GOT allocation to the ONFP in 1986. The annual LC recurrent cost of project activities after EOP of TD 213,000 is 4.5 percent of the projected GOT contribution to the ONFP budget (assuming it increases in real terms by 10 percent per annum over the period 1985 to 1991).⁹

Foreign Exchange: Project inputs which will require foreign exchange from the GOT are contraceptives, vehicles, vehicle spare parts and petrol, and spare parts, maintenance and depreciation of personal computers and office equipment (typewriters and xerox machines). These requirements over the life of the project, and estimates for their annual cost after the end of the project, are listed below:

FX RECURRENT COSTS		
	<u>Total LOP</u> (1985 TD)	<u>Annual at EOP</u> (1985 TD)
Contraceptives		
Private Sector	893.600	450.000
Vehicles		
Spare Parts and Petrol	210.000	42.000
Personal Computers		
Software & Maintenance	2.000	0.500
Office Equipment	1.500	0.500
TOTAL	1.107.100	493.000

(Note: These estimates do not include the total amount of foreign exchange required to support all of the activities of the ONFP. Estimation of these requirements is recommended as a component of the studies made to assist the ONFP prior to, or during, the proposed project).

The average annual additional recurrent cost over the LOP of TD 221,420 is 7.5 percent of the projected GOT contribution to the ONFP in 1986. The annual FX recurrent cost of project activities to TD 493,000 is 10.3 percent of the projected GOT contribution to the ONFP budget in 1991 (assuming the GOT contribution continues to increase in real terms by 10 percent per annum over the period 1986 to 1991).¹⁰

The annual foreign exchange requirement for project activities at the EOP is equivalent to 0.03 percent of Tunisia's total imports (fob) in 1983. Contraceptives, the largest component of these costs, would equal only 1.2 percent of total 1983 pharmaceutical imports.¹¹ These FX requirements seem to be such an insignificant proportion of the GOT's total pharmaceutical and import bills that it is difficult to perceive how the GOT would have difficulty allocating sufficient FX to finance these at the EOP. However, current intermediary organizations in Tunisia have received requests from the NFP to allocate project funds for the purchase of vehicle spare parts and petrol. Given the anticipated shift of Tunisia to a net oil importing country, it is likely that foreign exchange will be less available to all GOT ministries and programs.

In view of difficulties the GOT may have in the future in financing FX-requiring inputs for ONFP activities, it is anticipated that AID will continue to provide contraceptives for use in the GOT's public sector, family planning programs after 1990. Evaluation of the adequacy of the projected level of continuing contraceptive support (50% of 1984 public sector requirements), and of the need for other FX requiring inputs, will be important issues for consideration during the mid-term and final project evaluations.

D. PRIVATE SECTOR CONTRACEPTIVE PRICING ISSUES:

In the mid-1970's, prices for oral contraceptives and condoms sold in Tunisian pharmacies were reduced from 1500 millimes to 50 millimes per pill cycle and 30 millimes per condom three-pack. The GOT instituted this price increase in order to increase demand for contraceptives through private sector retail outlets. In spite of inflation rates from 9 to 12 percent, these prices have not been altered, thus increasing the GOT subsidy for contraceptives sold in the private sector. Further, although the contraceptives are provided without charge to pharmacists, their real profit per contraceptive sale has fallen. To the extent that pharmacists are motivated to increase sales of items with the largest profit margins, the GOT pricing policy has not provided them with an incentive to increase sales.

One objective of the proposed project is to encourage the GOT to allow the price of these contraceptives to rise to a level to cover at least the cost of the contraceptive, and eventually to cover the costs of packaging, distribution, pharmacists' margin, and ultimately the cost of the CSM office within the ONFP. Estimates of the prices which would be required to meet these cost-recovery objectives are listed below.

ESTIMATES OF CONTRACEPTIVE COST-RECOVERY PRICES

	<u>Orals(cycle)</u> (1985 millimes)	<u>Condoms(3-pack)</u> (1985 millimes)
Contraceptive	200	150
Over-packing (5%)	10	8
Wholesale distribution (10%)	21	16
Retail distribution (10%)	23	17
ONFP CSM Office	<u>59</u>	<u>47</u>
TOTAL	313	238

The above estimate of 313 millimes for a cycle of oral contraceptives is over a 6-fold increase over the current price of 50 millimes. The estimate of 238 millimes for a 3-pack of condoms is almost 8 times higher than the current price of 30 millimes.¹²

Although increases in contraceptive prices will be important to achieve project cost-recovery objectives, consideration must be given to whether price increases will lead to a significant decline in contraceptive purchases in the private sector without concomitant increases in contraceptive distribution in the public sector. Information on the price elasticity of Tunisians' demand for contraceptives is not available. Hence anecdotal information from Tunisia, and information from studies in other countries, will be used to consider this issue.

For example, the GOT has not instituted price controls on contraceptive foams, creams and jellies sold by pharmacies. Current prices for these items are several times higher than the proposed prices for pill cycles and condom 3-packs. Thus, even with significant price increases, pills and condoms will remain significantly less expensive than other contraceptive methods available from pharmacies. Further, even with the proposed price increases, the cost of an annual supply of pills will remain a low (0.2%) percent of average per capita annual incomes in Tunisia.¹²

An analysis of studies of contraceptive pricing in other countries¹³ found the following conclusions which may be of relevance to the Tunisian case:

- Studies in Jamaica, Pakistan and Sri Lanka found that when contraceptive prices increased from moderate levels an immediate drop in demand was observed, followed by a gradual increase in demand back to original levels. It was suggested that this pattern might be due to consumers "stocking-up" on contraceptives in anticipation of a price increase.
- A doubling of the price of injectible contraceptives in Thailand resulted in no change in the number of acceptors. This was attributed in part to the fact that the increased revenues were retained by the service delivery units.
- Price does not seem to determine choice of method. However, variations in price across sources has some impact on where contraceptives are obtained. However, consumers stay with commercial providers, even when subsidized public services are available, if substantial time costs are involved in obtaining services/supplies from the subsidized provider.
- The average price of a cycle of pills sold in private sector programs in 21 countries (15 of which have incomes per capita lower than Tunisia) ranged from US \$0.41 to US\$6.98, and for a condom 3-pack from US\$0.38 to US \$2.43. These prices ranged from 0.3 to 19.8 percent of per capita income in these countries. The proposed prices for Tunisia are lower than these prices.
- When the availability of FX is constrained, private sector distribution of contraceptives to rural areas tends to suffer most as high transportation costs reduce profits (need for governments to subsidize transportation costs to rural areas).

The above data tends to be reassuring about the minimal impact that contraceptive price increases would be expected to have on consumers' demand for contraceptives sold in pharmacies in Tunisia. However, the introduction of price increases should occur slowly, in order that the actual response of Tunisians to the price changes can be taken into account in terms of determining a pricing strategy for the entire country.

E. SUMMARY OF FINDINGS.

In spite of a general deterioration in the Tunisian macro-economic situation during the early 1980s, GOT allocations to the ONFP increased in real terms by 142 percent, and as of 1984 comprised 59 percent of total funding for the ONFP. If the

trends established during the 1980s continue, the GOT will support approximately 70 percent of the ONFP budget by 1986. Although the GOT has demonstrated its commitment to pick up the costs associated with their family planning program, donor support will be required after 1986 to maintain current ONFP programs until transfer of financial responsibility for these programs to the GOT is complete.

The proposed AID project will continue to support activities started under the centrally-funded project, as well as support relatively new ONFP initiatives in social marketing and private sector contraceptive distribution. However, the new project will not pick up many of the recurrent expenditures currently supported by the intermediary agencies. It is strongly recommended that AID offer support to the ONFP to identify ways that the transition between the funding support of the two projects can be made smoothly. In addition to this transitional support, several activities of the proposed project will assist the ONFP in matching future program activities to anticipated recurrent budgetary funds.

The annual local currency recurrent costs implied by the proposed project are estimated to equal 4.5 percent of the projected GOT contribution to the ONFP in 1991. In view of anticipated pressures on the GOT to reduce the growth of public expenditures, the ability of the GOT to pick up these additional recurrent costs will depend to a great extent on the strength and level of political support for family planning in Tunisia.

The annual foreign exchange recurrent costs implied by the project are estimated to equal 10.3 percent of the projected GOT contribution to the ONFP in 1991. It is expected that the additional revenue generated as a consequence of altering GOT contraceptive pricing policy will cover at least the local currency equivalent cost of the pills and condoms distributed to the private sector, and thus a large percentage of the above recurrent costs. Further, the estimated additional FX requirement of project activities is equivalent to only 0.03 percent of Tunisia's total import (fob) bill in 1983. Contraceptives, the largest component of these costs, are estimated to equal only 1.2 percent of total Tunisian 1983 pharmaceutical imports. These FX requirements seem insignificant in light of total Tunisian pharmaceutical and import bills, and it is not expected that the GOT will have difficulty allocating sufficient FX to finance these requirements in 1990. Nevertheless, the adequacy of planned AID post-project support (in the form of contraceptives for the GOT public sector family planning programs), will be an important issue for consideration during the mid-term project evaluation.

TABLE A6.3: A.I.D. Project Inputs by Component

	COMP #1	COMP #2	COMP #3	COMP #4	ADMIN	CONTR.	TOTALS
TA	1693.6	689.5		505.6	410.0		3298.7
TRAINING		91.8	671.0	15.0			777.8
COMMODITIES	30.0		30.0			909.3	969.3
OTHER				1212.0		126.7	1338.7
EVALUATION/AUDIT					130.0		130.0
CONTINGENCIES	180.4	81.0	73.1	182.1	56.7	108.6	681.9
INFLATION	79.9	28.2	30.3	88.0	27.1	50.1	303.6
TOTAL	1983.9	890.5	804.4	2002.7	623.8	1194.7	7500.0

TABLE A6.4: GOT PROJECT INPUTS BY COMPONENT

	COMP #1	COMP #2	COMP #3	COMP #4	ADMIN	CONTR	TOTALS
TA	93.3	135.0		517.0			745.3
TRAINING		22.4	149.3				171.7
COMMODITIES	1.0					183.1	184.1
OTHER		178.6	21.0	1.2		9.2	210.0
EVALUATION/AUDIT							
CONTINGENCIES	11.0	38.1	19.3	57.1		20.9	146.4
INFLATION	15.5	44.7	23.0	53.0		16.6	152.8
TOTAL	120.8	418.8	212.6	628.3		229.9	1610.4

Finally, the contraceptive cost-recovery objectives proposed by the project imply at least 6-fold increases in the prices of pills and condoms sold in the private sector. Anecdotal information for Tunisia, and from studies in other developing countries, is reassuring that such price increases will not result in permanent declines in private sector contraceptive sales, especially in light of the absolute amount of increase desired. Nevertheless, the introduction of proposed price increases should occur slowly, in order that the actual response of Tunisians (particularly low income households) to the price changes, can be taken in to account in determining a final pricing strategy for the country.

NOTES

3. Information for Section B was drawn from Manarolla, Jerre A. (March 1985) Economic Report on Tunisia, Washington, D.C.: NE/DP, Agency for International Development, 20 pp. plus appendices.
4. To the extent that family planning services are dependent on MSP personnel or are already provided in MSP facilities, or will be shifted to the MSP over the life of the proposed project, the adequacy of the MSP's recurrent budget is of concern. An October 1984 audit of rural health facilities in Tunisia found that these facilities were not being maintained in a sanitary manner due to the lack of operating funds. Other analyses (World Bank) suggest that hospitals recently constructed by the GOT will directly compete with rural facilities and programs for available recurrent budgetary funds. To the extent that demand for family planning services is a function of client's attraction to the conditions of the service delivery facilities, insufficient recurrent budgetary funds for rural areas will affect contraceptive acceptance and prevalence in rural Tunisia.
5. Appreciation of the dollar relative to the dinar has resulted in donors' contributions continuing to be a larger percentage of the total ONFP budget than was estimated at the time of the design of these projects. For example, it was estimated during the project's design that AID's contribution to the ONFP budget in 1984 would be 27 percent of the total; instead was 31 percent.
8. The budgetary figures given were taken from project component budgetary tables and based on 1985 price estimates for the inputs. The figures have not been inflated because they were developed for comparison with the 1985 GOT allocation to the ONFP.

9. The annual LC recurrent cost of project activities after EOP of TD 213,000 would be 5.9 percent of the projected GOT contribution to the ONFP budget in 1991 assuming the GOT only increases its allocation by 5 percent per annum from 1986 to 1991; and would be 7.9 percent of the GOT contribution to the ONFP budget if the GOT contribution did not increase in real terms from its 1985 level.
10. The annual FX recurrent costs of project activities after EOP of TD 493,000 would be 13.7 percent of the projected GOT contribution to the ONFP budget, assuming the GOT contribution only increased by 5 percent per annum for 1986 to 1991; and would be 18.3 percent of the budget if the GOT contribution did not increase in real terms from its 1985 level.
11. See Appendix Table A6.5.
12. Although the cost estimates provided are based on the actual, estimated costs of the contraceptives in 1985, the payments to retailers will fall from their current levels of 50 and 30 millimes to 23 and 17 millimes respectively. If the profit to retailers is maintained at its current level, the resulting prices to consumers would be 335 millimes for pill cycles and 250 millimes for condom 3-packs. Further, if current retailer profits of 50 and 30 millimes are assumed to equal 10 percent of the price of the contraceptives provided to the retailers, then the price of the contraceptives to consumers would rise to 610 millimes per pill cycle and 335 millimes per condom 3-pack.
13. Lewis, M.A. (September 1984) Pricing and Cost Recovery Experience in LDC Family Planning Programs, background paper for World Development Report, 1984, Washington, D.C.: AID, 96 pp.

Notes on Projected Expenditures over the Life of the Project

Projected expenditures for this project are given in the tables in Section 2; assumptions for each budget are included.

ASSUMPTIONS FOR THE BUDGET FOR PROJECT COMPONENT NO. 1:

Information, Education, and Communication

- 1) A.I.D.-financed technical assistance and audio-visual material will require payment in U.S. dollars. Estimates are based on prices in 1985 U.S. thousand dollars, and have been inflated at 5 percent, compounded annually, starting in 1987.

TABLE A6.5: Tunisia: Contraceptive, Pharmaceutical and Total Imports
1978-1984

	1978	1979	1980	1981	1982	1983	1984
TOTAL IMPORTS (TD 000.000)	899.7	1156.8	1428.4	1907.4	2008.4	2116.1	2260.0
PHARMACEUTICALS (TD 000)	14.9	20.7	24.4	28.2	35.1	38.3	-
% of Total Imports	1.7	1.8	1.7	1.5	1.7	1.8	-
CONTRACEPTIVES (TD 000)	-	-	-	-	2.6	6.7	8.9
% of Pharmaceuticals	-	-	-	-	0.01	0.02	-
% of Imports	-	-	-	-	0.00	0.00	-

Source: Institut National de la Statistique (1983) Annuaire Statistique de la Tunisie, Vol. 11.28, Tunis: Ministère du Plan et des Finances, pp. 221, 230.

- 2) The budget for A.I.D.-financed research, mass media and print materials activities will be converted to Tunisian dinars. Annual estimates are based on prices in 1985 U.S. thousand dollars, and have been inflated at 12 percent, compounded annually, starting in 1987.
- 3) GOT-financed inputs will be paid in Tunisian dinars. Annual estimates are based on prices in 1985 thousand dinars, and have been inflated at 12 percent, compounded annually, starting in 1987.
- 4) GOT personnel to be involved in the IEC activities are already employees of the ONFP or GOT.
- 5) The A.I.D. contribution for the focus group research declines from 100 to 80 to 60 to 40 to 20 percent of the total estimated cost over the LOP. The ONFP/GOT contribution will increase accordingly. It is expected that CSM activities will ultimately be shifted into the private sector. Should this occur at EOP, there will be no recurrent cost to the GOT in 1989.
- 6) The A.I.D. contribution for mass media message development and broadcast declines over the LOP. It is estimated that the recurrent cost (new) of this activity to the ONFP at the EOP will be TD 90,000 per year.
- 7) The A.I.D. contribution for development and print materials declines over the LOP. The ONFP contribution increases accordingly. The estimated recurrent cost of this activity to the ONFP at the EOP will be TD 47,100 per year.
- 8) The GOT contribution for A-V equipment is included for maintenance and depreciation.
- 9) Ten percent of annual totals has been added for contingencies.

ASSUMPTIONS FOR THE BUDGET FOR PROJECT COMPONENT NO. 2:

Contraceptive Social Marketing

- 1) A.I.D.-financed technical assistance, and observational, regional and U.S.-based training contributions will require payment in U.S. dollars. Annual estimates within the table are based on prices in 1985 U.S. thousand dollars and have been inflated at 5 percent, compounded annually, starting in 1987.

- 2) The budget for A.I.D.-financed research, délégué and pharmacist training, and posters and billboards will be converted to Tunisian dinars. Annual estimates are based on prices in 1985 U.S. thousand dollars, and have been inflated at 12 percent, compounded annually, starting in 1987.
- 3) GOT-financed inputs will be paid in Tunisian dinars. Annual estimates are based on prices in 1985 thousand dinars, and have been inflated at 12 percent, compounded annually, starting in 1987.
- 4) The marketing manager and 6 délégués to be involved in CSM activities are already employees of the ONFP or GOT.
- 5) Fees for délégué training and supervision are shifted from A.I.D. to the ONFP and are estimated to equal TD 6,000 per year at the EOP.
- 6) Fees for pharmacist training and motivation are shifted from A.I.D. to the ONFP and are estimated to equal TD 8,800 per year at the EOP.
- 7) Transport for délégué was estimated at TD 7,000 per délégué, per year, for six délégués.
- 8) The costs of poster and billboard production and display are shifted to the ONFP and are estimated to equal TD 50,000 per year at the EOP.
- 9) Observational tours were assumed to be for two persons to Indonesia for 25 days. Air Ticket (Tunis/Jakarta/Tunis)= TD 850,000/person, Per Diem=US \$109.00/person/day.
- 10) Regional CSM training exercises were assumed to be for one person and located in the Middle East. Cairo, Egypt was used as a basis for cost estimation. Air Ticket (Tunis/Cairo/Tunis) = TD 400,000, Per Diem=US\$ 87.00/day.
- 11) Ten percent of annual totals has been added for contingencies.

ASSUMPTIONS FOR THE BUDGET FOR PROJECT COMPONENT NO. 4:

Demographic and Service Delivery Research

- 1) A.I.D.-financed technical assistance, baseline data collection and conferences will be paid in U.S. dollars. Estimates are based on prices in 1985 U.S. thousand dollars and have been inflated at 5 percent, compounded annually, starting in 1987.

- 2) A.I.D.-financed research for resource targetting will be converted to Tunisian dinars. Estimates are based on prices in 1985 U.S. thousand dollars, and have been inflated at 12 percent, compounded annually, starting in 1987.
- 3) GOT-financed inputs will be paid in Tunisian dinars. Estimates are based on prices in 1985 thousand dinars, and have been inflated at 12 percent, compounded annually, starting in 1987.
- 4) GOT personnel to be involved in research activities are assumed to be the 8 staff currently employed by the Population Division of the ONFP.
- 5) GOT contribution for the pilot studies will include staff time, transport, etc.
- 6) The GOT contribution for computer equipment is included for maintenance and depreciation.
- 7) Ten percent of annual totals has been added for contingencies.

ASSUMPTIONS FOR THE BUDGET FOR PROJECT ADMINISTRATION:

- 1) A.I.D.-financed inputs for project administration are based on prices in 1985 U.S. thousand dollars, inflated at 5 percent, compounded annually, starting in 1986.
- 2) All other AID-financed inputs will be converted to Tunisian dinars. Annual estimates are based on 1985 prices in US thousand dollars, but have been inflated at 12 percent, compounded annually, starting in 1986.
- 3) Ten percent has been added to annual totals for contingencies.

NOTES TO THE BUDGET FOR CONTRACEPTIVES

- 1) Public sector distribution of pills and IUDs from 1980 to 1984 appears in Table A6.6 below.

TABLE A6.6: Public Sector Distribution of Pills and IUDs

<u>YEAR</u>	<u>Pill Cycles</u>	<u>IUD Insertions</u>
1980	177,148	31,792
1981	152,436	40,597
1982	131,036	47,267
1983	117,553	52,360
1984	116,665	56,610

Public sector distribution of pills declined from 177,000 cycles in 1980 to 117,000 cycles in 1984. Assuming that IEC inputs of this project will halt this decline, A.I.D. will provide 50 percent of the estimated minimum requirements for pill distribution in the public sector, or 60,000 cycles per year. The annual rate of increase in IUD insertion has declined since 1980. It is assumed that the annual rate of increase of IUD insertion (new and reinsertion) will increase at a rate of 5 percent per year from the 1984 level of 56,600 insertions. A.I.D. will provide 50 percent of the IUDs for these projected insertions. Given unclear statistics for public sector distribution of condoms, EMKO foam and conceptrol tablets, a constant level is estimated to be provided throughout the project.

2) Estimation of the GOT's contribution to procurement of contraceptives for distribution in the public sector will require: a) estimation of distribution of condoms, creme/gelee and foam, and foaming tablets in the public sector program, and b) delineation of UNFPA's contribution of contraceptives against this estimated total.

3) Private sector distribution of pills and condoms from 1980 to 1984 appears in Table A6.7. It is estimated that private sector demand will increase by 15 percent per year from 1984 levels. A.I.D. will provide 100 percent of the estimated private sector contraceptives in 1986, declining by 20 percent per year over the LOP. It is assumed that the GOT, utilizing revenue from private sector sales, will purchase the increasing percentage of contraceptives to be distributed in the private sector. It is assumed that the UNFPA will limit their contraceptive contribution to the public sector program so that at EOP, the Tunisian private sector is fully supporting the cost of importing the contraceptives distributed through pharmacies.

TABLE A6.7: Actual and Projected Tunisian Private Sector Distribution of Pills and Condoms

<u>YEAR</u>	<u>Pills (cycles)</u>	<u>Condoms (units)</u>
1979	477,000	840,000
1980	417,000 (-12.5%)	927,000 (+10.4%)
1981	596,000 (+42.9%)	1,232,000 (+32.9%)
1982	656,900 (+10.1%)	1,027,000 (-16.6%)
1983	902,170 (+37.3%)	1,130,250 (+ 9.1%)
1984 (E)	818,360 (- 9.3%)	1,028,133 (- 9.0%)
1985	941,114 (+15.0%)	1,182,353 (+15.0%)
1986	1,082,281 (+15.0%)	1,359,706 (+15.0%)
1987	1,244,623 (+15.0%)	1,563,662 (+15.0%)
1988	1,431,316 (+15.0%)	1,798,211 (+15.0%)
1989	1,646,013 (+15.0%)	2,067,943 (+15.0%)
1990	<u>1,892,915 (+15.0%)</u>	<u>2,378,134 (+15.0%)</u>
PROJECT TOTALS	8,238,272	10,350,009

SOURCES: 1) 1979-1983: Rapport d'Activities 1983 et Plan d'Action 1984, Tunis: ONFP, pp. 5-6

2) 1984 (estimate): Année 1984, distribution of pills and condoms in the public and private sector, ONFP xerox document.

4) Contraceptive unit costs (1985) were assumed to be as follows:

	<u>A.I.D.</u> <u>U.S.\$</u>	<u>GOT</u> <u>TD</u>
Pills (cycle)	0.11	0.200
Condoms (100 units)	4.75	4.750
Cu-T(+ inserter)	0.75	
EMKO Foam (12 cans)	13.68	
Conceptrol	0.07	

5) The annual cost of A.I.D.-financed contraceptives were estimated in 1985 U.S. thousand dollars and inflated at 5 percent, compounded annually, starting in 1987.

6) The annual cost of GOT-financed contraceptives were estimated in 1985 thousand dinars and inflated at 12 percent, compounded annually, starting in 1987.

7) Overpacking costs were estimated at 5 percent of the cost of the contraceptives. Both A.I.D. (U.S. \$) and GOT (TD) overpacking contributions were inflated at 12 percent.

8) A.I.D. shipping costs were estimated to be equal to 10 percent of the cost of contraceptives.

9) Ten percent was added to annual totals for contingencies.

In spite of the GOT's increasing financial commitment to the ONFP, additional real growth in support from the GOT will be required for the following reasons:

- In 1986, support to the ONFP under the Cooperating Agencies project may end. A major assumption of adopting this mode of intermediary A.I.D. assistance was that it would smooth the transition from the prior bilateral family planning project to a program financed entirely by the Government of Tunisia. Although the outlook for the Tunisian economy is more constrained than in 1980-81, the proposed new, bilateral project will not pick up the local currency operating expenditures (e.g. salaries, transport, etc.) financed under the intermediary effort.

- In absolute terms, growth in the GOT's support for the recurrent costs of the ONFP has been primarily in the Budget de Fonctionnement, not in the Budget des Activités (or program budget). Thus declines in AID or other donor recurrent funds will primarily affect the program activities of the ONFP (i.e. service delivery at the CREPF's and via mobile clinics, training, IEC and research), not in the staffing levels or salaries at the ONFP.
- Under the current program portfolio of ONFP activities, acceptor rates have stagnated. This suggests that modification and/or expansion of the family planning program will be required in order to raise contraceptive acceptor and prevalence rates.
- To the extent that family planning services are provided in MOPH facilities, real growth in the recurrent budget of the MOPH will be required. Specifically, an October 1984 audit of rural health facilities in Tunisia found that facilities were not being maintained in a sanitary manner due to the lack of operating funds from the MOPH. Other preliminary analyses by the World Bank suggest that hospitals recently constructed by the GOT will pose an additional strain on the recurrent budget of the MOPH. To the extent that the demand for family planning services is a function of client's attraction to the conditions of the service delivery facilities, the shortfall in the MOPH's recurrent budget will affect contraceptive acceptance and prevalence, especially in rural Tunisia. Although recurrent cost problems of the MOPH may have an impact on family planning service delivery, the remaining discussion in this section will focus on the ONFP and A.I.D.'s project with the ONFP.

The design of this bilateral project has been undertaken with the financial limitations of the ONFP and of social service ministries in the GOT more generally. Activities have been designed to work with existing divisions of the ONFP and to utilize existing personnel within the ONFP or other GOT ministry. The activities proposed under Component 4: Resource Targetting are specifically intended to assist the ONFP in clarifying how it can most cost-efficiently carry out its mandate.

The IEC component of the project has been designed as an effort to increase contraceptive acceptance and prevalence. The success of these efforts will be measured by the increase in the growth of demand for pills and condoms in private pharmacies, as well as from public facilities. This increased demand will increase revenue to the CSM effort in the private sector, and

would be expected to increase the cost-effectiveness of existing public sector efforts. A.I.D.-financed inputs will strengthen the capability of the existing IEC Division of the ONFP to develop IEC efforts that utilize the extensive mass media network in Tunisia. These inputs will provide the necessary investment expenditures required to modify the IEC capabilities currently existing in the ONFP.

The CSM component of the project is intended to work with private pharmacies in order to insure that they can meet the expected increase in private sector demand for contraceptives; and that pricing policies are altered so that the pharmacists are motivated to carry and promote pills and condoms, and to provide sufficient revenue so that minimally the cost of the contraceptives is covered. A more complete discussion of contraceptive pricing follows.

The training component of the project is intended to redirect the training activities of the ONFP from didactic training to in-service practical training. The didactic training activities that the ONFP now performs are intended to be shifted to the Tunisian academic institutions which now train health and social service professionals. As with the IEC activity, the A.I.D. inputs will provide the necessary investment expenditure to alter the skills of existing Training Division staff in order to alter their current program and activities.

The research component of the project will provide important assistance for: 1) the inclusion of family planning activities as a priority of the VIIth Plan for Tunisia, and 2) the collection and dissemination of information of importance to the focussing the family planning efforts in Tunisia on population groups and service delivery systems which will be the most cost effective for Tunisia.

Although the proposed bilateral project will be financed with ESF funds, it is Near East bureau policy that all bilateral projects include a contribution from the host country equivalent to at least 25 percent of the total cost of the project. The budget tables above give the inputs and their estimated cost to the GOT. In addition to these inputs, A.I.D. recognizes that the GOT will make a number of additional contributions to the project that have not been estimated because they cannot be anticipated at this time, and/or they will be provided in such small increments that they cannot readily be evaluated as a GOT contribution. Thus, the estimated GOT contribution is a minimum estimate of the actual contribution that the GOT will make to the project.

ANNEX VII: ECONOMIC ANALYSIS

This annex addresses the question of whether the proposed bilateral project constitutes a sound investment for AID and GOT funds from an economic point of view. The discussion considers both cost-benefit and cost-effectiveness evaluation issues.

COST-BENEFIT ANALYSIS

The application of cost-benefit analysis requires delineation of the benefits and costs of the proposed investment in economic terms. Application of cost-benefit analysis to family planning programs have taken one of the following approaches. One approach developed by Coale and Hoover (1959) is to evaluate the effect of reduced population growth rates on per capita income using a macroeconomic model. The other approach, developed by Enke (1960) and Zaiden (1971), is to calculate the present value of the expected consumption of the individual over his/her lifetime, and subtract the present value of what s/he would be expected to produce over a lifetime.¹⁴ Application of these approaches to evaluation of family planning programs in other developing countries has shown high positive returns, with the proportion of social benefits to individual/family benefits sufficiently high to warrant government subsidization of population/family planning efforts.¹⁵

The application of benefit-cost analysis to evaluation of this family planning project would require a number of assumptions which are detailed below. A minimum estimate of project benefits to Tunisia could be estimated as the discounted sum of government health and educational expenditures saved by averting a birth.¹⁶ Estimation of the number of births averted as a consequence of project activities could be made by subtracting the current rate of decline in the birth rate, from the expected accelerated rate of decline during the project. Although the births directly averted by the project will also result in fewer births in the future (i.e. the unborn cannot become parents), it is reasonable to assume that these additional births averted would not result in significant present benefits because they would most likely occur at least 20 years after the beginning of the project.

From the perspective of the GOT, project costs are assumed to equal the sum of AID's and the GOT's contributions to the project from 1986 to 1990. Government budgetary contributions would need to be shadowed priced to represent their opportunity costs in terms of the other social activities foregone as a consequence of undertaking the proposed project. AID contributions would be included at their nominal value, as the AID funds are not available for alternative investments in Tunisia. In addition to

the direct project costs, it is also important to include an estimate of the foregone output of the persons whose births are averted as a consequence of the project. However, the present value of these costs would not be as significant as employment of a person whose birth was averted would not begin until at least 15 years after the start of the project. Further, Tunisia is experiencing high rates of unemployment, hence the shadow price of labor would be expected to be significantly less than one.

Time in-country did not allow for quantification of these parameters and calculation of a project-specific NPV. However, one of the activities under the research component of the proposed project is to undertake a benefit-cost study of family planning efforts in Tunisia. This study will provide a refinement of the above framework and a quantitative evaluation of the results.

COST-EFFECTIVENESS ANALYSIS

Given the difficulty of assigning an economic value to a human life, cost-effectiveness analyses of social sector projects is often employed to determine which alternative intervention will achieve the desired objective(s) at the lowest cost. It was not feasible to apply this methodology to the proposed project for several reasons. First, several project component activities are relatively new to the Tunisian family planning program, thus information about the effectiveness of the activities in increasing contraceptive prevalence, or the number of births averted, was not available. Second, information about the cost-effectiveness of existing forms of family planning service delivery in Tunisia were not readily available. Finally, insufficient time was allowed for preparation of an analysis utilizing existing service statistics and the experience in other North African countries. However, the Population Council and the UNFPA will be analyzing data on the cost-effectiveness of rural family planning service delivery systems in Tunisia within the next year. In addition, the research component of this project will undertake a more extensive study of the cost-effectiveness of a wide range of existing, or experimental, family planning service delivery approaches.

NOTES

14. Yinger, N. et. al. (February 1983) "Third World Family Planning Programs: Measuring the Costs," Population Bulletin, Vol. 38, No. 1.
15. Lewis, M. (September 1984) Pricing and Cost Recovery Experience in LDC Family Planning Programs, background paper for the World Development Report, 1984, Washington, D.C., IBRD, pg. 6.

16. There are undoubtedly other governmental savings, and positive environmental externalities, which would result as a consequence of increasing contraceptive prevalence and decreasing the number of births as a result of this project. Thus, the assumption that project benefits equal only government savings on education and health will lead to underestimation of the benefits of the project, and hence an underestimate of its net present value (NPV).

ANNEX VIII: SOCIAL SOUNDNESS ANALYSIS

This population project will take place in a culture which is predominantly Islamic (98%). Accordingly, all project activities will be tailored to fit an Islamic context. Also, the population of approximately 7 million is distributed approximately half in urban areas and half in rural areas. In the urban areas of Tunis (with about 1/6 of the total population), Sousse, Sfax, Bizerte, Monastir and Zaghuan (with about 1/3 of the national population), contraceptive prevalence is nearly double that in the rural areas.

In 1964, Tunisia became the first Arab country to officially endorse fertility reduction as a means of socio-economic development. The crude birth rate (CBR) of 45 per thousand in the early 1960s had been reduced to around 35 by the early 1980s. This decline must be viewed in light of concomitant social and economic developments. The legal age for marriage was raised in 1964 from 19 to 20 for men and from 15 to 17 for women. Changes in the age structure contributed to the decline in the crude birth rate. The government limited family allowances to four children in 1960. Abortion on request was legalized in 1973. Thus contribution of the national family program to the decline in CBR is questionable. The 1978 World Fertility Survey found the average preferred family size to be 4.2 in Tunisia. A D.C. survey by R. Beaujot and M. Bchar estimated that 54 percent of Tunisians think four children to be ideal and another 10 percent think that more than four children is ideal.

Governmental Support of the Family Planning Program

The Tunisian family planning program began, in 1964, on a pilot basis. In 1973, the then National Office for Family Planning and Population (ONPFP) was created as a semi-autonomous agency within the MOPH. Its responsibilities were to plan, coordinate, implement and evaluate family planning activities in Tunisia. The ONPFP was moved into the MFPP in 1984 and its name was changed to the National Office of the Family and of Population (ONFP).

Governmental support for family planning in Tunisia, as a component of development, began in a speech given by President Habib Bourguiba on December 25, 1962 in which he said:

"We cannot prevent ourselves from feeling a certain apprehension in front of the human tide which rises implacably at a pace which exceeds in great proportions the increase of subsistence means. What would be the usefulness of an increased agricultural production or mineral wealth -- if the population is going to increase in an anarchic and insane way Man, who was able, owing to reason to dominate nature and progressively overcome illness, is capable of governing himself and controlling the procreation pace."

On January 9, 1961, law 61-7 authorized the sale of birth control products and drugs, and abrogated the French colonial policies which were aimed at creating high birth rates. Laws 63-26 of July 15, 1963 and 65-46 of December, 1965 limited the family allowance to four children. On April 21, 1964, law 64-1 increased the legal minimum age for marriage from 15 to 17 for girls and from 18 to 20 for boys, respectively. On July 1, 1965, law 65-24 authorized abortion "when it occurs during the first three months and when the spouses have at least 5 living children" or "when the health of the mother could be endangered by the pursuit of the pregnancy", so long as the abortion is "undertaken by a physician who legally practices his profession in a hospital or in a private authorized establishment." On September 26, 1973 "social and therapeutic" abortion was liberalized so that "abortion can always be practiced during the first three months of the pregnancy, but the condition of a minimum of 5 living children is no longer required."

Governmental support for family planning in Tunisia has been consistently strong since 1962, with the possible exception of a speech by President Bourguiba in 1966 when he called for an increase in the natality rate.

GOT Demographic Goals

Recent development plans in Tunisia have given attention to the relationship between demographic trends and social and economic development. In the early 1970s, Tunisia established demographic goals for the end of this century that call for a net reproduction rate of 1.2 by the year 2001 (e.g., child bearing at a rate of about 2.5 children per family, slightly above replacement level fertility). The projections in Table A8.1 were used as objectives for the current Vith Plan (1981-86) and for the subsequent 15 years to continue promotion of these goals.

TABLE A8.1: Vith Plan Demographic Objectives

	1981	1986	1991	1996	2001
Total population (in 000s)	6,535	7400	8307	9210	10,062
Births (in 000s)	226	231	236	229	216
General fertility rate (per 1000)	148	130	116	96	80
Crude birth rate (per 1000)	34.6	31.2	28.4	24.9	21.5
Deaths (in thousands)	50.5	53.2	53.3	52.4	52.8
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	1.9

Family Planning under Islam

The words of the prophet, given in the Koran, do not contraindicate family planning, although interpretations of the Koran differ across sects. Islam, unlike Christianity, clearly supports satisfaction of sexual instincts. Also, Islamic society does not accept unmarried women. These religious factors certainly influence birth rates in Islamic countries such as Tunisia. Also, values attached to procreative virility and to having a son, in particular in the case where only female offspring exist, tend to push up birth rates and contraindicate contraceptive practice.

Under Islam, the first advantage of marriage is to have children, and thus, a posterity. But, according to Tunisian religious scholars, a necessary condition to having children is the ability to provide for their health, habitat and education. When the head of the family cannot maintain his children, Islam permits (according to certain theologians) the use of contraceptive means to allow for a small number of children who are "strong and healthy". No Koranic text categorically authorizes or prohibits contraception.

At a conference in Rabat in 1971 on Islam and family planning, the conclusions were (1) Islam permits birth control for spacing children, (2) Islam prohibits irreversible sterilization, except in the case of personal necessity, and (3) Islam forbids abortion after the fourth month of pregnancy except if the mother's life is in danger; with respect to abortion before the fourth month, religious scholars disagree, but the position most in conformity with the religion is to forbid abortion at all stages of pregnancy except for urgent personal necessity.

In Tunisia, one of the first positions on birth control to come from a theologian dates back to the XIth century. Shay'kh Abu-l-Hasan Ali Ibn Abd Allan Al-Kalhmī said that a woman is permitted to have recourse to abortion during the first 40 days of a pregnancy. Contemporary theologians in Tunisia have generally taken positions favoring family planning. Committees of the religious cult of Kairouan and Gabès have spoken openly in favor of family planning.

At the same time, a minority of religious fundamentalists exists within the Tunisian society who are opposed to birth control. These groups are most visible in the university communities and are not presently large in number. It is interesting to note that while fundamentalism exists, it is most prominent in that sector of society which is most literate and, in other parts of the world, among the groups most likely not to

oppose family planning.

Given the history of family planning in Tunisia and its support among Tunisian theologians, it appears that the proposed project is appropriate in the Tunisian setting.

Economic Basis for Project

The importance of the relationship between population growth and economic development can be readily shown, using as an example the young adult population in Tunisia in 1960, 1980, and 2000. Table A8.2 shows observed trends in the size of the Tunisian young labor-force-age population, persons between 20 and 40, during the 1960s and 1970s and projected trends of the same population from 1980 to the year 2000. This table indicates labor force trends in Tunisia and their interactions with economic development goals and political processes.

Concentration on changes in the size of the 20 to 40 age group is important for two reasons. 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, if circumstances permit. They form new households, 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 and return from these foreign 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 not subject to most of the errors that tend to affect population projections. Those who 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 cannot be projected as precisely. Nevertheless, the data in Table A8.2 represent a comparison of the demographic experience of Tunisia during the period 1960 to 1980, with analogous figures for a future period, 1980-2000. For comparison purposes, comparable estimates have been included for other areas in the world.

The above data show an overall tendency of accelerating

TABLE A8.2: Young Adult (20-40 years) Population
in 1960, 1980 and 2000

	Young Adult Population (millions)			Growth Rate (percent)		Absolute Increase (millions)	
	<u>1960</u>	<u>1980</u>	<u>2000</u>	<u>1960-80</u>	<u>1980-2000</u>	<u>1960-80</u>	<u>1980-2000</u>
Tunisia	1.14	1.67	3.23	1.93	3.29	.54	1.56
W. Africa & North Africa	33.60	55.60	104.80	2.52	3.17	22.00	49.20
Developing Countries	589.90	945.30	1580.2	2.36	2.57	355.40	634.90
Developed Countries	280.00	339.50	359.40	0.96	0.28	59.50	19.90

Source: Based on United Nations population projections developed in 1982.

growth of young labor force participants in Tunisia. Whereas the absolute number increased by .53 million from 1960 to 1980, 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 African countries, it is substantial.

The economic implications of this demographic trend in Tunisia merit attention. Several questions arise. 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 accommodate, 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 that Tunisia has followed since independence and the results of these policies. Clearly the number of entrants to the labor market is growing more rapidly than the number of jobs being created. Demand in the education, housing and agricultural sectors is likewise problematic.

Message Development

Particular social considerations for message development and communications are given in Section III, CSM and Section II, IEC and in the Technical Analysis (Annex V) for these project components.

One target group which has not been adequately addressed is Tunisian men. Messages aimed at men will serve two purposes. First, men may be convinced to use contraception (e.g., condoms, vasectomy) on their own and, second, men may cease to forbid their wives to use contraception, as has often happened in the past. Also, messages aimed at reformulating public opinion regarding optimal family size might work to reduce cultural pressure on young couples to have many children. Messages will need to be contextually appropriate and tested with many different audiences, if backlash and program failure are to be avoided. In addition, to be most effective, messages must be aimed at specific target audiences and their impact evaluated.

Previous Project Design and Execution

This project builds on a history of twenty years of A.I.D.

assistance to Tunisia in the field of population. A.I.D. provided bilateral assistance to the GOT through 1981. Programming beginning in 1982 projected a phase down of all A.I.D. assistance after FY 86. Since 1982, a centrally-funded program conducted through cooperating agencies has supported operating costs in rural and peri-urban areas as well as some research, evaluation, training and IEC activities. Now that A.I.D. has reversed its phase-out decision, increased assistance levels permit a new bilateral program to be developed. This new program will build on activities planned through centrally-funded projects as well as new activities in IEC, the private sector and mass media. It is assumed that programmed, centrally-funded activities will continue at forecasted levels at least through FY 86. Activities which fall under the centrally-funded project include training of physicians and allied health personnel (JHPIEGO, IPAVS and INTRAH - replaced in 1984 by RONCO), voluntary sterilization (IPAVS), demographic projections (RTI under the IPDP), demographic analysis (Westinghouse and the Population Council), IEC, private sector promotion, operations research, and support of rural and peri-urban service delivery (the Population Council).

While progress has been made, the program has in recent years experienced a levelling-off of accomplishments. Recent GOT changes in the population program appear likely to bring about a new vitality in the program and the possibility for significant improvements in areas which were previously not emphasized, such as social marketing and private sector distribution.

The May, 1984 joint GOT/USAID evaluation of the Tunisian population program found eight primary areas of program weakness identified in Section IB, and this project addresses these areas specifically.

Particular attention must be paid, in the execution of this project, to previous experience with social marketing in Tunisia. In 1977-78, SYNTEX conducted a social marketing program which did not succeed due to problems in obtaining advertising of contraceptives; this prior failure has serious implications for design of this project. While this earlier effort is discussed in detail in the PP Technical Analysis with respect to feasibility of the proposed activities, it is important to note that product-specific commercial advertising in the mass media was not acceptable to the Tunisian authorities. Particular attention will need to be paid to the cultural context within which this set of activities takes place; it is necessary that, from the outset, the ONFP fully understands exactly what will be expected over the course of the project and that the USG fully understands the cultural constraints of this project component.

Social Consequences and Benefits

Geographic factors and Tunisia's limited natural resources, coupled with migration toward the cities, place pressure on these cities well beyond the capacity of the existing infrastructure. Public services are greatly overburdened in urban areas and are insufficient in rural areas. Moreover, economic pressure on the government will increase and the need for insuring cost efficiency in the program will become vital.

Potential benefits of the program to both the nation as a whole and to individuals served by the program have been well demonstrated. Planned population growth and family size are closely related to improved maternal and child health, increased food and water access on both a family and a national basis, improved access to education, and decreased demand for future revenues, among other benefits.

ANNEX IX: ADMINISTRATIVE ANALYSIS

1. Administrative Structure of Organizations Involved in the Project

A. GOT

The ONFP will be the primary recipient of U.S. assistance under this project. The ONFP's principle functions include establishing policies, programs and standards for the delivery of family planning services; insuring implementation of a broad range of activities designed to increase the voluntary acceptance and use of modern means of fertility control; development of adequate training programs; development of IEC; implementation of appropriate research and evaluation, and other aspects central to the effective execution of a national population and family planning program.

The ONFP was established by law as a "public entity of an industrial and commercial nature". The classification gives it financial autonomy and, under the tutelage of the Ministère de la Famille et de la Promotion de la Femme, relative management autonomy. Limits are imposed by current laws governing the conduct of all public entities, by the "Conseil Administration" (composed of representatives from the MFPP, MOPH, MOA, MSA, MOE and MOP), and by "Contrôle des Dépenses". Financial autonomy is the authority to disburse without prior approval from other agencies. The ONFP has authority to recruit and to contract for services.

The ONFP maintains three major budget categories: 1)

operating expenses (O.E.) budget, 2) field activities (program) budget; and 3) investment budget.

With respect to O.E., the ONFP's technical divisions submit their respective proposals once per year. These are reviewed sequentially by the "Direction Administrative et Financière" (DAF), the "Direction Generale" (DG) and the MFPP, and are finally arbitrated by the MOFFD. The investment budget is reviewed by the MFPP and negotiated with the Ministry of Plan.

The MOPH is an important player in the ONFP's function; many of the public sector family planning supplies and services are in fact delivered through service outlets of the MOPH, often by MOPH personnel. Thus, the ONFP is expected to coordinate its efforts within the overall health infrastructure of the country. The MOPH is required -- by law -- to assist the ONFP in its functions, and to provide staff and training.

MOPH-ONFP collaboration is evidenced in the areas of personnel and training. ONFP service delivery personnel are largely MOPH employees; many MOPH professional-level administrators are former ONFP employees, and ONFP trains MOPH staff in family planning. The MOPH would like to see mobile teams (of which MOPH staff are members) providing basic health services in addition to family planning services. By comparison only family planning services are being provided now.

Two MOPH units appear to collaborate closely with the ONFP (i.e., below the PDG-Minister level): the Office of ONFP-MOPH Coordination (includes other coordinative functions, i.e. liaison with international donors working in health), and the Bureau de Soins de Santé de Base (SSB), responsible for primary health care (PHC) service delivery. Both directors of these units are former ONFP employees; the latter is also an MD (gynecologist), with years of field experience in basic health services (BHS).

The ONFP is in constant contact with the MOPH through these units. Foci for collaborative action by the two organizations include health/family planning programming at the regional level, and training -- particularly of MOPH physicians in family planning, and of family planning service delivery personnel (largely MOPH staff) in MCH/BHS.

ONFP collaboration with other Ministries and institutions (e.g. MSA, MYS, unions, etc.) has not been institutionalized; assistance/training in family planning is offered or requested on an ad hoc basis. The ONFP is trying to revitalize commissions to work on an ongoing basis with various organizations (e.g. occupational health, National Pedogogical Center, social assistance schools). Areas and means of effective collaboration

will need to be pursued and developed during project implementation.

Since this project will work primarily with the ONFP to carry out project activities, it is important to note that up to the present time, the ONFP has not only coordinated services, but has also provided services, supervised and evaluated service delivery, and trained service providers. The focus under this project will be to shift a large portion of service delivery to other governmental organizations (such as the Ministry of Health and the Ministry of Social Affairs) and to the private sector. There are two basic reasons for this shift; first the ONFP is presently running a service delivery system which operates parallel to those of other governmental bodies (e.g., the MOPH), and second because service delivery must be emphasized by other providers if a spread effect is to take place from this project.

The CSM component of the project will work with the social marketing unit within the IEC Division of the ONFP. While this unit already exists, it is presently staffed by only the unit chief and part-time by the ONFP pharmacist. This staffing is insufficient to provide the contacts with private sector providers on a regular basis. The project proposed hiring five detailers who will work directly with private pharmacists and physicians. These detailers are necessary if proper training and motivational activities are to take place on a regular, scheduled basis with all private sector individuals involved in CSM activities. At present no comparable staffing exists within the ONFP. The medical wholesalers have detailers, but their focus is more on promotion of brand products and not on training in contraception and promotion of family planning. While creation of these positions creates recurring costs for the ONFP, these costs can be defrayed by 1) income generated in price increases for contraceptive sales in the private sector, and 2) by transferring qualified ONFP staff to these positions from other redundant positions within the ONFP.

Focus on training of personnel from other ministries and on training instructors in the various faculties should serve to build capacity among these institutions and to broaden and improve family planning service delivery throughout the country. At the same time, training of these individuals, particularly the pharmacists in the private sector, serves to empower these other organizations and individuals and to potentially reduce the power base of the ONFP. While this seems at present not to pose problems with the leaders of the ONFP, one must be aware that reluctance about such power shifts may exist. In light of the recent shift of the ONFP from the MOPH to the MFPP, this potential for reluctance to shift power must be considered throughout project implementation. Assumption of activities by other organizations will need to be carefully monitored.

B. USAID

USAID/Tunis eliminated its direct hire (DH) HPN position in 1984 in anticipation of the Tunisian program phase-out by A.I.D.. A PSC was hired to manage the HPN portfolio, and to assist the Mission in an orderly phase out of activities through CY 1985.

The decision to phase out of Tunisia was revised in mid-1984, and population activities emerged as one of the Mission's priorities. An assistant population officer is presently being recruited to serve in the program office of the Mission and to monitor the project.

2. Implementation Issues

This project is aimed at three target populations: ONFP staff, family planning service providers and, ultimately contraceptive acceptors. The ONFP staff will receive technical assistance and training in the areas of management, programming, performance appraisal, research and evaluation. In addition the CSM component of the project will provide a program support for the social marketing unit in the IEC division. Public service providers will receive training and private sector providers will receive training and experience diminishing price subsidies accompanied by increasing profitability for the contraceptives they sell. Consumers will receive public information and education and will have greater access to a wider selection of contraceptive methods as a result of the project.

Addressing these three beneficiary groups will ensure a maximum spread effect for the project. By building capacity in the ONFP, especially in the area of programming, the project aims to develop the ability of the ONFP to continue functioning in priority areas after donor assistance is reduced or eliminated. The involved donor agencies have been largely responsible for the programming style used to date, and an abrupt reduction of assistance might leave the ONFP unable to respond to training, service delivery and coordination needs, at least in the short run. In addition, project focus on costing out activities will provide a basis for administrative determination of program cost effectiveness in setting programming priorities.

These changes at the ONFP will not be easy to implement, however. The present administrative model, based on the French civil service model, is predominant throughout the GOT. One cannot expect instantaneous change and the resistance is likely to be intense. The project is fortunate, however, to be slated for implementation under a PDG who is trained in administration

and sympathetic to the directions desired under the project. Also, the acquisition of new computer capacity, while not a panacea for solving these problems, may motivate the finance division to implement better costing mechanisms. Project requirements for documentation of expenses for each subproject will likewise serve as a financial incentive in this regard.

The second set of beneficiaries, public service providers (outside of the ONFP) and private providers (primarily pharmacists and private practice physicians) will benefit from training and enhanced contraceptive availability. Since the training focus of the ONFP will shift to continuing education of providers (primarily on an in-service basis) with a phased-down training of instructors in the faculties of medicine, pharmacy, nursing, and social work, one would expect to see two major outcomes. First, new professional graduates may be better trained in terms of family planning methods and in ways of conveying family planning messages. Secondly, the increased in-service training should assist practicing professionals in these areas. The project's spread effect should be enhanced since a greater number of direct service providers will be better trained in family planning. Also, given the broader marketing of contraceptive methods and enhanced distribution schemes pharmacists can expect to see greater profits as a result of increased prices and sales. As discussed in the Social Marketing section of the PP, increased prices will also serve as a motivating factor for pharmacists to stock and sell contraceptives, thus adding to the spread effect.

Caution must be expressed, however, with regard to the training efforts aimed at this set of beneficiaries. First, since the shift of basic training to the faculties of academic institutions involves a training of trainers approach, one must examine whether these trained faculty members will be motivated first to add the new content to their curricula and, secondly to adequately address the topics if added. Almost always curricula are viewed as the minimum content necessary in an educational program and rarely are topics dropped over time, except perhaps under major curriculum overhaul. New content is viewed generally with reluctance, both from the point of view of time for covering the content and from disbelief in the necessity of the content. The ONFP will need to perform a good deal of political ground work with the academic faculties if this shift of content is to be successful. Thus, values and attitudes of faculty will need to be addressed with respect to the appropriateness of family planning, in general, and of specific methods of family planning in particular. Particular caution must be taken so as not to drop basic family planning education from the ONFP and then fail to have it picked up by the faculties. Such a situation would work to reduce contraceptive prevalence, counter to the project

goal.

A second caution must be expressed in terms of those practitioners who are to be trained either by the faculties in basic education or the ONFP in continuing education. There is an assumption that these practitioners will be intrinsically motivated to apply their new family planning knowledge. One must note that often practitioners view themselves as overworked. Thus new responsibilities, such as the assumption of family planning service delivery, are viewed as add ons to an already neavy workload. Structural changes to lighten workloads may become necessary to ensure follow through on new family planning responsibilities. Another potential problem which must be dealt with is the value and attitude set of the provider. Training must adequately convince these providers that family planning is important from national, family, and individual perspectives. In addition, relative strengths and weaknesses of each method must be understood, so that in consulting with potential contraceptors, the provider is able and willing to provide enough information so that the client can freely choose the appropriate method.

The final set of project beneficiaries, contraceptive acceptors, will benefit from broader information on specific methods of contraception, and should thus be able to more freely and appropriately decide on a contraceptive method. In addition, contraceptive availability and family planning services should be improved given the project's activities in their areas. While information, education, contraceptive availability and services are to be enhanced, it is important to note that the current contraceptive prevalence (33.7% of MWRAs use modern methods) is among those who were certainly mostly likely to accept contraception. Potential acceptors in the remaining 66% will be more difficult to reach and convince. The CSM program will use mass media to reach those who have not yet been well informed regarding specific methods of contraception. But, as the number of contraceptors increases, new contraceptors will become increasingly difficult to find.

CATEGORICAL EXCLUSION OF ENVIRONMENTAL
THRESHOLD DECISION

Name of Project: USAID/TUNISIA Bilateral Population Program
(664-0331)

Project Description: This project supports IEC, social marketing, training, research/evaluation, operations research, and provides nominal supplies of contraceptives to the Tunisian family planning program. The focus of the project is on developing a cost-effective and efficient program on the base already established with foreign assistance in Tunisia. In addition, emphasis is placed on building capacity within the infrastructure which exists in Tunisia for family planning services and for demographic and development planning.

The project has no construction components and will have no impact on the environment. Based on regulations in Handbook 3, Chapter 2, Regulation 16, Paragraph 216.2(c)(1),

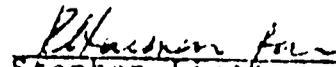
"The following criteria have been applied in determining the classes of actions included in 216.2(c)(2) for which an Initial Environmental Assessment and Environmental Impact Statement generally are not required: (i) The action does not have an effect on the natural or physical environment:"

and 216.2(c)(2)(viii):

"Programs involving nutrition, health care or population and family planning services except to the extent designed to include activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc);"

we recommend a categorical exclusion of the environmental threshold decision for the project.


James R. Phippard
Director, USAID/Tunis


Stephen Linther
AID/NE Environmental
Officer

ANNEX XI: ACRONYM LIST

A.I.D.- Agency For International Development
BHS/BHC - Basic Health Services/Basic Health Care
CA - Cooperating Agency
CSM - Contraceptive Social Marketing
CP - Contraceptive Prevalence
CY - Calendar Year
CYP - Couple Years of Protection
DAF - Division Administrative Financière
DG - Direction Générale
DH - Direct Hire
FP - Family Planning
FY - Fiscal Year
HPN - Health/Population/Nutrition
IEC - Information, Education and Communication
INPLAN - Integrated Population and Development Planning
KAP - Knowledge, Attitudes and Practices
LTTA - Long Term Technical Assistance
MFPF - Ministère de la Famille et de la Promotion de la Femme
MOA - Ministry of Agriculture
MOE - Ministry of Education
MOP - Ministry of Plan
MOPH - Ministry of Public Health
MSA - Ministry of Social Affairs
MYS - Ministry of Youth and Sports
O.E. - Operating Expense
ONFP - Office National de la Femme et de la Population
OR - Operations Research
PDG - President Directeur Général
PHC - Primary Health Care
PIL - Project Implementation Letter
PM - Person month
PSA - Public Service Announcement
PSC - Personal Services Contractor
PY - Person year
RTI - Research Triangle Institute
SSB - Soins de Santé de Base
STTA - Short Term Technical Assistance
TA - Technical Assistance
USAID - United States Agency for International Development