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Family Planning Training Project
(PAC II)

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TRIP REPORT

Countries Visited: Tunisia and Morocco
Dates In-Country: May 3-19, 1987
Travelers: Dr. Oluremi Sogunro
Nancy D. Benson
Purpose: To conduct a survey of institutions
that provide or have the potential
of providing training in clinical
family planning
Trip Report No.: 66

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I. EXECUTIVE SUMMARY

Dr. Oluremi Sogunro, PAC II Technical Skills Coordinator, and Nancy D. Benson, consultant, were in Tunisia from May 3 - 16, and in Morocco from May 16 - 19, 1987.

A. Tunisia

The major purpose of the visit to Tunisia was to conduct a survey of family planning clinics, training institutions, and service providers to determine clinical family planning training needs. More specifically, the survey was intended to help prepare the proceedings of the PAC II clinical workshop to be held in Turkey from June 22 - 27, 1987 with representatives from Tunisia, Morocco, Lebanon and Turkey.

The key findings include the following:

1. There is a relatively good mix of contraceptive options provided to clients even though providers seem to be more in favor of IUD.
2. Supervisory midwives, though competent in providing family planning services to a large extent, still require updating in some aspects of contraceptive technology such as:
 - mechanism of action of methods
 - effectiveness
 - non-contraceptive benefits
 - contra-indications to use
3. There are few hands-on practice in pre-service and in-service family planning training programs.
4. Cu-T 380A is being rapidly introduced into the contraceptive reservoir in Tunisia public family programs.
5. The national contraceptive prevalence rate is significantly overestimated.
6. Pap Smear tests are not generally conducted in Tunisia public family planning programs.

Major Recommendations include:

1. That more hands-on training for midwives be part of pre service and in-service family planning training programs for midwives.

2. That more knowledge of contraceptive technology be more emphasized during training.
3. That training in family planning programs incorporate the use of Pap Smear tests into clinic procedure.

B. Morocco

The objectives of the Morocco visit had to be changed because the original dates set by RONCO were not convenient for the Moroccan government and thus the stay was reduced to two working days.

The new objectives were to assist the Moroccan government in:

- identifying participants for the Turkey Clinical Family Planning workshop; and
- determining the clinical training needs of family planning service providers through a small number of contacts and a group interview of midwives.

Significantly findings include:

1. There is not enough contraceptive mix in the Moroccan family planning program.
2. Midwives require more up-to-date information on contraceptive technology.
3. Training programs for midwives/nurses do not emphasize family planning; Time allocated to practical training in family planning is insufficient.

Recommendations are:

1. RONCO to assist MOH to develop an in-service training program to include clinical family planning skills.
2. RONCO to assist MOH in developing procedures and protocols for delivery of family planning services.

II. INTRODUCTION AND BACKGROUND INFORMATION

The need for this assessment survey arose from RONCO'S first regional workshop held in September 1986, out of which came recommendations that RONCO provide assistance in clinical family planning, among other areas. The title of the September workshop was "Regional Training in the Near East and North Africa: Needs, Purposes, Plans and Strategies". The goal was to see the feasibility of regional family planning training given variations in language and politics of the countries involved. The workshop participants also defined what kind of assistance could be provided at the regional level. Among the recommendations was a need to undertake regional training activities in clinical family planning. Subsequently, RONCO decided to organize a workshop in Turkey in June, 1987 on clinical family planning, bringing together representatives from several countries.

Following from these recommendations, RONCO arranged for a survey of those training institutions which conduct pre- and in-service training to health personnel who provide clinical family planning services in the Near East and North Africa region. Such a survey would also help in the preparations for the Turkey workshop.

To date the survey has been conducted in Egypt, Jordan, and Turkey.

A. Tunisia

During the Tunisia trip, meetings were held with the central officials of the ONFP (French national office of family planning and population) of, administrators, and service providers at the ONFP clinics (CREPFs) and professors in the medical and public health schools, as well as with an official of the CFFP (Educational Development Center) in Tunis. A final courtesy meeting was held with the President Director General (PDG) of the ONFP, Prof. Hedi M'henni. Briefing and debriefing sessions were held with the Health and

Population Officer of the USAID Mission, as well as with RONCO regional office staff. Most of the survey was done outside Tunis, in three urban coastal governorates, and in one rural governorate in the interior of the country.

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B. Morocco

The objectives for Morocco were revised, the visit was postponed by one week and the duration of stay was reduced to two days. Therefore, rather than conduct a country-wide survey, activities in Morocco were limited to meeting the prospective candidates for the Turkey workshop and clarifying issues such as workshop objectives. During this trip, a briefing meeting was held at the USAID Mission with the Population Officer, after which the visiting team proceeded to the Central Office of Family Planning to meet with two representatives of the Population Division and eight prospective candidates for the Turkey workshop.

Afterwards, the team met with Dr. Abdel-Hady Mechbal, Director of Technical Affairs at the Ministry of Public Health, with whom the list of candidates and criteria for selection were discussed. At the end of the Morocco visit, an exit meeting was held with the AID Population Officer at the USAID mission.

A later date (end of June) was proposed by the mission for a RONCO visit. This was because the Ministry of Public Health was engaged in a large nation-wide immunization campaign. However, because the visit was important in preparing for the Turkey clinical workshop which has been scheduled for the end of June, the proposal by the Ministry was not acceptable to RONCO.

III. FINDINGS

Tunisia

1. In very general terms, in-service training in family planning appears to have been decentralized in Tunisia. Regional training teams visited are well motivated and training can be done to a large extent independently of the CFR (National Training Center (CFR). However, two trainers expressed the concern that the training teams have not been officially recognized by the ministry and this might lead to abolition of the teams at a later date.

2. There is a good mix of contraceptive methods available to clients; there is a preference for the IUD but this appears to be due to a preference for the IUD by service providers. Many service providers feel that IUD insertion and follow up is easier to accomplish than explaining pill use, and requires relatively little effort on the part of clients in terms of use and continuity.

3. There seems to be a rural-urban variation in the acceptability of the IUD. According to statistics from one rural governorate, women in rural areas are skeptical of IUD-induced menorrhagia, making the IUD rather unpopular among them. Menorrhagia apart, perhaps some of the complicating determining factors are logistical and managerial:

- a. the visit of mobile clinics that serve these rural areas are not well-timed and potential clients may not be at home.
- b. because of the policy of inserting IUDs on certain days during the menstrual cycle, many women may be missing IUD insertion if their menses do not coincide with the visit of the mobile clinics. The idea of mobile rather than static clinics may contribute to the statistical variation in IUD acceptance between rural and urban areas.

Even though women in rural areas seem to choose the pill over the IUD, further studies would need to be conducted to determine continuation rate of the pill, given the complexity of pill use.

4. While training of non-physicians does not adequately prepare them for the task, provision of family planning services appears to be in their hands. Many interested and motivated midwives depend on self-learning and informal, on-the-job training to improve their knowledge and skills in clinical family planning.

5. The supervisory midwives and some midwives at the CREPFs have excellent information on contraceptive technology. However, two midwives interviewed in Sousse stated that there is a gap in knowledge and skills between them and midwives working in rural clinics as well as recent graduates from the Medical School.

6. While these supervisory midwives are competent and could supervise practical training of other midwives in contraceptive methods, we found that they require updating in some aspects of contraceptive technology such as:

- Mechanism of action
- Effectiveness
- Instructions for use
- Non-contraceptive benefits
- Contra-indications to use
- Danger signals

7. The ONFP centers are more suitable for training midwives than the teaching hospitals for the following reasons:

- a. In teaching hospitals there is frequently a preference by clinical professors to concentrate on training medical students, intern and resident doctors.
- b. There is a sufficient number of clients in the ONFP clinics to provide opportunities for in-service training of midwives.
- c. The ONFP clinics are largely similar to the environment in which these midwives would work later on.

8. In Sousse and Kasserine, statistics show an increasing demand for bilateral tubal ligation. This may be related to increased counselling on surgical contraception and, in fact, the presence of a regional office for Association for Voluntary Surgical Contraception (AVSC) in Tunisia.

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9. While the Lippes Loop is being withdrawn from use, the Cu-T380A is rapidly being introduced. However, service providers do not seem to know the rationale for patient selection for different types of IUD.

10. The system for follow-up of clients is well-designed and this is particularly so at the CREPFs. However, problems such as lack of staff prevent full implementation of this system. The follow-up system is commendable for bilateral tubal ligation and IUD clients, since they are easier to follow than pill users. This is especially so in the rural areas. IUD clients are asked to return to the clinic after one week, then one month, then three months, and indeed any time need arises after insertion. I wonder then that more IUD clients return to the clinic than pill clients.

11. There is generally a shortage of midwives in some places visited and an expressed demand for this category of health worker. This is because midwives are no longer trained in rural areas and thus they (midwives) find it difficult to return to rural areas after completing their study in urban coastal cities. The visiting team learned that a relatively new cadre of health workers called obstetric nurses is being trained to supplement midwives, especially in the rural areas.

12. There are generally no problems with the supply of contraceptive commodities in clinics. The ONFP currently monopolizes the trade. The ONFP also distributes to the private sector for sale at highly subsidized prices.

13. Contraceptive Prevalence Rate (CPR) varies from one governorate to another. In some places the CPR is well below the national average. Moreover, the team learned

that the national figure of 41% is overestimated. The actual percentage is about 26%.

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14. There is a clear need for more training materials in the institutions visited. The demand includes materials on curriculum development, contraception, and surgical techniques.

15. The use of the Pap smear does not appear to be common. No service provider mentioned this test to the visiting team.

16. Vasectomy appears to be culturally unacceptable.

17. Record-keeping and statistical analysis of data are well done. CREPF administrators visited have charts showing the statistical data on population and family planning in their governorates.

18. There is a wide gap between theoretical and practical, in-service training in family planning for non-physicians in Tunisia. However, there are ways to improve and emphasize hands-on training. Workshops could be extended by one day while hands-on training is coordinated by some ONFP centers. Another way might be for governorate CREPFs to take over the responsibility for practical training while regional training teams supervise the training from one governorate to another.

19. There is generally no use of a check list to guide the midwife in helping the client choose a method of contraception or to identify high-risk patients for certain contraceptive methods.

20. There are no set standards on how many IUDs a trainee needs to insert before being certified.

21. There is no set policy on re-training intervals for providers.

22. Only the combination pill is currently available in Tunisia. There is need to have the pill containing progestogen only (called mini-pill in the U.S.) and sequential pills.

23. In providing instructions to IUD clients, service providers do not mention how to check for the string. Apparently IUDs are sometimes expelled spontaneously or displaced inside the uterus, leading to pregnancy as a complication. This complication was mentioned by several midwives.

24. Injectable forms of contraception are not legally available in Tunisia.

25. Family Planning clinics do not generally treat sexually-transmissible diseases.

26. Condoms are not encouraged because male participation in family planning is rare. This may pose a problem in the near future because of worldwide growing demand for use of condoms to prevent AIDS.

27. A. Prescription of IUD for breast-feeding mothers is universal, even though the reasons are not well known. Since the average duration of breast-feeding is about six months and average post-partum amenorrhea is six months, it is safe for a lactating mother to commence a reliable method of contraception by the third month or as soon as she starts adding supplementary food to breast milk, whichever comes sooner.

28. Barrier methods of contraception are generally not used, partly because they are culturally unacceptable (embarrassing, messy, etc.) and also because the ONFP has not been importing them.

3. Morocco

In-service training in family planning has not been firmly established, either at the national or provincial level.

2. Sufficient time is not allowed for family planning during basic training. Practical training is minimal.

3. Choice of contraceptives greatly emphasizes the pill. Our source indicates that about 70% of contraceptive users are pill clients. However, other methods are available, such as IUD and condoms. Surgical sterilization is not viewed as a method of contraception; rather women undertake this procedure for health reasons.

4. The visiting team has found no concrete evidence of the existence of written procedures and protocols on the delivery of family planning services.

The midwives that the team met with do not seem to understand technical details in contraceptive technology, such as:

- a) Side-effects of contraceptives
- b) Non-contraceptive benefits of contraceptives
- c) Danger signals of contraceptives
- d) Complications of contraceptives
- e) Newer methods of contraception
- f) Mechanism of action

IV. RECOMMENDATIONS

A. Tunisia

The following recommendations are presented to RONCO for consideration: That

1. Hands-on training for midwives, as part of pre-service and in-service training (see #18 under FINDINGS) be increased.

2. More knowledge of contraceptive technology be made available to all family planning service providers in general and the supervisory midwives in particular since they are training their junior colleagues.

3. CREPF clinics be used as practical training sites for midwifery students at the medical schools and pre-service and in-service training of midwives.

4. RONCO advises AID/Tunis to provide safer types of contraceptive pills (mini-pills and sequential pills) to the government of Tunisia.

5. RONCO advises AID/Tunis to provide training in and the use of PAP smears in family planning clinics.

6. ONFP regional training teams be officially recognized by the government of Tunisia and no longer seen as "RONCO training teams".

7. RONCO provides training materials to support training activities carried out by the regional teams.

8. USAID/Tunis develop a strategy to promote the increase in the enrollment of students in midwifery training programs.

9. Criteria be established for the certification of midwives, e.g. the number of IUDS to be inserted and the number of pelvic exams to be done by trainees.

10. Re-training of midwives be done at regular intervals, in accordance with established guidelines.

B. MOROCCO

The visiting team recommends that RONCO:

1. Assist the Ministry of Public Health (MOPH) in developing a long-term program of in-service training at the provincial level to include contraceptive technology.

(MOPH continues to demonstrate interest in working with RONCO to develop a provincial training activity).

2. Assist MOPH to develop a program to update the knowledge and skills of trainers of non-physician health workers in family planning and contraceptive technology.

This should include information on:

- a) Mechanism of action
- b) Indications for use
- c) Complications
- d) Danger signals
- e) Newer contraceptive methods.

3. Assist MOPH to develop written procedures and protocols on provision of family planning services. Already the Ministry of Public Health has an unwritten protocol for tubal ligation, even though this is not seen as a method of contraception. For instance, a woman may not have tubal ligation unless she has four living children one of which is a son who is at least two years old.

4. Advise AID/Morocco to assist MOPH in expanding the contraceptive horizon in the clinics.

C. GENERAL

We also recommend that before the mid-project evaluation, the RONCO PAC II Evaluation Coordinator visit all the PAC II subprojects in NENA countries for detailed formative evaluation.

APPENDIX A

List of Contacts

A. TUNISIA

ONFP, Tunis, Tunisia

1. Prof. Hedi Mhenni, President Director General ONFP
2. Mr. Kacem Griba - International Division

CRF, Tunis

1. Mr. Mongi B'chir, Director
2. Mme M'henni - Administrator
3. Mme Jaballah - Supervisory midwife

Centre de Recherche et de Formation Pedagogique, Tunis

1. Dr. Habiba Paen Rondhane, Deputy Director

Medical School, Tunis

1. Dr. Ali Bousnina - Coordinator of Program for Paramedical Students

Medical School, Sousse

1. Dr. Ben Said, Gynecologist and Obstetrician

Medical School, Monastir, Department of Community Medicine

1. Dr. Abdullah B'chir
2. Dr. Kamel Essghairi

School of Public Health, Sousse

1. Mr. Mohammed Zouari, Assistant Director

Centre Regional d'Education et Planification Familiale (CREPF)

Ariana

1. Mr. Abde Nader, Administrative Director

Bizerte

1. Mr. Ghedira, Administrative Director and Regional Delegate

Sousse

1. Mme M'lika, Supervisory midwife
2. Mr. Nejib Bel Haj - trainer

Kasserine

1. Mr. Abdel Wahed Abdir, Administrative Director and Regional Delegate

USAID, Tunis

1. Mr. Jim Vermillion, Health and Population Officer

MOROCCO

1. Dr. Abde Mechbal, Director of Technical Affairs, MOPH
2. Mr. Onchaif Brahim, Office of Family Planning, Rabat
3. Mr. El Khedri Ali, Office of Family Planning, Rabat

USAID/Rabat

1. Mr. Carl Abdou Rahman, Population Officer