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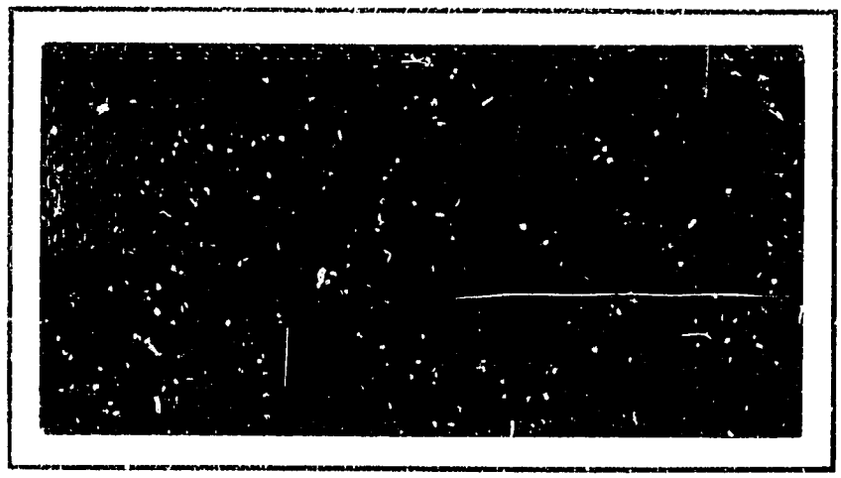

AMERICAN PUBLIC HEALTH ASSOCIATION
International Health Programs
1015 Fifteenth Street, N.W.
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FAMILY PLANNING IN RURAL TUNISIA: A REPORT ON PROGRESS

A Report Prepared By:
MELVYN C. THORNE, M.D., M.P.H.

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ABBREVIATIONS

AID/W	Agency for International Development/Washington
FFA	Force Field Analysis
FP	Family Planning
GOT	Government of Tunisia
IEC	Information, Education, and Communication
IFRD	International Fertility Research Development
ILO	International Labour Organization
INTRAH	International Training in Health
IUD	Intrauterine Device
MCH	Maternal and Child Health
MOH	Ministry of Health
MOSA	Ministry of Social Affairs
MWRA	Married Women of Reproductive Age
ONPFP	Office National de Population et Planning Familial
PDG	President Director General
TBA	Traditional Birth Attendant
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development

I. INTRODUCTION AND BACKGROUND

ONPFP) and on his numerous working contacts. As a result of his contributions to the Phase II evaluation, he was asked to assist the ONPFP in reviewing the evaluation report in light of current progress and developments.

I. INTRODUCTION AND BACKGROUND

Scope of Work

At the request of the United States Agency for International Development (USAID), the consultant was asked to assist the Office National de Population et Planning Familial (ONPFP) and the Population Council in reviewing the ONPFP's progress in developing proposals to implement the recommendations of the Phase II Mid-Term Evaluation Mission (March 1980). He also was asked to help develop plans for a three-year, assisted effort to expand family planning services into the rural and underserved areas of Tunisia.

Background

In October 1979 and March 1980, the Government of Tunisia (GOT) and the AID conducted in two stages an evaluation of the progress of the bilateral project entitled Tunisian Family Planning Services (AID Project No. 664-0295). (The project began in 1978 and was scheduled to terminate in 1981.) The report on the evaluation of Phase II contained many recommendations. Efforts to implement these recommendations were delayed, however, because of major changes in the government which subsequently led to shifts in policies and operations. A new prime minister, new governors, and a new minister of health were installed. The president director general (PDG) of the ONPFP, Mr. Mezri Chekir, became the chef de cabinet in the Prime Ministry. His position was filled by Mrs. Souad Chater, who for some years had managed all the social services of Tunisia in the Ministry of Social Affairs (MOSA).

In the year since the report on Phase II appeared, the GOT and the ONPFP have been reassessing their goals and activities. The current consultation, timed to coincide with a programming mission of the Population Council, provided an opportunity to review the decisions and actions that have been taken in response to the Phase II evaluation.

Mrs. E.S. Maguire of AID/Washington (AID/W) conceived and guided (in March 1980) the innovative, two-phased joint evaluation of the Tunisian family planning and population effort. The consultant assisted Mrs. Maguire, the other three members of the AID team, and the five Tunisians on the counterpart team in reporting their findings, conclusions, and recommendations. The consultant drew on his earlier experience as a representative of the Population Council and technical adviser to the GOT (he was involved from 1968 to 1972 in the organization that preceded the

II. REVIEW OF REPORT ON EVALUATION OF PHASE II

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Although the ONPFP's director of international cooperation, Mr. Mourad Ghachem, organized a series of meetings with key staff of the organization, it was not possible for the consultant to conduct an adequate review of the Phase II evaluation during his brief visit. None of the staff, except Mrs. Chater and Mr. Ghachem, had read the report. A number of staff maintained that they had not received the document, although multiple copies, in French, had been sent to the ONPFP in June 1980. Furthermore, Mr. Ghachem complained that the follow-up sheets, the use of which had been recommended by the evaluators, had been sent to the appropriate chiefs last October but had not been completed and returned. Mr. Thraya, in the training section, was the only person who returned the form.

The review was hampered for other reasons as well. Mrs. Chater was overseas during the week preceding the meetings; Mr. Charfeddine, of the evaluation section, could not return from Geneva in time to participate in discussions; and the representatives of the Population Council were more interested in programming assistance to the ONPFP to extend rural services than in reviewing the report on the evaluation because it is difficult to assemble the components of a feasible program. Also, the consultant's visit was very brief; a complete review could not be made in the time available.

Mrs. Chater and the AID mission agreed with the consultant that a more thorough review of the report should be scheduled to coincide with Mrs. Maguire's visit to Tunisia in June. By that time, ONPFP staff would have in hand the results of their reviews of each governorate and the studies that Mrs. Maguire had commissioned.

III. SUMMARY OF MEETINGS

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March 23: Gelabert, Getson, Brown, and McEvoy

On March 23, 1981, the consultant met with Mr. William Gelabert, director of the mission, and Mr. Allan Getson, population officer. Dr. George Brown and Ms. Peggy McEvoy of the Population Council also attended the session. Mr. Gelabert said that Mrs. Chater has initiated a fundamental reassessment of the policies and operations of the ONPFP. She is, he added, championing integration and trying to look three to five years ahead. Mrs. Chater's efforts interest the AID, which should phase out its assistance over these five years. Mrs. Chater is beginning to promote decentralization of planning for family planning services, and is encouraging the governorates to provide feedback. This approach is new in Tunisia. Mrs. Chater also is trying to actively involve Ministry of Health (MOH) workers in family planning. In the past, targets were set by the central ONPFP; Mrs. Chater is trying to get the governorates to set their own, realistic, targets.

Dr. Brown, Mr. Gelabert, and Mr. Getson all noted the difficulty of obtaining information, especially financial and budgetary information, from the ONPFP. Mr. Getson said that he had had difficulty obtaining the monthly service statistics.

Later that evening, a dinner meeting was held with Dr. Brown and Ms. McEvoy. Other meetings were scheduled over the next two days to discuss the development of plans for assistance from the Population Council.

Efforts to conduct planning sessions during Mrs. Chater's absence were problematical. First, ONPFP staff were reluctant to share information and to discuss budgets. Second, it is difficult to understand how assistance in planning and managing rural services can be provided when a person is not available full-time in Tunisia. Mrs. Chater is opposed to the presence of a resident consultant because she believes this approach reinforces Tunisia's dependence on foreign advisers. Third, no clear approach to a "rural strategy" has been presented to the Population Council. Nor does it appear that there is an organizational focus for such a strategy in the ONPFP.

March 24: B'chir, Babout, and Ghachem

Mr. Mongi B'chir, ex-chief of the ONPFP's Family Planning Directorate, currently the part-time, principal technical adviser to the PDG, joined Mr. Hamadi Babout and Mr. Mourad Ghachem of International Cooperation for discussions with the consultant. Mr. B'chir said that he is now introducing population sciences into the curriculum of the medical school.

Service statistics for 1979 and 1980 were summarized in a two-page general-information flyer that presented on one side the "Evolution of the Principal Family Planning Methods During 1979 and 1980" and, on the other, "Principal Measures of Consolidation to Family Planning Activities in 1980" and "Principal Objectives for 1981" (see Appendix B).

Mr. B'chir noted that the spurt of activity observed by the evaluators in February and March 1980 has not continued. Use of the IUD increased somewhat in 1980, but use of pills declined, and the number of tubal ligations remained stagnant. Twenty-six new consultations in family planning (FP) have been provided in the "green belt" (i.e., the "poor suburbs") of Tunis. Three doctors of the ONPFP have been visiting the interior programs to ensure that quality medical services are being provided. A number of staff have left the ONPFP, and many changes have since been made. The crude birth rate has risen. Mr. B'chir detected an "age phenomenon": urban women, 30-40 years old, he said, were behaving as though they had reverted to natural levels of fertility, although they had earlier limited their fertility. If his observations are substantiated by further study, family planning services will have to be tailored to take into account age. Mr. B'chir asked at a recent round table: Are women who have been practicing family planning for ten years now beginning to drop it? The answer might explain why demand for tubal ligations has not increased. The factors associated with continued use of contraceptives need to be studied.

Mr. B'chir described a method of decentralization that he had suggested to Mrs. Chater and which will change the character and the structure of the ONPFP. The idea is to make the delegates both responsible for and competent in analyzing needs and planning an action-strategy for family planning services in each governorate. The delegates must learn how to determine what needs to be done in each locale and then be able to take the necessary action without waiting, as in the past, for orders from the central ONPFP. A series of documents, including information on the number of women of reproductive age (MWRA), has been prepared for the delegates. The delegates are to use the information to calculate indicators of activity, identify those which are rising or falling, determine why increases or declines are occurring, and then decide what to do. They are to make decisions and to propose to the ONPFP action which they think would be helpful. The ONPFP will be a coordinator, becoming involved only if the results of the decentralized initiatives are either remarkably poor or remarkably good.

It may be as many as four years before the decentralized system begins to function well, but it should be most effective in the longer term. Programs need to be adapted to local conditions, both opportunities and difficulties. If the results of family planning efforts are poor, the particular reasons need to be identified and solutions sought. Are pills available? Are the mobile teams working? Has the population been notified in advance? Does the maternity detail have a worker who promotes family planning methods? How are clients received? These and similar

questions might be asked to determine why efforts are or are not successful.

The ONPFP's adoption of the new approach, after an initial six months of hesitation, has resulted in a change in both methods and organizational structures; 1980 was a year of transition. The organization known as International Training in Health (INTRAH) will be training nine delegates, nine supervisory midwives, and four other personnel from the departments of administration and social affairs.

During the meeting on March 24, Dr. Brown described an alternative approach, the "user perspective." In this approach, all services are made available, individuals' selections are identified, and the most appropriate ways to present services are determined. Ms. McEvoy spoke of the value of quick mini-surveys to determine which services are acceptable to most people.

Dr. Thorne, the consultant, asked how the ONPFP wants to cover the many points raised in the report on the Phase II evaluation. Mr. Ghachem said that Mr. Gelabert had reviewed the report thoroughly with Mrs. Chater; he estimated that at least 70 percent of the recommendations have been addressed. The current meeting, he said, was for a general overview of the program. Later, each section of the report could be reviewed with the appropriate section head.

In discussing what could be done to extend services, other than employing mobile teams, Mr. B'chir referred to use of public health nurses (infirmiers hygienists), noting that they are the most stable and most widely dispersed service providers in Tunisia. He added that they have been used successfully in Jendouba. Use of these personnel presents problems, however. The infirmiers hygienists would have to assume additional responsibility for which they would receive no monetary bonuses (primes). Furthermore, they would not be under the control of the ONPFP. It would be difficult to get the infirmier hygienists to do family planning because international organizations have habituated these personnel to expect bonuses for this kind of work. Logically, family planning services should be provided by retrained workers in ministries with extended networks of personnel (e.g., the infirmiers hygienists at the MOH; the animatrices sociales (social-work assistants) at the MOSA; and the vulgarisateurs agricoles (agricultural educators and extenders) at the Ministry of Agriculture).

Mr. B'chir noted that the two animatrices (educators and motivators), assigned to each governorate between Phase I and Phase II of the evaluation, cover the urban, and not the rural, areas. One covers the dispensaries and maternal and child health (MCH) centers in the capitals of the governorates. The delegates say that these workers are useful. Their forms are being analyzed by Mr. Charfeddine; the results of the analyses are not available at this time.

According to Mr. B'chir, the effort to relaunch the postpartum program has been unsuccessful because health personnel in the maternities refuse to do family planning work, noting that others received bonuses when they did such work. Funds to remunerate the staff are not available. The motivation of paramedical personnel is an obstacle to reactivation of the postpartum program. The results of the International Fertility Research Development (IFRD) Project in ten maternities may provide some useful insights.

During the meeting, a brief review was made of the section entitled "Recent Program Initiatives" (see page 7 of the Phase II report). The following is a summary of the consultant's findings.

- The Family Planning Directorate has been dismantled. Services now are the direct responsibility of delegates from each governorate.

- The two animatrices do useful educational work in the governorates, but it is not known what effect they have had on the postpartum program. The results of their work probably are encouraging.

- The medical quality of family planning services is now ensured. Three doctors from the medical division of technical services make field visits to monitor quality. The delegates meet every two months. At their last meeting they concentrated on a "community diagnosis" to analyze delegations within their governorates (see Proces Verbal, Appendix G).

- Delegates now have authority to make decisions about three different budgets--one for training, one for the operation of clinics, and one for the education and motivation of the public.

- Budget line-items are monitored with a modified GANTT chart. The method works well. Delegates now prepare fifteen separate reports (on vehicles, education, etc.) and monitor services every three months using epidemiological techniques. (Mr. Getson noted that he has received only the first report for 1980.)

- Delegates have received a set of forms and questionnaires to identify population subgroups, births, organized groups, family planning activities, equipment, the variables for each method that influence family planning behavior, and solutions in each governorate.

- The program review and planning committee for rural service delivery, Comite de Reflexion sur le Milieu Rural, met once in 1980 and then disbanded. Only three committees are meeting now: Mass Media, Intermediaries, and Organizations (Milieu Organise).

The section entitled "Highlights of the Phase II Evaluation" (see page 8 of the report) was reviewed also. The following is a summary of the consultant's findings.

- The analysis in each governorate of service statistics continues. A more detailed analysis will be made by the delegates. Assessment and action-planning will be decentralized to each governorate.

- Ten centers will initiate an experimental program with injectables in January 1982. The program will be under the direction of Dr. Boukhriss.

- Mrs. Chater is involved actively with several committees preparing the Sixth Plan.

- The National Population Council did not meet last year, because of the many changes in the government, but it probably will be convened in April or May 1981. A number of regional population councils meet, often with health officials, sometimes with officials of the Ministry of Agriculture. The regional groups are active in Tunis, Gabes, Nabeul, Mahdia, Kairouan, Sousse, Bizerte, and Tozeur. Mrs. Chater has been stimulating activity among the councils since August 1980. The councils will convene in October to discuss the ONPFP program.

- The group considered a new, comprehensive ONPFP family planning service delivery strategy for rural Tunisia (see page 8 of the report). Various components of the strategy were discussed, including:

  --increased salaries for <u>animatrices sociales</u>;

  --reopening of the schools for <u>animatrices sociales</u>, closed since 1976;

  --development of delegates' analytical competence;

  --establishment of a UNFPA program in organized sectors, and home visits; and

  --use of thirteen rural "Centres de Jeunes Filles."

Mr. B'chir said that the following activities should be described in the report:

--Saturday round tables for all professionals at the ONPFP to discuss such topics as motivation, education, and age of clients;

--training of delegates;

--community diagnosis by delegates;

--collaboration with the MOH, MOSA, and Ministry of Agriculture; and

--operational and this-point-in-time studies to determine why use of IUDs has increased or decreased. (This kind of study was undertaken in Tozeur in 1980. Later, in Gafsa, a study of IUD withdrawals (etudes ponctuelles) was made.)

Mr. B'chir believes that, to be programmatically useful and to improve the management of services, analysis must be done locally. The analysis should be based on the division of the population into rural-dispersed, rural-semi-grouped, and semi-urban groups.

According to Mr. B'chir, the Ministry of Plan asked the ONPFP to produce very high levels of "averted births." Unfortunately, there are few scientific facts on which to base such projections. Mr. B'chir wanted to make projections incrementally, on the basis of earlier performance. However, he was pressured to do otherwise by his colleagues who wanted to raise the number of tubal ligations performed. There should have been open competition among methods to ensure equal access to all forms of contraception. Except for the introduction of the injectables, there are no other "exogenous factors," no more surprises or unknowns, that would lead one to expect a significant increase in the use of any one method. Rather, one would expect modest progressions in response to better and more pertinent management. Mr. Ghachem noted that performance depends on the deployment to the field of good people. Performance has improved in Siliana since Khrifa's work there.

March 24: Thraya and Chater

Mr. Thraya, chief of training, and Mrs. Chater joined the meeting attended by Dr. Brown, Ms. McEvoy, and Mr. Ghachem.

Mr. Thraya said that he had not seen the evaluation report, neither the French nor English version. He had begun to describe his approach to training delegates and other personnel in the governorates, and the general program of the Training Center, when Mrs. Chater joined the group. Dr. Brown said he needed to gather data to present a project and a budget. Dr. Thorne suggested that the group review the rural strategy described in the evaluation report.

Mrs. Chater spoke of the problems of trying to create a coherent national program by "living by projects" (vivre en projets), lurching from one system to another. She has formed a small committee to develop a plan for the period 1982-1986. She has decided that personnel in the governorates should express their opinions before a strategy is elaborated. By June, she expects that a thorough study will have been made of the situation, and of the client population, and that the appropriate action will have been determined.

The population's attitudes have changed, and are evolving still. The integration of family planning into health services is necessary but could ruin everything. The ONPFP is convinced that family planning must be the business of all the organizations--governors, delegates, the Ministry of Interior, the Ministry of Agriculture, the Ministry of Social Affairs, and the Ministry of Health. A precedent has been set in the legislated use, for example, of animatrices sociales. However, coordination is needed. The ONPFP will coordinate, do studies, train a wide range of personnel. But, if workers in other ministries are overloaded, they will not make time to provide family planning services. Training must be repetitive because its effect wears off. The work must be followed up with proper supervision. The most important supervision will be in the governorates. Mrs. Chater now has three doctors traveling to the field; she is monitoring this practice to determine whether another approach will be needed. Logistics and supply are the responsibility of Mrs. Chater's field coordinator, Mr. Griba, who has just begun to travel around the country. The supervisor should be a good teacher and know field services well.

Mrs. Chater read aloud the thirteen recommendations for a rural strategy (see pages 27 and 28 of the report in French, pages 21 and 22 in the English version), and concluded with the comment, "There, more or less, is how it will be done, I think." The mobile teams must be studied in each region, she continued, for their yield, to determine how they might be deployed more efficiently. In each locale, the number of women at risk, the number already protected, and the number that remain to be protected must be determined. Geographic routing must be studied again, and routes must be revised to obtain more acceptors per circuit of visits. Mrs. Chater emphasized that the gains in productivity will be gradual and progressive. She said efforts would begin in central Tunisia and progress from there. Follow-up must be guaranteed, but coverage, too, must be extended. This could be accomplished by having the mobile teams visit new areas as well. Coordination and harder work are lacking, Mrs. Chater believes. The need for coordination was never more apparent than when Mrs. Chater assembled the delegates for two days of meetings. The delegates wanted to help, but they did not know how they could do so.

There is a chief of social services in each governorate. Mrs. Chater intends to bring the chiefs together with the delegates in a series of briefings in each region. The staff will participate in a course, at the end of which they will have one day to discuss what can be done to improve

the coverage, efficiency, and effectiveness of services in their respective areas. The course will be organized by the INTRAH and coordinated by Mrs. Chater's regional delegate. A much larger meeting, scheduled every three months perhaps, will involve personnel from agriculture, health, social services, education, etc. The objectives will be to train and upgrade field staff, improve delivery of services, and provide demonstration and educational kits and material. Mr. Thraya will ensure that quality training is provided. Training will be adapted, category by category, to the needs of the several different kinds of personnel. It also will be adapted to specific geographic areas.

During the meeting, Mr. Thraya said that efforts will be made to establish direct contact with fieldworkers, to coordinate the activities of these workers, and to teach them how to coordinate and train others. An initial program has been developed with the aid of the director of social affairs. There will be two sessions, the North at Tunis and the Center and South at Sousse. Twenty persons will participate in each session, although fifteen would be a more desirable number. The participants will be taught how to evaluate their community and service operations, how to manage services, and how to identify problems in their localities. Training sessions will be held once or twice each month; the maximum will be six sessions per semester for no more than forty workers per month. Training must be limited because of a lack of resources. Supervision will be provided primarily through the regional directors. The ONPFP will provide supervision by sampling the Liaison Forms. According to Mr. Thraya, "To social workers, we will say, 'You're doing family planning already; we can help you do it better.'"

Mrs. Chater enlarged upon the capacity of the Ministry of Social Affairs to undertake work in family planning. The MOSA employs 660 animatrices sociales and approximately 100 persons who work in literacy programs. Approximately 1,200 other persons are involved in educational activities. All personnel have diplomas and all have received three years of professional training; some have received training in family planning. They can do family planning education in households, as well as follow-up, because they are the only persons who have received professional training in this kind of work. A woman on the pill will be followed up when she is visited by an animatrice sociale, who will send to the ONPFP a special form indicating that the woman is continuing to take her contraceptive, has problems, etc. The Office of Social Affairs will evaluate field programs. Women who have stopped coming to clinics for pills can be followed up automatically by social workers, using the Liaison Form, which is being simplified at this time.

There is an advantage in using professionals for fieldwork: They can provide feedback to the program. Non-professionals can, perhaps, do some motivation, but they cannot provide adequate feedback. Social workers now operate in communities with as many as 10,000 or as few as 2,000 persons; hence, smaller communities present a problem. The training school for

social workers has been reopened, but it will be six years before new workers are graduated from the program.

Dr. Thorne recalled the difficulties of trying to use social workers in rural family planning programs in the early 1970s. Most were young, unmarried girls from the cities, and their employment presented a variety of problems. Dr. Thorne gave as an example the unsuccessful operations-research effort at Sedjenane in 1971, where a young social worker, instead of persuading those who had discontinued the pill to return to the clinic, underwent culture shock herself. Mrs. Chater agreed with Dr. Thorne, noting that she had studied the problem of rural coverage by social workers in 1963. Only in 1971 did Tunisia begin to recruit for training young women from rural areas. Since then, some have adapted well in the rural areas; some have even married.

Dr. Brown asked which of the workers in the public health infrastructure would be most apt to advance rural family planning services. Mrs. Chater's answer was the infirmiers hygienists. Mrs. Chater qualified her response, however. She said that these public health nurses first must be trained, and then attached to mobile teams. They need to learn how to talk with prospective clients. Their employment presents problems, Mrs. Chater said, because, unlike the personnel at the MOSA, the infirmiers hygienists are not trained for social analysis and discussion, they carry a full workload already, and they do not have a broad view of people and their contexts.

Mrs. Chater observed that the minister of health, an administrator but not a physician, and she had been appointed at the same time. They have traveled together to many governorates, discussing integration and attending meetings of regional public health councils. The minister of health is a strong supporter of family planning and integration. He agrees with Mrs. Chater that services for and education of the public must be provided by health and family planning workers who visit together mosques, souks (markets), factories, etc. Mrs. Chater emphasized that these workers must coordinate educational efforts during special disease campaigns, well-improvement programs, campaigns to clean up the environment, vaccination campaigns, etc. The value of the education should be judged locally. In Tunisia, populations either are or are not convinced; they know what they do and do not want. It is for this reason that motivational work is difficult.

Mrs. Chater agreed with Mr. Thraya that broad-scale distribution of condoms by infirmiers hygienists would be counterproductive, and only those who request them should receive them. She said that people must be told about the problems of population so that they will understand the WHY of the national program. Mr. Ghachem believes that it is better to direct people to family planning centers for contraceptives, and not to distribute the products among households, to avoid the danger of misinformation. Mrs. Chater said that the minister of health intends to produce a circular specifying the specific roles of various public health employees in family planning. The pamphlet probably will not be released until May, after the Neodestour Party Congress convenes.

Mrs. Chater does not favor the distribution of oral contraceptives by paramedical workers, or even by social workers. She is willing to conduct careful tests using the infirmiers hygienists, but not lower-level workers. Ms. McEvoy pointed out that lower-level staff have been used successfully in Jendouba. Mrs. Chater countered that local populations can be difficult and fussy; they may, she said, walk ten kilometers to a pharmacy or to the Circumsciption Hospital, ignoring the nearby dispensary, to get what they want. The ONPFP will pay more attention to distribution in the private sector in order to track purchases. With the aid of the director of the Central Pharmacy, the ONPFP is designing a series of forms to determine where large volumes of pills are being purchased. They will try to determine, for example, whether clients in poor communities such as Mellasine bought significant amounts of the 914,000 cycles sold in 1980. In the rural areas, the number of small pharmacies penetrating the country is increasing rapidly. The ONPFP wants to track pharmacists who circulate among markets on their special days.

Dr. Brown and Mrs. Chater said that they had discussed some of the components of a strategy for an enhanced rural program. Mrs. Chater said that well-considered action plans should be forthcoming from the series of etudes ponctuelles (local studies of current conditions). A week would be devoted to an analysis of performance in 1980, and locally-adapted action-strategies would be formulated. In 1980, performance in Gafsa and Le Kef was poor, but good in Sfax. Although performance was poor in Kasserine, it has begun to improve. All the problems must be identified and appropriate solutions must be found.

Dr. Thorne commented that such decentralized, but assisted, evaluation was excellent. He asked whether provision had been made for continuous monitoring of targets and intermediate indicators (this was recommended by the evaluators; see page 21, English version).

Mr. Thraya replied that the delegates need to be trained to plan, program, manage, and train other workers, and not simply to do promotional work themselves. Mrs. Chater rejoined that she did not think that personnel in the governorates could provide training; public information, yes, but training, no. Mr. Thraya, she said, should go out to do the training, and deploy central ONPFP staff to the regions. Mr. Thraya replied that training was a technique that could be taught to the delegates, although this has never been done. Mrs. Chater replied that it is a responsibility of the regions and governorates to apply, to implement, decisions and programs.

Dr. Thorne referred to Figures 4 and 5 in Appendix E of the report, and asked how the ONPFP intends to keep track of decisions, of what has been done, and of what remains to be done. Mrs. Chater said that Dr. Brown had asked the same question. The ONPFP is just beginning to develop new approaches to management. Its first tasks were to develop teamwork and decentralize operations to competent delegates who report directly to Mrs. Chater but who are coordinated by Mr. Ben Amor, Mrs. Chater's chief

of services. Mrs. Chater wants to remove family planning from the realm of "special projects" so that it can become part of routine, ordinary work. Mrs. Chater indicated that, of course, rural areas must receive special attention, but she is not certain that a special mechanism will be needed to manage activities in these areas. She is at this time breaking in several new administrative systems, and will be some months before it is known whether these systems will work or whether some new, special arrangement will be needed.

Dr. Dali and two physicians are coordinating medical activities. Mr. Benzarti is trying to eliminate gaps in the communications programs. A simple reporting form is being filled out by doctors. Mr. Griba travels around constantly with the form. These various efforts are just beginning; in six months, it should be obvious either that the efforts are working or that something more dynamic is needed.

Mr. Griba, the director of material resources for services, Administrative Section, is an inspector; he reports directly to Mrs. Chater. Mrs. Chater is following Mr. Griba's progress; in three or four months, she will be able to describe the evolution of Mr. Griba's role and determine whether or not he has been integrated well into the program.

According to Mrs. Chater, the ONPFP has introduced a new method to plan overtime. Officials are throwing out ideas and waiting to see how their personnel react to them. Field personnel are being asked to identify problems and to help decide what needs to be done. Each year progress will be reviewed, and staff will determine what needs to be done. This approach is new, and it will take time to take effect.

In concluding the discussion on March 24, Mr. Thraya noted that, since 1980, the ONPFP has been in a new, a "scientific," phase. He said all staff are learning a new language, and that it will be several years before everyone is speaking the same words. He added that he will be providing extensive training in the regions to further progress.

March 25: Dali, Mansour, Ghachem, Betbout, and McEvoy

Dr. Rafaat Dali, chief of the Medical Section, Dr. Farouk Ben Mansour, medical inspector, Mr. Ghachem and Mr. Hamadi Betbout of Bilateral Cooperation, and Ms. McEvoy joined the consultant for discussions on March 25.

Dr. Dali complained that he never received the evaluation report (although he was a member of the team that evaluated both Phase I and Phase II). Mr. Ghachem complained that Dr. Dali had not returned the evaluation sheets based on the Phase II report. He sent the sheets to Dr. Dali in May and June 1980, and then sent another reminder in November.

The group reviewed the section in the report on efforts to strengthen family planning services (see page 15, English version). Dr. Dali noted that twenty-five new dispensaries providing family planning services have

been erected. Both the medical and paramedical ranks have been strengthened, and a large group of doctors, approximately 450, was graduated in 1980. The first group of students was graduated from the facility in Sfax that year. All are receiving some training in family planning. The number of paramedicals is increasing, too. "Integrated medicine" has advanced under the leadership of the current minister of health, who has asked that all dispensaries in Tunisia provide family planning services. The Minister has issued instructions to the regional public health directors to oversee the effort.

Decentralization is bringing support activities closer to dispensaries, but the quality of clinical services is being called into question. The program is not, Dr. Dali said, capable of delivering services of the quality that the population is demanding. There are still deficiencies in equipment and personnel. Quality-control is being monitored by Dr. Dali, and by Drs. Mansour and Kachid, during field visits. More than a year ago, Dr. Dali instituted a system of self-evaluation by the mobile teams; this kind of appraisal has since been discontinued; the mobile teams now send their logs directly to the Population Division, where routine statistics are compiled. (This was the procedure followed earlier.) However, the Medical Division continues to review the workbooks (carnet d'activité) of the supervisory midwives.

It is important that norms for surgical activities be established. All service records have been reviewed with the World Health Organization (WHO).

The use of midwives to insert IUDs is working well. The number of insertions has increased considerably; so has the number of withdrawals, but this fact is not disquieting. The phenomenon has been studied in two delegations, one in Gafsa. It was found that the Copper T is very popular, but the Lippes Loop is not. The program changes the Lippes every two to three years on request. The private sector, the study showed, is becoming increasingly important as a source of family planning services.

The group discussed revitalization of the postpartum program (see Section G, page 18, English version). All agreed that a monster has been created. Efforts in the maternities of Tunis, Sousse, Sfax, Bizerte, Beja, and Jendouba have been beset with numerous problems as staff have sought to bring motivational activities to the bedsides of parturients. The health personnel were especially upset when they learned that special payments would not be made for family planning motivation. Both Drs. Dali and Mansour are pessimistic about the postpartum program, which is mired in administrative and organizational, and not medical, problems.

One and a half months ago, an official decision was made to market the micropill, Miligynon. Minidryl is one of the pills that has been selected.

The group turned to a discussion of the effectiveness and efficiency of the mobile teams. Dr. Dali said that he no longer knows how the teams

are faring. He no longer receives reports on their activities; reports now go directly to the Statistical Section. Anything that concerns the organization of services is referred to the PDG's office. The Family Planning Directorate has been eliminated. "We have become simply a Medical Section," Dr. Dali said. "Before, we were in direct contact with the Education Section and the other sections, as well as with the delegates, but no longer. Now we all report to the General Directorate." The management of fieldwork is being decentralized, but the supporting services of the ONPFP have become more centralized.

Seminars in maternal and child health and family planning continue. The number of seminars has even been increased.

Dr. Dali is optimistic about integration which, he says, is advancing slowly. It may take another four to five years before services are integrated completely. The physicians in Tunisia who are completing training will spend more time on preventive activities, including family planning. Unless the ratio of doctors to population increases, physicians will not have the time to do family planning work. (Doctors now see as many as one hundred women each day.) The midwives are inserting IUDs in women in the maternities; their work is satisfactory. The shortage of midwives, long an obstacle in the program, is being relieved as more midwives enter and complete training.

According to Dr. Dali, family planning services are being delivered and are well accepted by the population everywhere where there is a hardworking, motivated provider of services (e.g., Mrs. Gargouri in Sfax; project staff in Jendouba; staff of the Dutch project in Le Kef, who worked with two gynecologists; the hygienists and the other team members in Gafsa; staff of the community medicine program in Sousse; etc.).

The Committee on Integration ended its work five months ago and issued a final report, as did the Committee on Basic Health Services.

The consultant asked how new, special programs and family planning methods are being introduced, and about the uses of the existing infrastructure (see page 26, English version). Dr. Dali said that the question should be directed to Mrs. Chater, because such things are "above the level of the medical division." Asked about the potential role of the traditional birth attendant (TBA), Dr. Dali remarked that the TBAs still deliver more than 50 percent of births in Tunisia, but he cautioned it would be indiscrete of him to comment further on the subject.

In reviewing his notes on this and other interviews conducted during his visit, the consultant concluded that working relations between Dr. Dali and Mrs. Chater, and between Dr. Dali and Mr. Ghachem, are strained.

March 25: Benzarti, Bousnina, and McEvoy

The consultant met on March 25 with staff of the Information, Education and Communication (IEC) Section, including Mr. Benzarti, the chief, and Mr. Yahia Bousnina. Ms. McEvoy also participated in the discussions.

Mr. Benzarti presented a detailed plan of communications activities. He noted that the IEC Section is preparing an inventory of materials on hand, and assessing their quality, and identifying the particular subgroups for which they would be most appropriate. Staff want to develop a simple flyer on each method, especially for use in rural areas and with illiterates. Before, each governorate was free to set up its own communications program; now, there will be more contact with the central ONPFP and more concentration on the development of a communications program. The IEC Section is requiring the delegates to submit a monthly report on not only the number of meetings held, but also on the quality and content of the meetings. The level of skills of both the delegates and midwives vary significantly; thus, a series of seminars will be held to upgrade skills and to ensure that all health personnel have the skills they need. A schedule of regional educational activities was prepared covering the period December 23, 1980 - March 28, 1981. The schedule reflected the need to restrict expenses (see page 32, English version).

During her visit to the program in October 1980, Ms. Casanova provided three documents designed for rural populations in Mexico. The material had been pretested on women in Kasserine and Sfax. The use of non-written picture stories seems to be a good idea, but specific symbols must be changed. Five women in Kasserine and twenty women in the MCH center in Sfax correctly identified the object(s) in a picture when asked, "What do you see?" Some things, such as the three calendars in a row, were not understood. Changes had to be made (e.g., the hen had to be replaced by a rooster to depict daybreak in Tunisia).

It would be feasible to prepare eight ten-page picture presentations on each method. Ms. Casanova's flyers have been shown to students at the School of Fine Arts. The students have been asked to revise the models to reflect conditions and situations in Tunisia. Mr. Bousnina is calculating the costs of reproducing the materials for use nationally. It is not certain that the materials will work; they must be pretested. Ms. Casanova's report on her study has been translated. It may be of use to those who are modifying her model. Both the initial, Tunisified, model and the final model will be pretested.

Dr. Thorne complimented the staff of the IEC Section on their effort to pretest the models. In the past, pretesting often has not been done. All agree that it is the key element in the successful production of educational materials well adapted to specific target groups.

Dr. Thorne asked why the staff have not produced a replacement for the simply illustrated handout, "To Be A Mother, To Be A Fatner," which had been particularly popular among field staff because it could be given to a client, and contained clear, simple pictures that helped the client remember what had been explained. The booklet seemed to be useful; why, then, did the ONPFP stop using it? Mr. Ghachem said that a search had been made for better materials, for pictures that did not show genitals. Personnel at headquarters want new things, he reported.

From 1974 to 1977, an increasing number of professionals working in family planning became preoccupied with educational materials. Intermediate-level and political personnel were the main targets for communications materials; clients and prospective clients received less attention. An eight-page flipchart on the "rural exodus" was produced for Rural Cooperation with the help of the International Labour Organization (ILO). Materials were produced for use in the "organized sectors" (e.g., factories). In 1973, staff began to use radio. There are now four transmissions each week. Television once was used. The ONPFP shifted away from use of simple flyers for prospective rural and illiterate clients, but it is beginning once again to employ them. Because 92 percent of women know about contraception but only 25 percent practice it, and because discontinuation rates are high, the ONPFP is opting for one flyer for each method: the IUD, sterilization, and pills. These materials, and not written texts, will be needed to implement the ONPFP's rural strategy.

March 25: Kilani

In the absence of Mr. Charfeddine, who did not return until the afternoon of March 26, Mr. Kilani, from the Research and Evaluation Section, met with the consultant.

Commenting on service statistics for 1980, Mr. Kilani suggested that the 20 percent rise in the number of IUD insertions could be attributed primarily to the popularity of the Copper T, introduced in 1979, to the enthusiasm of certain doctors, and to the "Arab Telephone" (word-of-mouth communication). A number of physicians have said that the Copper T is easier to insert than the Lippes Loop, which remains in stock in certain governorates even when supplies of the Copper T are exhausted. A certain proportion of women are switching from pills (down 11 percent in 1980) to the Copper T. The results from an initial distribution of pills in Jendouba were encouraging, but use of the pills later declined sharply.

Competition from the private sector is an important factor in recorded pill use in the public sector. The results of a survey of private physicians will be presented at a round table on the private sector on April 11. Mr. Kilani thinks that contraception in the private sector is much higher than the figure now cited: 10 percent. Pills can be purchased in the private sector for as few as 50 millimes a cycle--a strong incentive. Pharmacies are being set up throughout the country. Kairouan had only

three pharmacies in 1963; it now has fourteen. The ONPFP should encourage and use the private sector carefully. Some young women obtain their pills directly from a pharmacy. Some Tunisian physicians would prefer that women who have not had a medical examination not receive pills. Young physicians especially want to guard against the spread of rumors and medical complications, such as anemia. Dr. Thorne noted that some studies have shown that the hemoglobin levels of women on oral contraceptives increase, but decrease slightly when women use IUDs. Mr. Kilani pointed out that in a 1973 survey increased spotting was reported among women on pills.

Dr. Thorne asked Mr. B'chir's hypothesis that older women are abandoning contraception to conceive. Mr. Kilani is doubtful that there is sufficient evidence to support this claim.

Acceptance rates for tubal ligation have stagnated. Mr. Kilani, hazarding an explanation, noted that, earlier, there had been great competition among some of the governorates to produce high acceptance rates because of the Bourgiba Prize. When the novelty of the prize wore off, the effort was abandoned, at least in part. Where services are good and where a female physician is available, response is good. But, because economic, religious, and cultural activities vary among Tunisians, strategies must be developed especially for each region. Objectives have to be formulated in each delegation and governorate. Earlier, the delegate was a political representative of the ONPFP; now, he must travel to local areas, stay long enough to engage in real dialogue with the population, and scientifically analyze what can be undertaken in each region. Having reviewed the results of earlier research and evaluations by the ONPFP, Mr. Kilani sees the need for a new approach. He believes new methods are needed to identify and rectify problems in providing services, ensuring the participation of physicians, and educating the populace.

Ms. Laila Haouia, an economist recruited at Dr. Thorne's request, presented the service statistics for 1980, arranged by method and governorate. Ms. Haouia had calculated the percentage change from 1979 to 1980 for each method, but she became unnerved when the consultant copied several of her figures. She said that the 1980 statistics were not "available" because they were "only provisional and certain governorates were missing."

In 1980, Gafsa had the highest incidence of new pill acceptors in Tunisia: 67.0 percent, almost three times the national average of 24, and almost twice as high as the rate for the next governorate (37). Why? Mr. Kilani offered several reasons. Gafsa is the second most urbanized governorate, after Tunis, because of the mines. The Tuniso-Belgian project recruited personnel from the region and reached every corner of the governorate; the result was high acceptance rates. The same results were produced in Bir Ali Ben Khalifa and Jendouba, where intensive efforts led to high acceptance rates, which subsequently declined sharply when the

projects ended. The UNFPA is now doing a study of special projects in Beja, Kef, Nabeul, Bir Ali Ben Khalifa, Jendouba, and Gafsa. It is examining the infrastructure of the projects, and their objectives and accomplishments, to try to determine what might be the best approach in Tunisia.

Kairouan has had a new delegate for five months now; there, pill acceptance has increased to 28 percent. The delegate from Gabes went to Monastir in early 1980. Gabes was taken over by Mrs. Gargouri, who also runs Sfax. All three governorates did well in 1980.

Incidence of IUD insertions rose in eleven of the fifteen governorates, or pairs of governorates, which reported statistics for 1980. In eight of the fifteen governorates, the rate of incidence was at its highest in seven years. Nationally, IUD insertions increased to 35.0 per 1,000 women of reproductive age, also the highest point since 1974 (see Appendix D). The trends in 1980 in use of IUDs, pills, and tubal ligations, for Tunisia and for each governorate, are depicted graphically in Appendix C.

Tubal ligations in 1980 remained constant at 9.3 per 1,000 MWRA, falling in nine of the fifteen areas (see Appendix E), but rising more than 5 percent in six others. Incidence of tubal ligation was at its lowest point in seven years in four areas, and for Tunisia nationally. These results fall short of the optimistic projections contained in the report on Phase II (see Appendix F).

The incidence of new pill acceptors fell in all areas but Kairouan in 1980; nationally, it declined 11 percent.

The number of new users of condoms also was reported to have declined 8 percent for Tunisia in 1980; use of jellies rose 33 percent.

(These calculations were made in Baltimore using the 1980 statistics obtained from Mr. Charfeddine (see Appendix A) just before Dr. Thorne departed. Although Mr. Charfeddine calculated and analyzed the 1980 trends before he departed for Geneva, the ONPFP did not make available his reports. The consultant presumes that the poor national showing, with little change in contraceptive prevalence, which these figures indicate, made this a sensitive subject for the new PDG during the time of transition.)

Mr. Kilani reviewed the current status of research and evaluation activities (see page 34 of report). The survey on continued use of the IUD and pills is nearly completed. Staff have made tabulations, but they are waiting for a computer program from London to analyze the marginals. The first results should be available by June. There has been some delay in constructing the variables. Dr. Bernard advised that continuation surveys be made every five years. A request for another survey in 1983 has been submitted to the AID and the UNFPA.

The results of the national fertility survey are in the computer in London. Mr. Chekir will be returning with the complete tabulations. Preliminary reports should be available during the third trimester, and the final report should be ready by the end of 1981. The results of a study on "social" abortions (child-mothers, illegitimates) in the 1970s also should be available by that time. Twenty women remain to be interviewed, but analysis has begun. An analysis of special projects is expected in June.

An economist, Mr. Mohamed Hachem, was recruited one and a half months ago. He will work with Ms. Haouia on a study of the cost-effectiveness of the mobile teams.

A study on the cost and value of infants is being programmed by the demographer Baraket and the psychologist Moncef Nasser.

Mr. Bouraoui is working on a study on the perceptions of children and the size of families.

The results of a 1977 study on abortion are in the computer. A final report is expected by the end of 1981.

The series of round tables to share the results of research is working well. The third round table was held on March 14. At that time, Mr. B'chir presented his theory that contraception is abandoned at later ages, although he could not substantiate his claim. Evidence on which to judge the value of this opinion will be forthcoming from the fertility survey.

The results of Mr. Mohamed Ayad's initial analysis of the cost-effectiveness of using family aides were too sketchy. Mr. Ayad concluded that the effort was too expensive, but he failed to mention the source of his comparisons. Mr. Bouraoui is now collecting the information from the delegations which is needed to analyze Mr. Ayad's findings.

March 26: Nacef, Rejeb, Charfeddine, and Thraya

On March 26, the consultant met with Dr. Taoufik Nacef, who is in charge of the Ecole de Cadres and the Department of Social and Preventive Medicine, University of Tunis. Dr. Nacef is revising the nursing curriculum for a modularized approach. He has had little contact with the staff of the ONPFP.

Dr. Habib Rejeb, who also participated in the March 26 meeting, has not discussed either with Mrs. Chater or staff of the ONPFP the integration of family planning into the Central Tunisia and Siliana-Sidi Bou Zid Project. Dr. Rejeb believes that integration will be successful only if responsibilities are identified clearly and assumed by the designated

staff (see memo to ONPFP staff, 1975). Dr. Rejeb travels often to the field. He is extremely weary of working in the central bureacracy.

At his brief meeting with Dr. Thorne, Mr. Charfeddine said that he had had four three- or four-hour working sessions in Geneva with Dr. Roger Bernard. He said he had prepared statistical analyses, with narrative interpretations, before he left for Geneva; he was surprised that these analyses had not been given to Dr. Thorne.

Also present at a March 26 meeting was Mr. Thraya, chief of training. Mr. Thraya does not approve of sending the form to the delegates; he does not think this tactic will produce the information staff need to program field activities. He feels that the views of clients, the population, and service providers should be recorded, in addition to the opinions of the delegates, some of whom he thinks are neither competent nor, perhaps, trainable.

Dr. Thorne and Mr. Thraya discussed the utility of teaching delegates how to use the Nominal Group Process and Force Field Analysis (FFA) to collect and focus the views of others. Dr. Thorne pointed out that the form for delegates contains two of the three parts of the FFA (it does not identify possible solutions). Mr. Thraya is reasonably content that his approach to upgrading the skills of delegates and to developing subprovincial plans of action is being recognized and acted upon.

March 26: Chater (Debriefing)

At the March 26 debriefing with Mrs. Chater, Dr. Thorne explained that, although he had received the cooperation of ONPFP staff and had useful discussions about various aspects of the ONPFP's 1980 program, he had not been able to make a satisfactory, systematic review of Part II of the evaluation. He offered several explanations. First, he said, none of the ONPFP staff he interviewed had read the entire report. Second, only one division head, Mr. Thraya, had completed the evaluation review sheets distributed to ONPFP staff in November 1980. Three, because both Mrs. Chater and he had arrived only the day before the scheduled two-day review, neither had had time to prepare adequately for the task. Fourth, Mrs. Chater wanted to have in hand the results of an assessment of the problems in each province, and a list of recommended solutions, to rethink and devise a new program strategy. Several months are needed to collect and analyze this kind of information. Fifth, the statistical analyses were not available to the consultant because Mr. Charfeddine had not been able to return from Geneva on time.

Dr. Thorne suggested that a complete review of the report be deferred until June, when Mrs. Maguire, who was scheduled to visit Tunisia at that time, would be able to participate. It was agreed that by June all ONPFP

staff concerned with the review would have read the entire report and completed the evaluation sheets. Statistical reports and draft projections also were to be available.

Mrs. Chater suggested that the forms might be a problem because staff, fearing embarrassment, are reluctant to commit themselves to written responses. Dr. Thorne sympathized, and suggested that staff be allowed to keep their forms, using them only as personal, detailed notes. To this, Mrs. Chater replied, "Yes, to ensure that they go through the necessary mental gymnastics."

Dr. Thorne confided that he had expected that Mrs. Chater would have wanted to assemble all her principal staff around a table and listen to their points of view as they systematically covered the more than four hundred points in the report. At this kind of session, Mrs. Chater could have been given a comprehensive overview of the programs and major issues, although, of course, she could have entered into the discussion whenever she felt disposed to do so.

Dr. Thorne presented graphs of trends in incidences in 1980 for each method (i.e., total number of new acceptors of a method divided by total number of married women of reproductive age). He had calculated these figures easily, using the clear, self-instructional format that Mr. Charfeddine and Dr. Bernard had prepared in March 1980 (see Appendix C, Graph C-1).

Dr. Thorne's calculations showed that the number of IUD acceptors had risen 19.5 percent, from 29 per 1,000 MWRA to 35 per 1,000 MWRA. Mrs. Chater is sure that this trend will continue. The increase, it was pointed out, was due in part to the popularity of the Copper T. The large number of withdrawals was not discussed, although it was agreed that the staff's willingness to remove IUDs is psychologically reassuring to prospective acceptors. Mrs. Chater wants acceptors to be analyzed for anemia and infection. She also wants good follow-up.

Use of oral contraceptives is down 11 percent, from 27 to 24 new acceptors per 1,000 MWRA. Mrs. Chater noted that the statistics are only for the public sector; sales of pills in the private sector probably will continue to rise. Mrs. Chater has requested that a survey be made, governorate by governorate, to track the distribution of pills in the private sector. According to the director of the Central Pharmacy, 914,000 cycles of pills were sent to private pharmacies in 1980; this was almost double the amount (480,000) reported for 1979. Mr. Ghachem said that because a large number of pharmacies had been opened in the past several years in smaller communities, the availability of pills will increase and more pills will be distributed.

The number of tubal ligations performed in Tunisia remained constant in both 1979 and 1980: 9.3 percent. Mrs. Chater said that the issue of

tubal ligations was complex. She explained that the number of operations had not increased, partly because physicians are not available and services are poorly organized. Mrs. Chater said she was working directly with the delegates to improve the organization of services throughout the governorates, to increase both productivity and efficiency. She herself is initiating a program to contract with general surgeons to do tubal ligations specifically in Medenine, Gafsa, and Sidi Bou Zid. Dr. Thorne agreed with Mrs. Chater that general surgeons should do as well as gynecological surgeons, provided they perform a sufficient number of tubal ligations to keep in good practice, but he asked whether it is feasible to try to improve the organization of the expensive infrastructure at this time, considering the restrictions which would be imposed on the budget.

Other figures were cited at the debriefing. It was learned that use of condoms and foams has risen 5 percent, from 17 percent of MWRA to 18 percent of MWRA. The number of abortions has increased slightly, 3 percent, from 22 percent of MWRA to 23 percent of MWRA. Overall, total contraceptive prevalence probably has declined. One could conclude, therefore, that it would be especially difficult to reach the goal of 20,000 averted births per year, which Mr. Mansour Moalla of the Ministry of Plan referred to as that "heavy call upon us," and which Mrs. Chater mentioned during her discussion of the ONPFP's role in the pending Sixth Five-Year Plan.

The projected incidences (see Figure 11, Appendix F) will need to be revised. Dr. Thorne suggested that the ONPFP use a splay of projections--simple continuation of past trends, an ademagraphically optimal projection, and two intermediate trends--to show the results of moderate and concerted efforts to increase the services the program provides. Mrs. Chater said that she is an active member of an inter-ministerial ad hoc planning commission that is reviewing population projections for the Plan; she added that she is asking other ministries to specify what they may be able to contribute because their efforts must be coordinated with the activities of the ONPFP to ensure that population growth rates are reduced.

Mrs. Chater and Dr. Thorne agreed that a detailed analysis could be made of family planning services in each governorate to determine where improvements could be made. The analysis would show also where services are being provided correctly. Correct approaches could be followed elsewhere. In other words, management by exception probably would be the most effective way to improve national total program performance, the consultant suggested. Mrs. Chater said that she intended to delegate responsibility for such an analysis to the delegates, with whom she is working directly; she added that she is developing a program to upgrade their skills and to provide education and guidance in analysis and planning. She cautioned that this would take time but added that the fruits of the effort probably would begin to appear by mid-term. The effort, Mrs. Chater said, has the support of the ministers of health and social affairs, as well as the support of the governors. (Mr. William Gelabert concurred later that, in his judgment, a fundamental reappraisal of the strategy to provide family

planning services in Tunisia is being undertaken and that it is likely that the efforts of the various government services will continue.)

Mrs. Chater said that, because of initiatives, performance in Sfax has improved significantly and some progress has been made in the lagging governorates of Gabes, Kairouan, and Medenine. Mr. Griba, Mrs. Chater's coordinator, is providing feedback from the regions.

In discussing the rural strategy, Mrs. Chater said that a new approach must be found. It is still not clear what lessons can be drawn from the results of performance in 1980. Mrs. Chater is trying to improve the infrastructure. Once she has in hand the results of a detailed analysis of the situation and possibilities in each governorate, she will be able to develop a strategy that can be reviewed by the governors and other authorities whose support is needed. On February 11 and 12, 1981, Mrs. Chater met with the delegates to reexamine strategies. The group decided that it would have to reexamine, for example, the schedules of the mobile teams. If there are few acceptors in places where the teams stop, it may be more efficient to reduce the number of visits to those sites, increase the number of visits to other sites, or visit previously unserved areas. Detailed geographic studies have been initiated to identify the needs of communities with populations of 2,000. No special committee, group, or person is monitoring progress or attempting to develop strategies to provide family planning services in rural areas.

Mrs. Chater said that integration is considered essential to the expansion of services. The minister of health, appointed at the time Mrs. Chater assumed her position, has traveled often with Mrs. Chater to the governorates. They have discussed at length the issue of integration, and they both agree that it is important. The minister of health has spoken to health personnel in the governorates and has distributed a special circular in which he emphasizes the responsibility of health personnel to provide family planning services. Mrs. Chater's strategy is to identify, through her delegates, the organizational resources in each governorate that can be tapped or coopted to provide family planning services. (In an earlier, brief interview with Dr. Thorne, Dr. Rejeb said that he has not discussed either with Mrs. Chater or staff of the ONPFP the integration of health and family planning activities in the Siliana and Sidi Bou Zid Project.) Dr. Thorne pointed out there is rivalry between the MCH administrators and the ONPFP delegates, and that this is presenting a problem. Mrs. Chater replied that the current minister of health had discussed the issue with the administrators during his field visits and had distributed a circular in which he urged the administrators to advance family planning and to schedule a meeting every three months to review family planning efforts in their governorates.

In response to Mrs. Chater's request to share negative impressions, Dr. Thorne said that he had observed strain in the working relationships

of staff of the Medical Division and others at the ONPFP. He said that an apparently good system had been installed to ensure the rapid review of the field reports on family planning activities before they went into the files of the Statistics Division, but that that system had been disrupted. The monthly reports from the mobile teams now bypass the Medical Division and go directly to the Statistics Division, where, as before, they remain until the information is compiled periodically into routine reports. Mrs. Chater said that everyone in the ONPFP has been meddling in everyone else's business. To correct the situation, she has defined the roles of central personnel so that everyone will know their own limits and responsibilities. She also has promoted the concept of teamwork. The Medical Division is responsible for ensuring the medical quality of FP services (e.g., it must ensure that IUDs are inserted under sterile conditions and that secondary anemia is detected and treated). The delegates must monitor and manage the FP services. They are in direct telephone contact with Mrs. Chater.

Dr. Thorne asked about the Central Tunisia Project. Mrs. Chater said that to the project known as "Famille Active" it would be possible to add rural FP activities. An economic map is being developed in each governorate and delegation to show even the location of sources of water. The results of these basic studies will become the basis for an improved strategy of action and will be useful, for example, in rerouting the mobile teams.

Mrs. Chater and Dr. Thorne agreed that good progress is being made in the training program, and especially in training the delegates in program analysis, planning, programming, and evaluation.

Dr. Thorne is encouraged by the initiative of staff in the IEC Section who, following the visit of Ms. Casanova, produced an illustrated handout for rural illiterates. Mr. Ghachem had admitted that, despite the success ten years earlier of the handout "To Be a Mother, To Be'a Father," the ONPFP had stopped producing materials for direct distribution to the population and had begun to concentrate on mass publicity and the production of materials that could be used by service personnel. The earlier prototype had been well received by prospective clients and was in constant demand because it was something that family planning workers could give to their clients to help them remember what they had been told. It is also encouraging that staff are pretesting the modifications of Ms. Casanova's materials which are being designed by students at the Ecole de Beaux Arts. Mrs. Chater commented that one female student at the Ecole de Beaux Arts did her *mémoire* on this subject.

Dr. Thorne raised the subject of research. Mrs. Chater said that she was particularly interested in practical research studies, the results of which could be used to improve operations and family planning services.

Mrs. Chater has tried to get the *animatrices sociales* and *assistantes sociales* to include more family planning in their regular activities. Dr.

Thorne noted that, traditionally, students at the training school were required to do surveys of conditions and attitudes in the home. The surveys included questions on family size and attitudes toward family planning. Mrs. Chater said that these kinds of surveys are important and would be continued. She noted that in 1978-1979, a "mixed team" that included medical students was organized by the Amical des Etudiants in Gabes to do a survey of attitudes and preferences. The effort was, she thought, an effective way to promote collaboration on family planning.

March 26: Gelabert (Debriefing)

Dr. Thorne scheduled a debriefing with Mr. William Gelabert, director of the mission, on March 26. Mr. Gelabert applauded Mrs. Chater's efforts to conduct a genuine planning exercise. The result, it is hoped, will be a truly Tunisian program in family planning that does not rely on the support of a central, foreign-funded organization. Mrs. Chater is trying to create a self-reliant, inter-institutional program that will be able to continue after the financial support of the United States and other donors has been withdrawn.

Forward financial planning is crucial to the ONPFP. Whatever arrangements are made, AID funding must be phased out entirely over the next three to five years. The recurring costs for gas, rent, salary supplements, and the like must be assumed gradually by the Tunisian government. AID support for IEC could be reduced to zero within three years. Support for laparoscopy (rental of the Ariana clinic) might be phased out sooner, perhaps within two years.

Mr. Gelabert doubts that Mr. Chekir would have made more progress than Mrs. Chater in this year of transition. On assuming her position as PDG, Mrs. Chater found that little had been done to establish relations with other Tunisian organizations. Mrs. Chater's performance at the Ministry of Social Affairs was impressive. She ran a sizable establishment, and whe was the only Tunisian in public office who could tell Mr. Gelabert what her operating budget was and how much it cost to run a service vehicle.

Mrs. Chater's emphasis on institutional changes probably is wise. It is only through institutional change that the ONPFP can operate a successful program in the rural areas, given the human and financial constraints that are present.

IV. CONCLUSIONS

IV. CONCLUSIONS

The following is a summary of the consultant's observations and conclusions.

- It was not possible to make an adequate review of the mid-term evaluation during this visit. The PDG, Mrs. Chater, agreed to reschedule the review to coincide with Mrs. E. Maguire's visit in June.

- The approaches to the organization, management, and targeting of the national program have been superseded by the PDG's new approach to and reassessment of the ONPFP. The new "scientific" approach decentralizes the elaboration of strategy to the delegates of governorates. The delegates will learn how to analyze local contexts and problems and to develop locally-adapted activities to promote the increased use of birth-control methods among specific subgroups of the population.

- The Division of Family Planning Services was eliminated when the ONPFP was reorganized. Working relationships between the staff of the new Medical Section and the offices of the PDG have been strained. Reporting has been centralized; all sections of the ONPFP and all delegates of the governorates now report directly to the PDG.

- No central organizational entity has been developed to monitor and manage nationally the important components of family planning services (e.g., provision of tubal ligation services). Nor has a rural strategy been elaborated and monitored.

- The ONPFP and the Central Tunisia-Siliana-SBZ Project have not coordinated program activities.

- The PDG has not obtained sufficient feedback from the governorates to reformulate a "rural strategy."

- The performance of the national program was poor in 1980, a year of many political and managerial transitions. The number of IUD insertions increased a substantial 20 percent. Withdrawals remained high, rising from 37 percent to 41 percent of total insertions between 1977 and 1980. The number of tubal ligations stagnated, rising appreciably only in Nabeul, Monastir, Sousse, and Sfax, and reaching seven-year lows in Kasserine, Siliana, Jendouba, and Beja, and Tunisia

nationally. The rates for new acceptors of pills declined in all governorates, except Kairouan; they fell 11 percent nationally.

- The Population Council is faced with the difficult challenge of programming assistance to improve family planning in rural areas. The ONPFP is reconsidering, but has not yet elaborated, the service strategies it wishes to pursue. It is now in the initial stages of a national reassessment of approaches to family planning, and it has decided to promote especially the use and participation of other Tunisian organizations at all levels--national, governoratal, and local. In the movement toward increased self-reliance, the PDG does not wish to have another full-time representative of an external agency (e.g., the Population Council) in Tunisia.

- The concern of Mrs. Chater and her staff, including Dr. Dali, for the quality of family planning services is evident. It is, probably, a response to criticism of the program, the limited use which the population makes of existing services, and reaction to the infrequent, but grievous, complications associated with some of the methods (e.g., anesthetic death, bowel perforation during tubal ligation). Although it is constructive to emphasize quality of service, the insistence on use of highly professional workers (e.g., use of social-assistance workers to educate and follow up clients, use of public health nurses to distribute pills, etc.) and declining funds for operations may lead to the limited coverage of rural populations and limited access to contraceptives. The PDG needs to formulate a strategy to cover dispersed populations that is based on a sound consideration of logistics and available manpower.

- The services projected for tubal ligations during the mid-term evaluation were unduly optimistic, and those for IUDs were pessimistic. A range of reasonable, alternative projections should be made for the next plan period.

V. RECOMMENDATIONS

V. RECOMMENDATIONS

The consultant recommends the following courses of action.

1. In June, the ONPFP should work with Mrs. Maguire to review systematically the mid-term evaluation. The diagnoses and strategies should be reviewed governorate by governorate using the results of the etudes ponctuelles prepared by the delegates. An assessment should be made of the role of the private sector and of ways to better use the expertise available there.

2. The AID and other donors should coordinate their support of the ONPFP's effort to decentralize and to adapt locally programs in family planning services.

3. The ONPFP should develop a clear, central mechanism to monitor and guide progress in the following key areas: increased use of birth-control methods in rural areas, ensured provision of quality tubal ligation services, and continuing availability of family planning services in all targeted areas.

   Some organizational mechanism must be found to monitor, actively and responsively, FP services to overcome the managerial impasse between the Medical Section and the offices of the PDG.

4. The AID should arrange for constructive, joint programming between the ONPFP and the Central Tunisia-Siliana-SBZ Project.

5. A special study should be made of obstacles to the provision of tubal ligations. A reanimated action program should be developed and implemented to capitalize on the large investment in manpower training and equipment, and on the potential impact that tubal ligations may have on fertility.

6. The ONPFP should move ahead briskly to develop, pretest, revise, and distribute widely to rural illiterates illustrated handouts on family planning methods.

7. Specific requests for social-assistance workers should be identified, costed out in terms of time, and compared with realistic workloads to assess, practically, how well these persons may be able to work with various subgroups of the population, particularly rural women.

8. The Population Council should be allowed to formulate a workplan and a schedule that can be adapted to the needs of the proposed project as it develops. Over the next year, it should be allowed to develop the specific details of a program of assistance to improve rural family planning as a rural strategy begins to emerge from the reassessment of the ONPFP's approaches.

9. More realistic family planning service projections will need to be calculated. The new calculations should reflect consideration of the service strategies adopted by the ONPFP following completion of the current reassessment.

APPENDICES

Appendix A

FAMILY PLANNING SERVICE STATISTICS FOR TUNISIA AND ALL GOVERNORATES (1980)

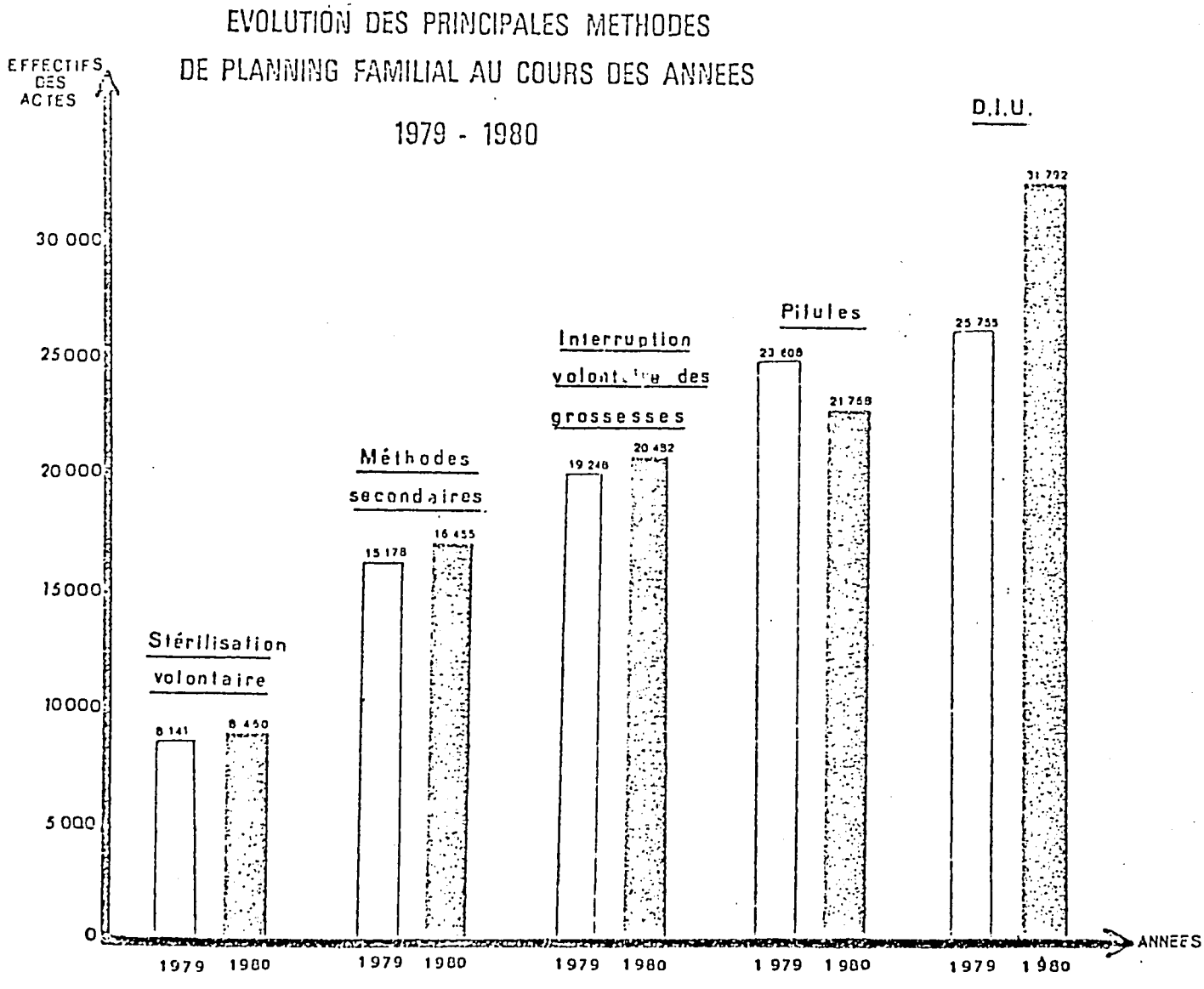
Appendix A

FAMILY PLANNING SERVICE STATISTICS FOR TUNISIA AND ALL GOVERNORATES (1980)

Méthodes / Gouvernorats	Total des visites	Contraceptrices		Insert. primair. de DIU	Retrait de DIU	Pilules			Condoms		Gelées		Ligatur. des trompes	Avortem. sociaux
		Nlles	Anc.			Nlles	Anc.	Cycles	Nlles	Anc.	Nlles	Anc.		
Tunis	83.906	18.020	42.763	7.834	2.432	3.665	6.125	17.910	1.870	560	841	154	2.306	8.084
Nabeuln	13.938	1.226	8.164	482	206	452	3.170	4.979	324	517	192	104	-	-
Bizerte	39.713	4.808	24.618	2.150	1.467	1.305	6.362	9.940	592	502	248	59	902	1.358
Béja	20.695	3.002	12.348	1.697	496	493	1.063	3.482	62	31	16	9	927	595
Jendouba	27.935	3.313	19.117	946	589	1.541	6.961	19.384	185	93	282	83	396	936
Kef	31.959	2.866	18.098	1.360	778	1.089	5.829	13.552	66	19	9	-	553	463
Siliana	19.858	1.733	12.237	799	202	935	3.871	5.326	64	45	20	9	18	22
Kasserine	19.149	2.673	11.972	1.239	305	1.301	4.998	9.094	68	59	211	163	42	413
Sidi Bouzid	13.984	1.277	6.136	464	182	498	1.635	4.235	91	107	456	176	-	-
Gafsa	41.410	2.941	25.353	1.032	730	2.568	12.336	24.756	480	186	309	39	73	932
Médenine	11.238	2.522	6.467	759	250	853	3.763	6.512	707	228	616	143	67	162
Gabès	31.073	3.575	18.836	827	329	1.711	11.319	14.522	745	452	613	116	200	287
Sfax	80.872	7.401	35.655	3.442	1.685	879	3.747	11.116	2.005	2.520	1.166	705	1.046	1.284
Kairouan	16.998	2.265	7.304	495	180	880	1.642	5.177	476	80	7	3	272	292
Mahdia	16.709	2.106	12.129	1.065	578	761	2.385	7.271	275	203	215	127	408	657
Monastir	25.987	3.656	16.333	1.729	506	1.016	4.259	6.526	431	722	591	142	269	750
Sousse	25.374	7.242	11.414	3.141	671	771	1.266	4.231	512	165	77	14	448	2.343
Nabeul	35.209	6.073	19.026	2.331	1.408	1.050	5.383	8.135	985	1.508	648	401	533	2.054
ENS. TUNISIE (1)	556.207	76.799	307.970	31.792	12.994	21.768	86.114	177.148	9.938	7.997	6.517	2.447	8.460	20.482
TUN.ENTIERE 79 (2)	521.933	72.700	303.034	25.755	11.652	23.608	97.027	196.916	10.442	8.855	4.736	1.905	8.141	19.248
TUN.ENTIERE 78 (3)	527.501	81.149	316.533	26.273	9.226	27.017	109.813	233.647	12.304	11.035	4.674	2.093	8.832	20.999
Rapport 1/2	1,07	1,05	1,02	1,23	1,12	0,92	0,89	0,90	0,95	0,90	1,38	1,28	1,04	1,06
Rapport 1/3	1,05	0,89	0,97	1,21	1,41	0,80	0,78	0,76	0,81	0,72	1,39	1,17	0,96	0,98

Appendix B

EVOLUTION OF THE PRINCIPAL METHODS OF FAMILY PLANNING IN 1979-1980



Le graphique ci-dessus fait ressortir que le niveau enregistré en 1980 par les différentes méthodes contraceptives - exception faite pour les nouvelles acceptantes de la pilule - marque une reprise par rapport à la baisse amorcée depuis la fin de 1977:

- *Dispositif Intra-Utérin : (DIU) + 23, 43 % (+ 6037 actes)*
- *Stérilisation volontaire : +3, 92 % (+ 319 actes)*
- *Interruption volontaire de la grossesse : + 6, 44 % (+ 1134 actes)*
- *Pilules : - 7, 66 % (- 1840)*
- *Méthodes secondaires (condoms, + gelées...) : + 8, 14 o/o (+ 1877)*

Les deux méthodes considérées comme les plus efficaces démographiquement, à savoir le Dispositif Intra-Utérin (DIU) et la Stérilisation volontaire, ont, en 1980, enregistré une hausse importante.

Il est à noter que ces données ne tiennent pas compte des activités du secteur privé.

PRINCIPALES MESURES DE CONSOLIDATION DES ACTIVITES DE PLANNING FAMILIAL EN 1980

Développement de l'Infrastructure:

. Ouverture d'une Clinique de Planning Familial au Bardo;

. Ouverture de 4 centres de Protection Maternelle et Infantile et de Planinng Familial dans les régions rurales;

. Création de 26 centres de consultation dans le cadre des centres de santé de base des cités de la ceinture verte de la Capitale;

. Equipement de 28 centres de Protection Maternelle et Infantile et de Planning Familial dans plusieurs régions du pays.

Amélioration de l'accueil et des services:

. Renforcement du personnel notamment le personnel médical et para-médical;

. Perfectionnement régulier des différentes catégories de personnel.
A cet égard, plusieurs médecins généralistes ont reçu une formation en Planning Familial, d'autres ont été formés en coelioscopie;

. Développement de la coopération avec les Ministères et Organisations nationales concernés.

Extension des services de Planning Familial:

. Création au niveau régional de deux délégations la première pour Tunis et sa banlieue et la deuxième pour le gouvernorat de Tozeur;

. Augmentation du nombre des équipes mobiles évoluant dans les zones rurales et rationalisation progressive de leurs circuits.

Développement de la Communication:

. Amorce d'une action de diversification des modes d'information;

. Adaptation du message au degré d'évolution du milieu.

PRINCIPAUX OBJECTIFS POUR L'ANNÉE 1981

— S'attacher, au niveau du terrain, à travailler d'une façon de plus en plus rationelle en procédant régulièrement au diagnostic de la situation, pour une adaptation constante des programmes de Planning Familial aux besoins;

— Rapprocher le plus possible les services de planning familial de la population en accordant un intérêt particulier aux régions rurales, aux zones périphériques des grandes villes et à la " ceintures verte " de la Capitale;

— Améliorer la qualité des services : accueil, prestations et surtout suivi;

— Intégrer progressivement l'action du planning familial dans les activités des structures de base de la santé publique, ainsi que dans celles de tout service, social éducatif et culturel qui peut aider à la promotion de notre politique de population;

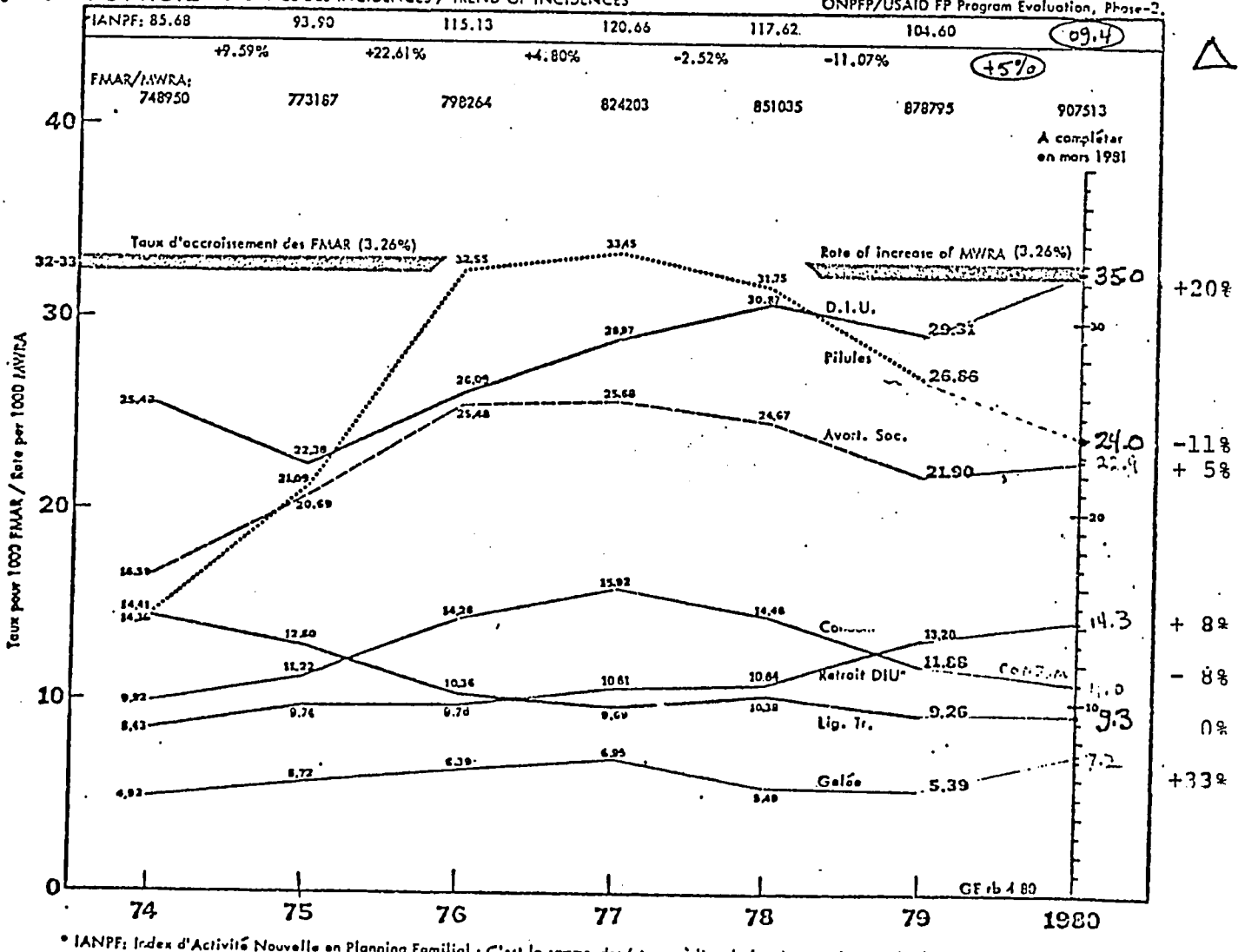
— Promouvoir et développer l'information de façon à donner à chaque couple la possibilité de décider, en toute connaissance de cause, de la taille de sa famille.

Appendix C

GRAPHS OF TRENDS IN ANNUAL INCIDENCE FOR ALL FAMILY PLANNING METHODS IN TUNISIA AND EACH GOVERNORATE (1974-1980)

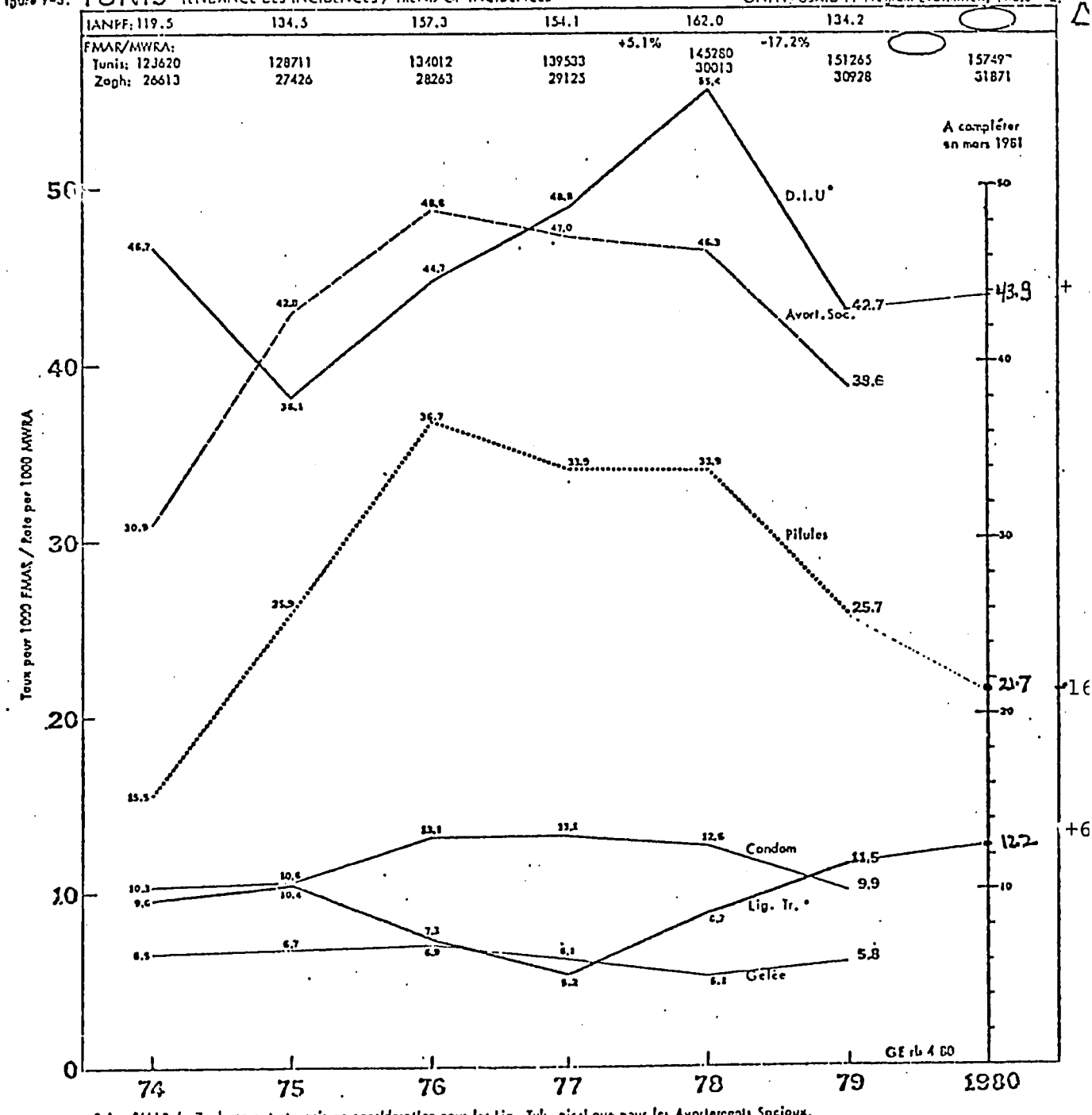
Figure 9. **TUNISIE** TENDANCE DES INCIDENCES / TREND OF INCIDENCES

ONPFP/USAID FP Program Evaluation, Phase-2.



* IANPF: Index d'Activité Nouvelle en Planning Familial : C'est la somme des 6 taux à l'exclusion du taux des retraits du DIU.
PFPAI: Primary Family Planning Activity Index: This is the sum of the six input rates, excluding the rate of IUD removal.

Figure 9-3. TUNIS TENDANCE DES INCIDENCES / TREND OF INCIDENCES ONPFP/USAID FP Program Evaluation, Phase - 2.



* Les FMAR de Zoghwan ont été pris en considération pour les Lig. Tub. ainsi que pour les Avortements Sociaux.

* The MWRA of Zoghwan were included in the denominator for the calculation of rates of Social abortion and Tubal Ligation.

Figure 9-4. BIZERTE TENDANCE DES INCIDENCES / TREND OF INCIDENCES ONPFP/USAID FP Program Evaluation, Phase - 2.

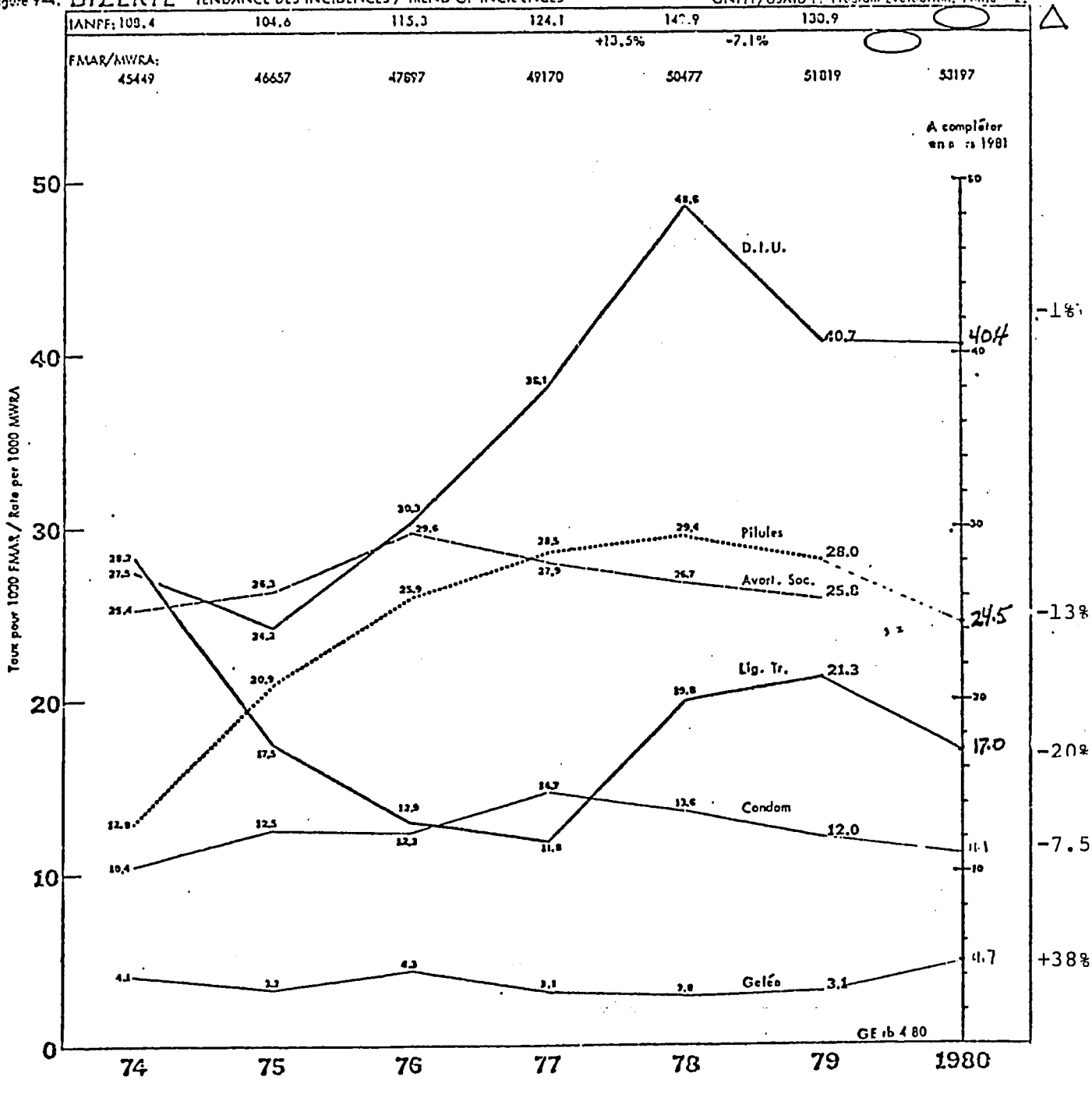


Figure 9-9 BEJA TENDANCE DES INCIDENCES / TREND OF INCIDENCES

ONPFP/USAID FP Program Evaluation, Phase - 2.

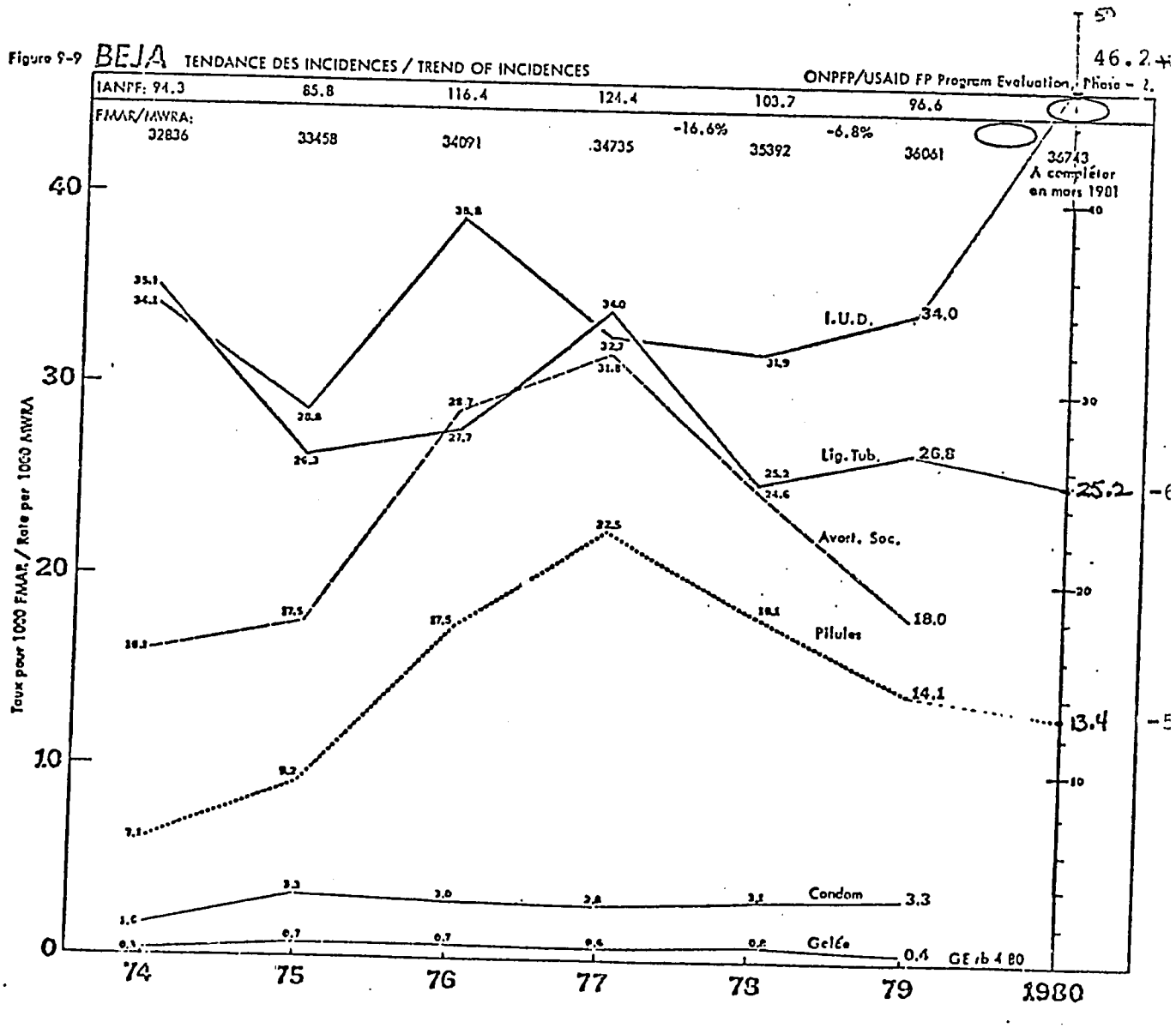


Figure 9-11. JENDOUBA TENDANCE DES INCIDENCES / TREND OF INCIDENCES

ONPFP/USAID FP Program Evaluation, Phase - 2

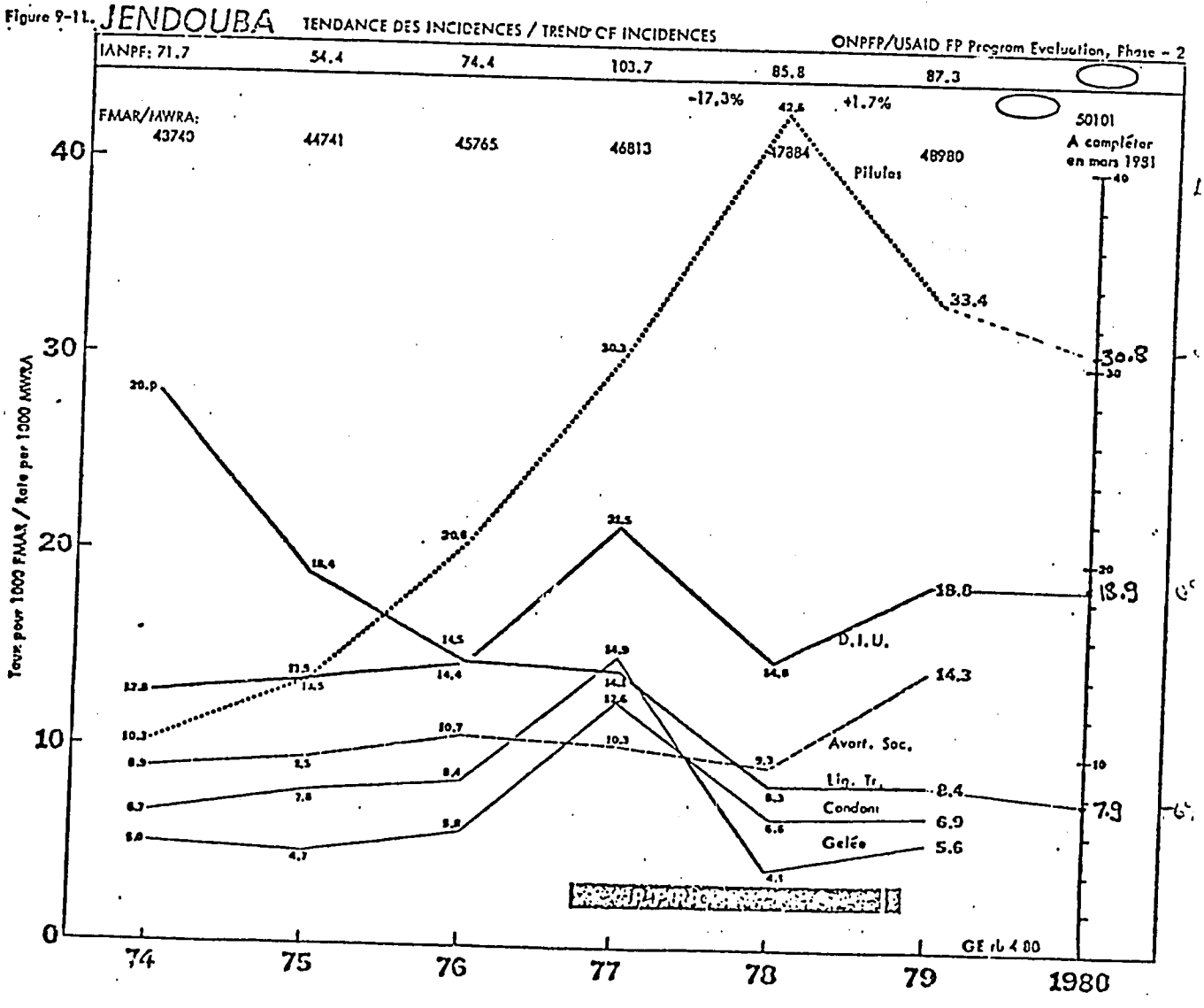
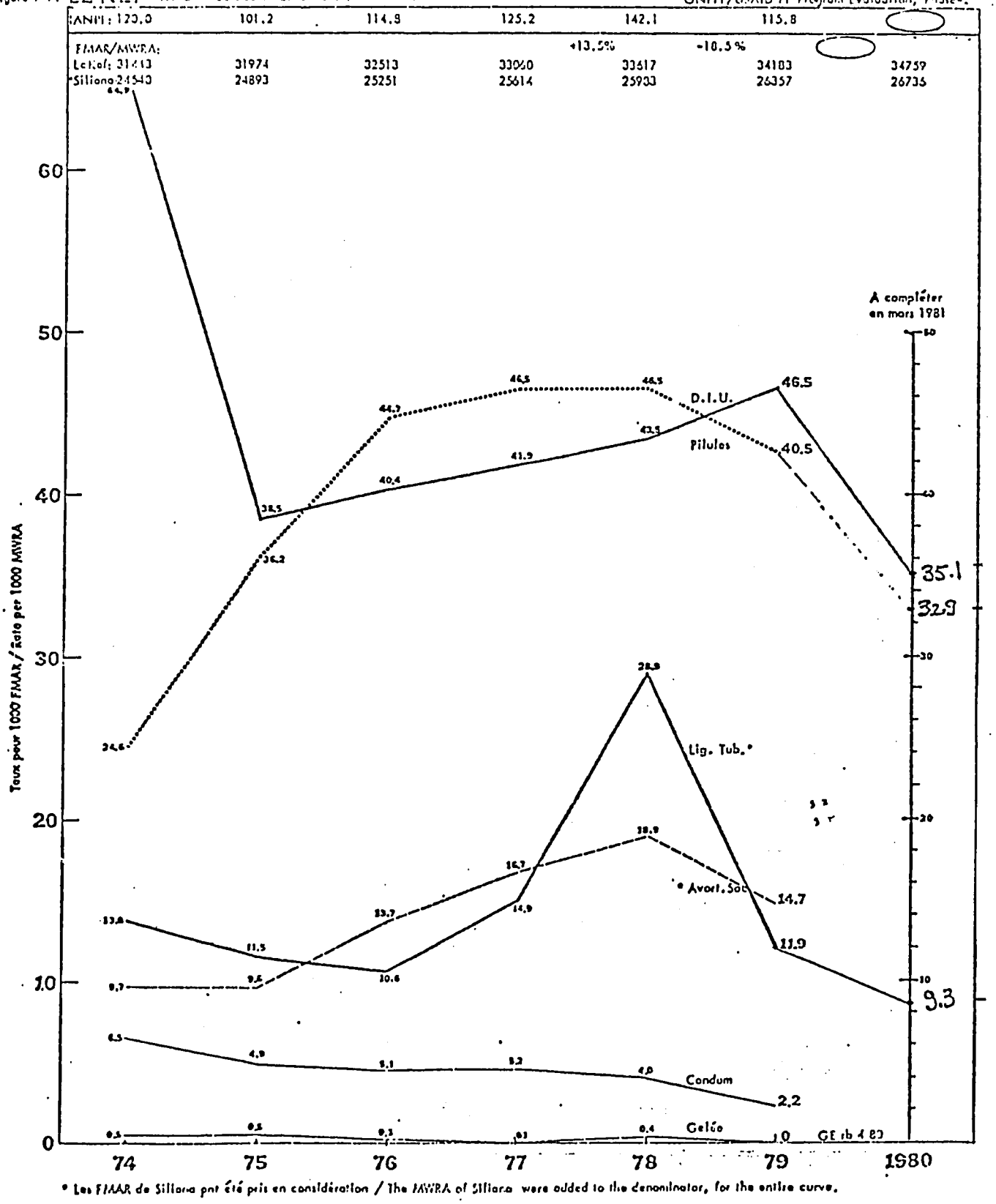


Figure 9-7. LE KEF TENDANCE DES INCIDENCES / TREND OF INCIDENCES

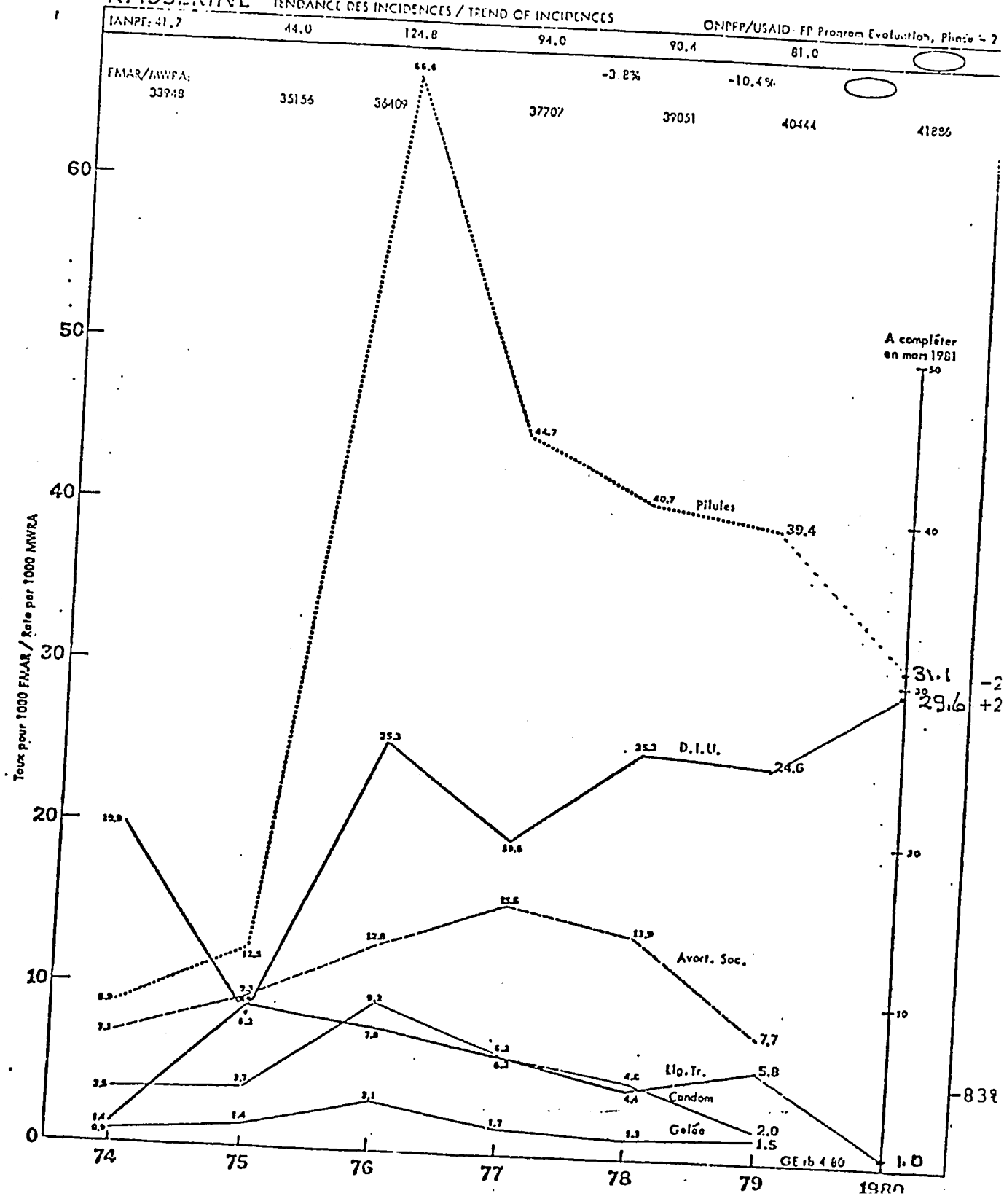
ONFP/USAID FP Program Evaluation, Phase-2

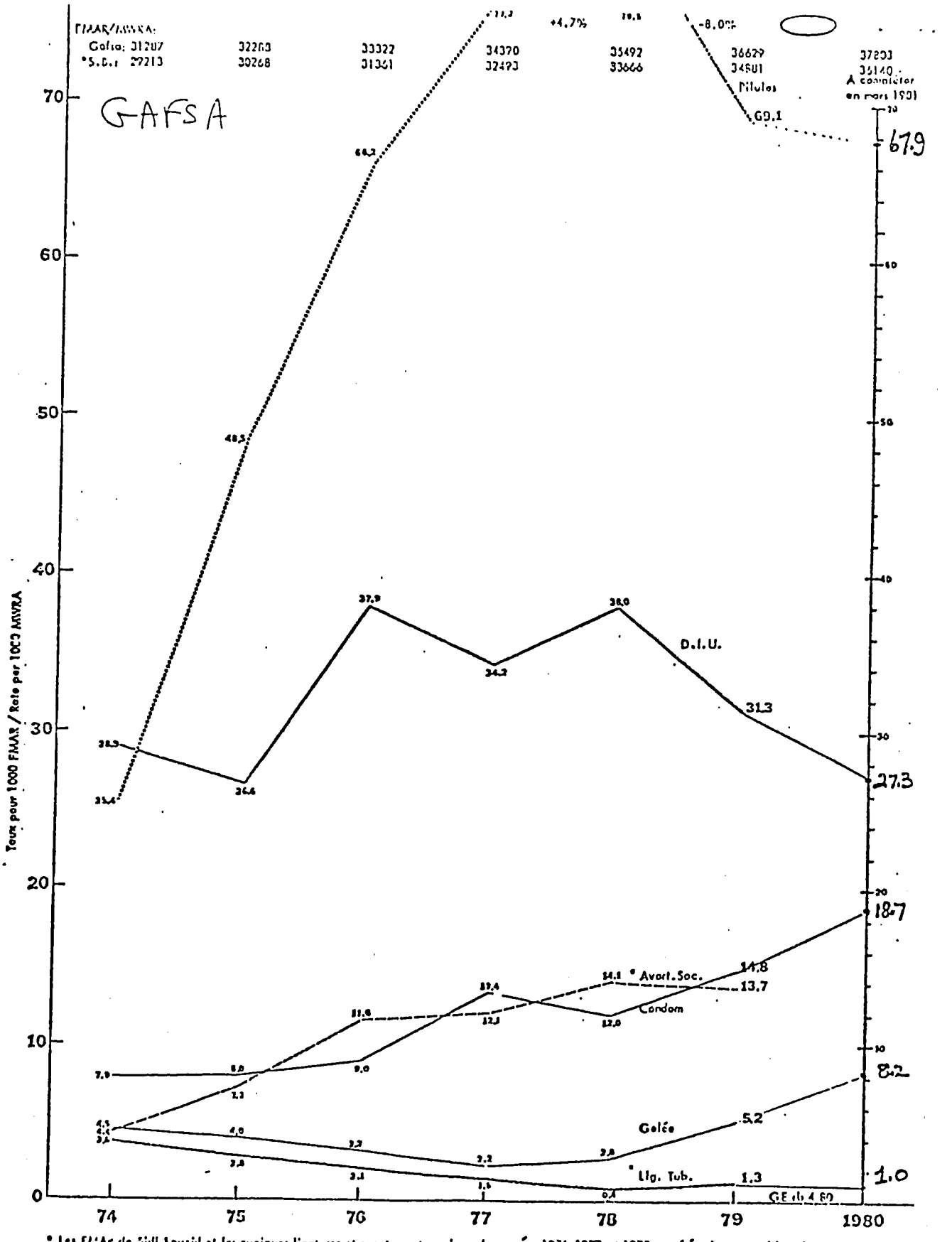


* Les FMAR de Siliana ont été pris en considération / The MWRA of Siliana were added to the denominator, for the entire curve.

Figure 9-12. KASSERINE TENDANCE DES INCIDENCES / TREND OF INCIDENCES

ONPFP/USAID · FP Program Evaluation, Phase 2





* Les FMAR de Sidi Bouzid et les quelques ligatures et avortements sociaux des années 1976, 1977, et 1978 ont été pris en considération.
The MWRA of Sidi Bouzid and the few ligations and abortions of 1976, 1977, and 1978 were included in the calculation of the rates.

Figure 9-14. MEDENINE TENDANCE DES INCIDENCES / TREND OF INCIDENCES ONPFP/USAID FP Program Evaluation, Phase-2

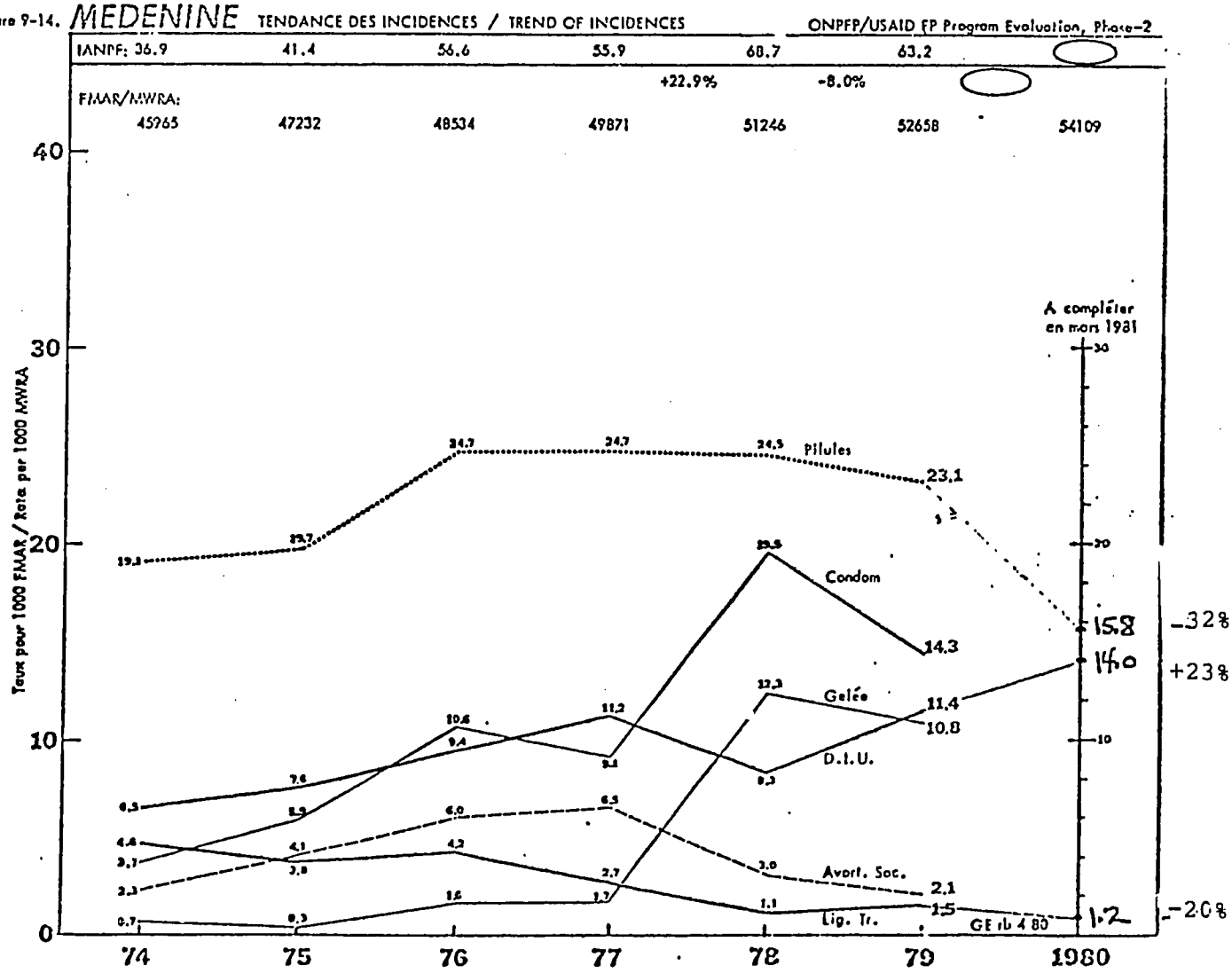


Figure 9-10. GABES TENDANCE DES INCIDENCES / TREND OF INCIDENCES

ONPFP/USAID FP Program Evaluation, Phase - 2.

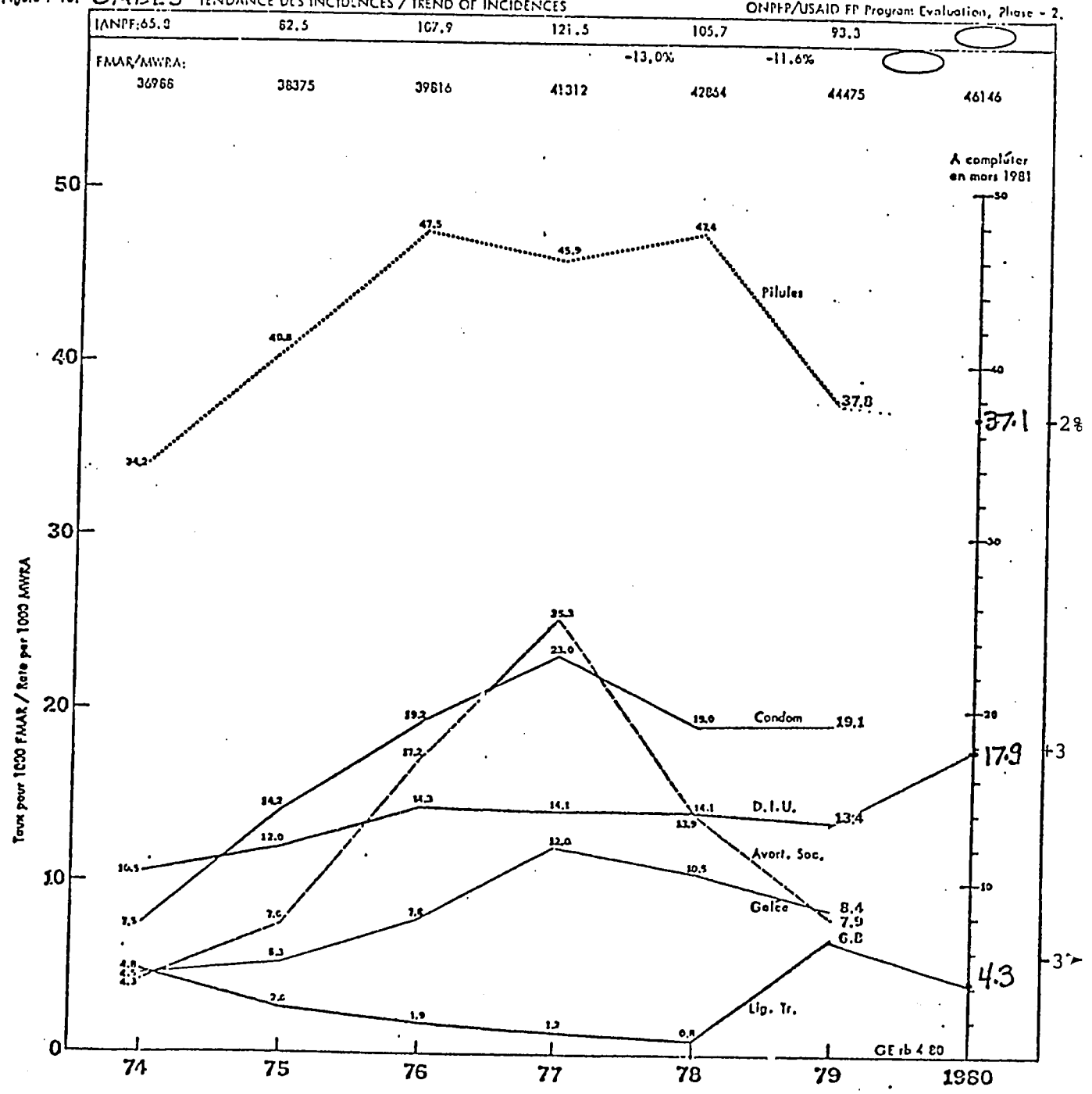


Figure 9-8. SFAX TENDANCE DES INCIDENCES / TREND OF INCIDENCES

ONPFP/USAID FP Program Evaluation, Phase - 2.

	74	75	76	77	78	79	1980
IANPF:	113.0	125.2	149.9	150.2	128.7	113.9	
FMAR/MWRA:	63410	65259	67162	69120	71135	73207	75344
				-14.3%		-11.5%	

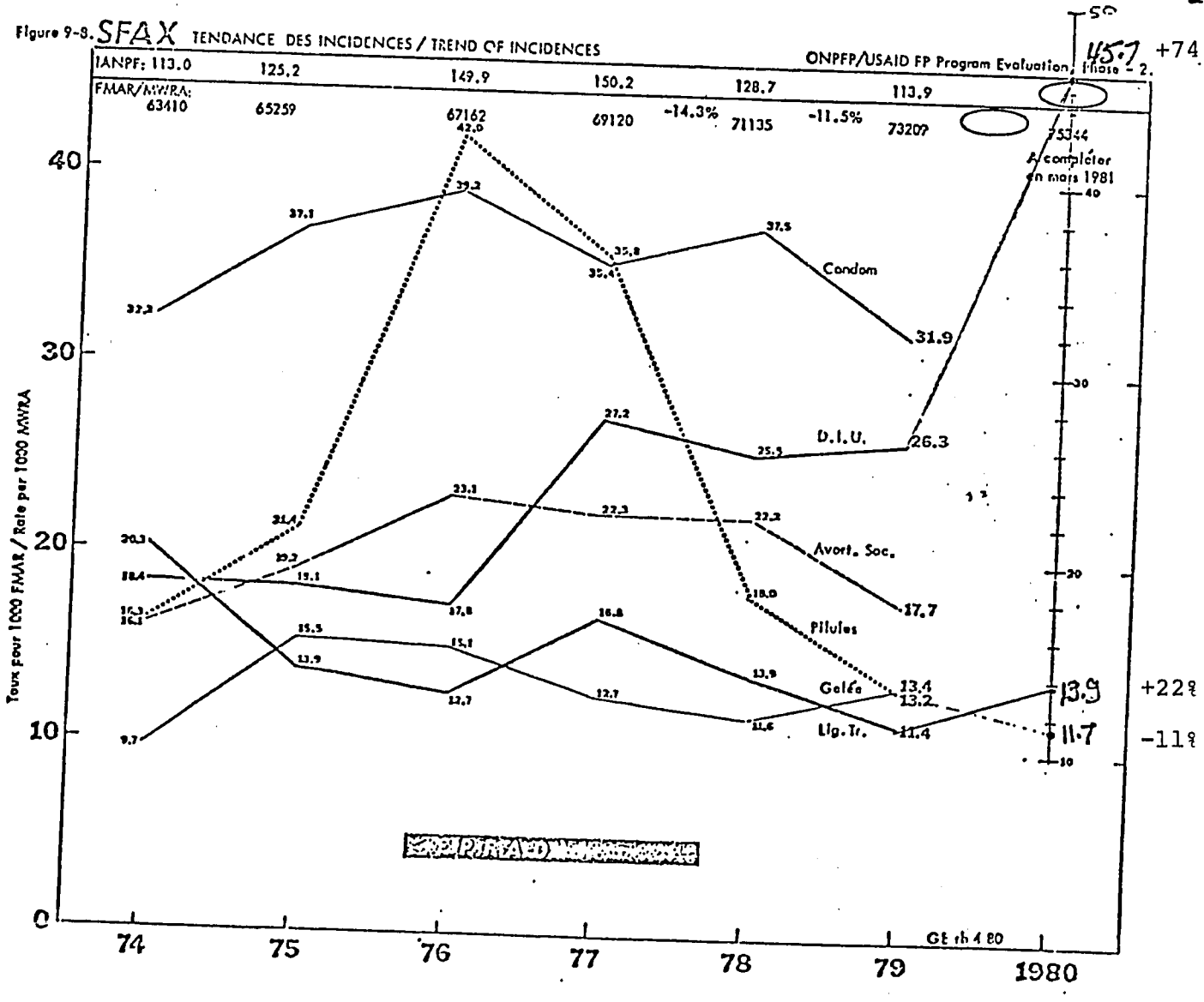


Figure 9-15. KAIROUAN TENDANCE DES INCIDENCES / TREND OF INCIDENCES ·ONPFP/USAID FP Program Evaluation, Phase - 2

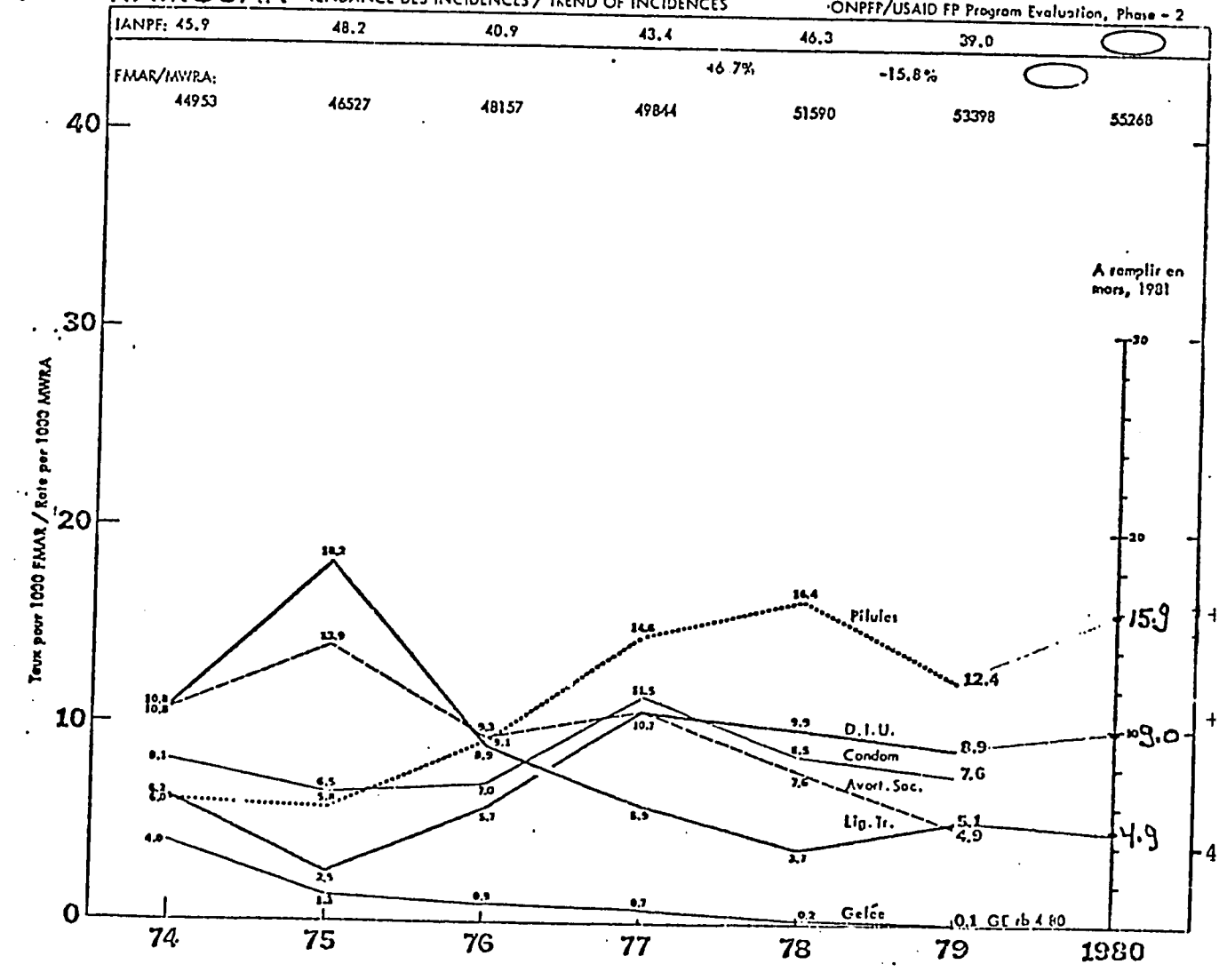


Figure 9-13. MAHDIA TENDANCE DES INCIDENCES / TREND OF INCIDENCES ONPFP/USAID FP Program Evaluation, Phase - 2.

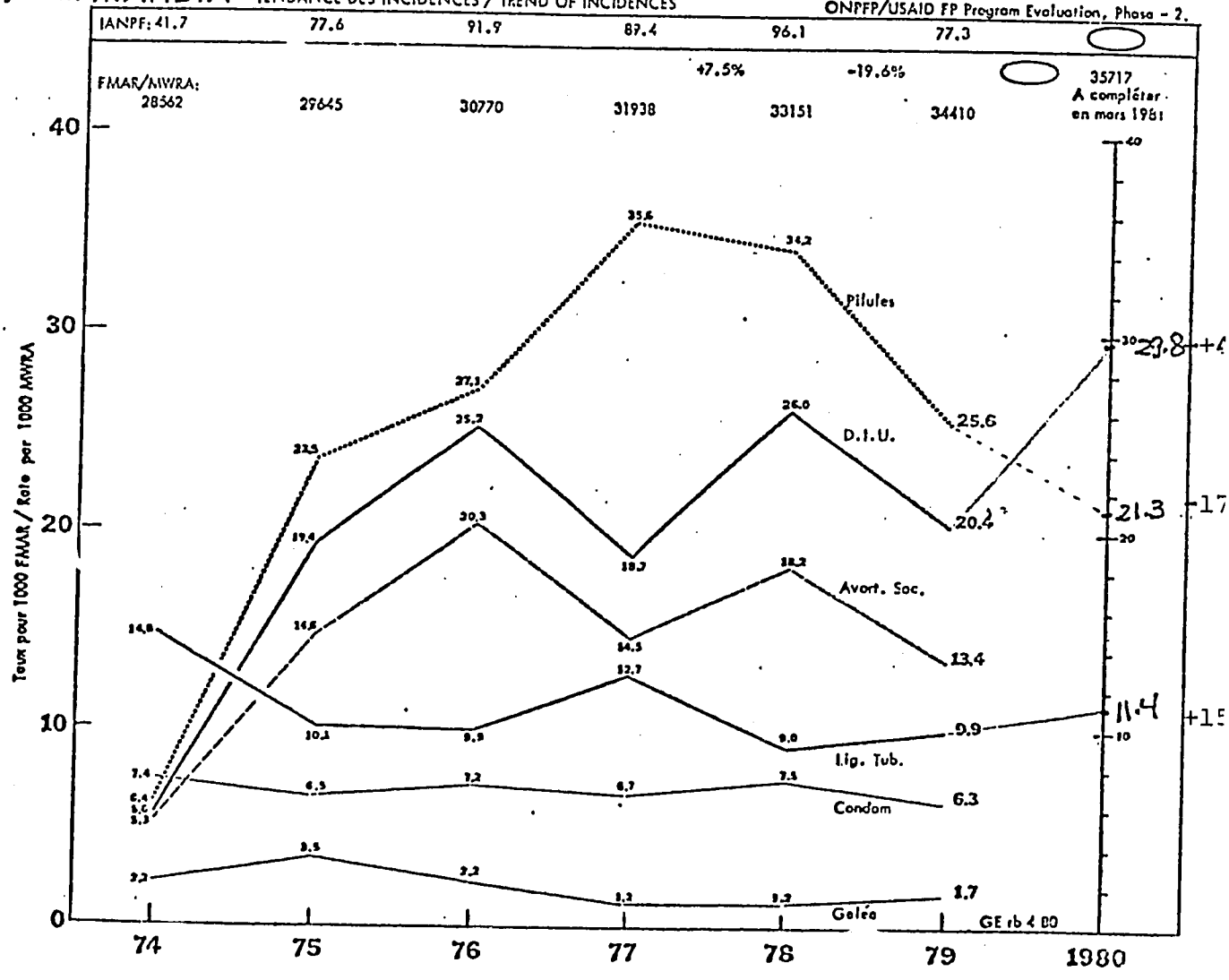


Figure 9-5. MONASTIR TENDANCE DES INCIDENCES / TREND OF INCIDENCES

ONPFP/USAID FP Program Evaluation, Phase-2.

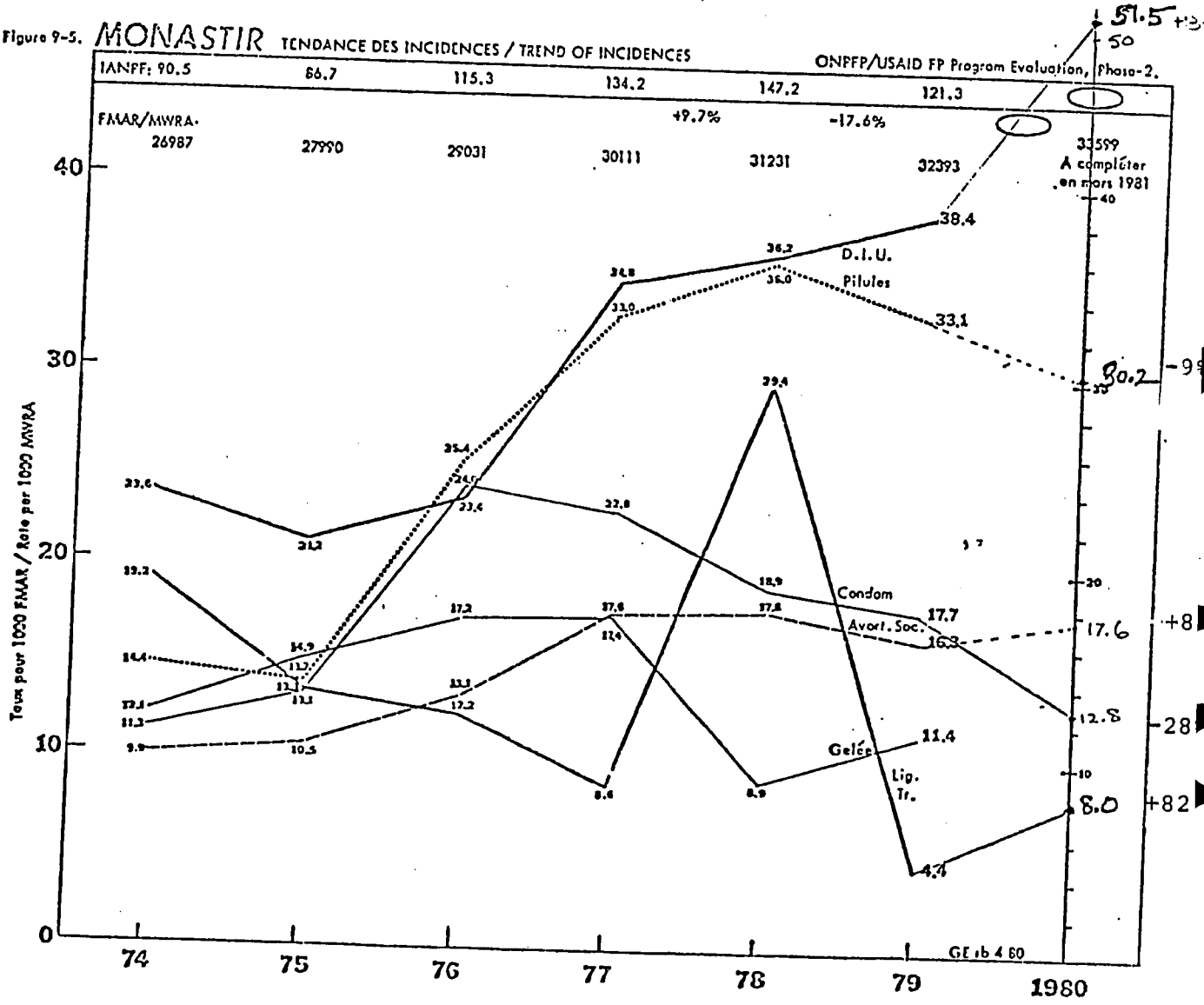


Figure 9-1. SOUSSE TENDANCE DES INCIDENCES / TREND OF INCIDENCES

ONDEP/USAID FP Program Evaluation Phase - 2.

IANPF:	98.7	127.0	170.8	192.2	165.3	168.7	
FMAR/MWRA:	33160	34410	35725	37062	35490	39952	41469
				-13.5%	+1.4%		A compléter en mars 1981

Taux pour 1000 FMAR / Rate per 1000 MWRA

Avort. Soc.

D.I.U.

Pilules

Condom

Lig. Tr.

Gelée

75.7 +1

56.5 -9%

18.6 -5%

12.4 -5%

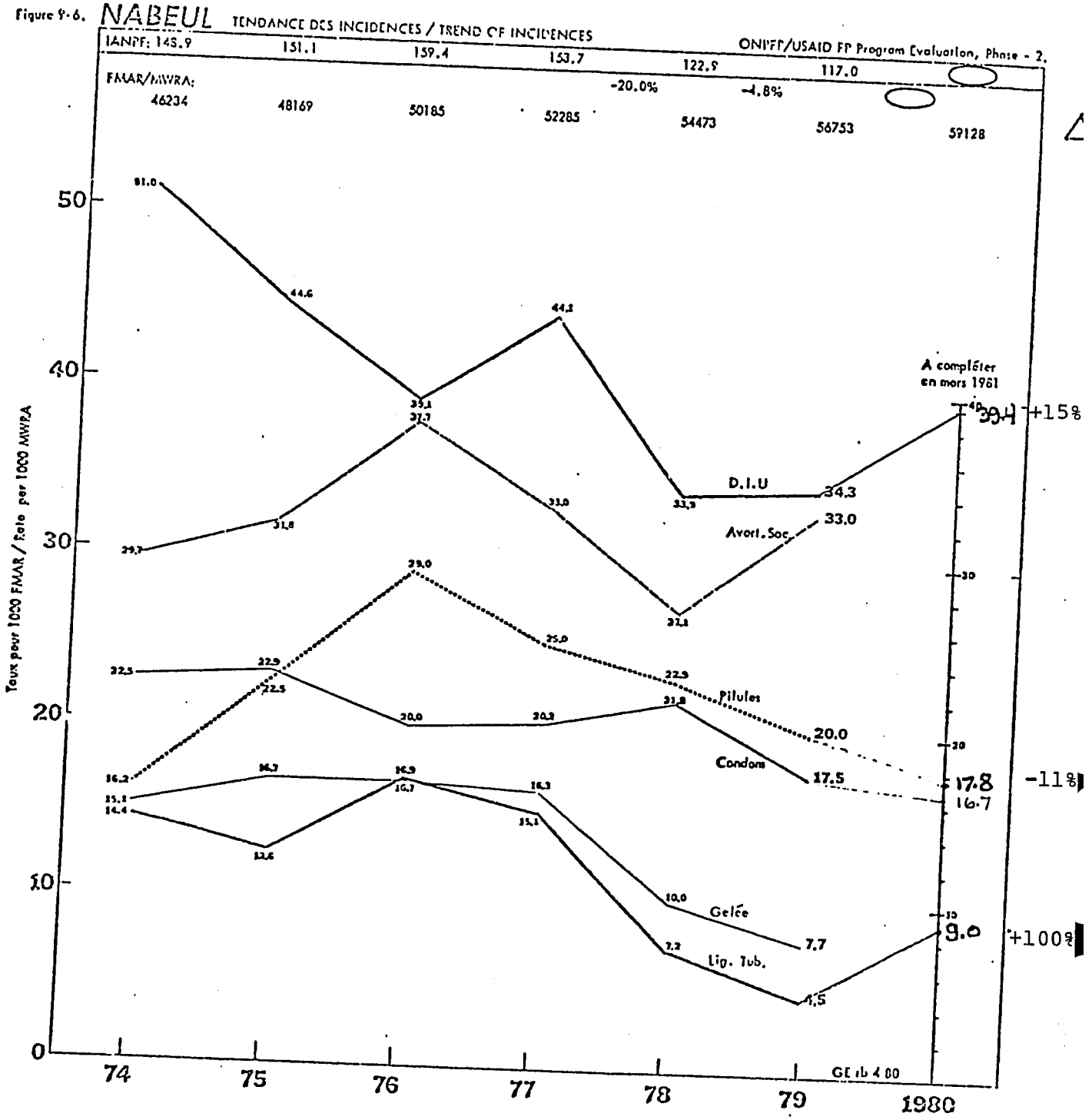
10.8 +42%

GE rb 4 80

74 75 76 77 78 79 1980

Figure 9-6. NABEUL TENDANCE DES INCIDENCES / TREND OF INCIDENCES

ONIPF/USAID FP Program Evaluation, Phase - 2.



Appendix D

PERCENTAGE CHANGE IN INCIDENCE OF NEW ACCEPTORS
(PER 1,000 WOMEN OF REPRODUCTIVE AGE) OF CONTRACEPTIVES
IN EACH GOVERNORATE
(1979-1980)

Appendix D

PERCENTAGE CHANGE IN INCIDENCE OF NEW ACCEPTORS (PER 1,000 WOMEN OF REPRODUCTIVE AGE) OF CONTRACEPTIVES IN EACH GOVERNORATE (1979-1980)

Methods / Governorate	Total Visits	Contraceptives New	Contraceptives Old	IUD Insertions	Percent of IUD Insertions, 1979-1980	New Pill Acceptors	Percent of New Pill Acceptors, 1979-1980	New Condom Acceptors	Percent of New Condom Acceptors 1979-1980	New Jelly Acceptors	Percent of New Jelly Acceptors 1979-1980	Tubal Ligations	Percent of Tubal Ligations 1979-1980
Tunis				43.9	+ 3	21.7	-16					12.2	+ 6
Zaghouan													
Bizerte				40.4	- 1	24.5	-13					17.0	-26
Béja				46.2*	+36	13.4	- 5					25.2**	- 6
Jendouba				18.9	0	30.8	- 8					7.9**	- 6
Kef				35.1	-25	32.9	-19					9.3**	-22
Siliana													
Kasserine				29.6*	+20	31.1	-21					1.0**	-83
Sidi Bouzid													
Gafsa				27.3	-13	67.9	- 2					1.0	-23
Médenine				14.0*	+23	15.8	-32					1.2	-20
Gabès				17.9*	+34	37.1	- 2					4.3	-37
Sfax				45.7*	+74	11.7	-11					13.9	+22
Kairouan				9.0	+ 1	15.9	+28					4.9	- 4
Lahdia				29.8*	+46	21.3	-17					11.4	+15
Monastir				51.5*	+34	30.2	- 9					8.0	+82
Sousse				75.7*	+17	18.6	- 5					10.8	+42
Nabeul				39.4	+15	17.8	-11					9.0	+100
TUNISIE (1)				35.0*	+20	24.0	-11	11.0	- 8	7.2	+33	9.3**	0

* Highest annual incidence for years 1974-1980.

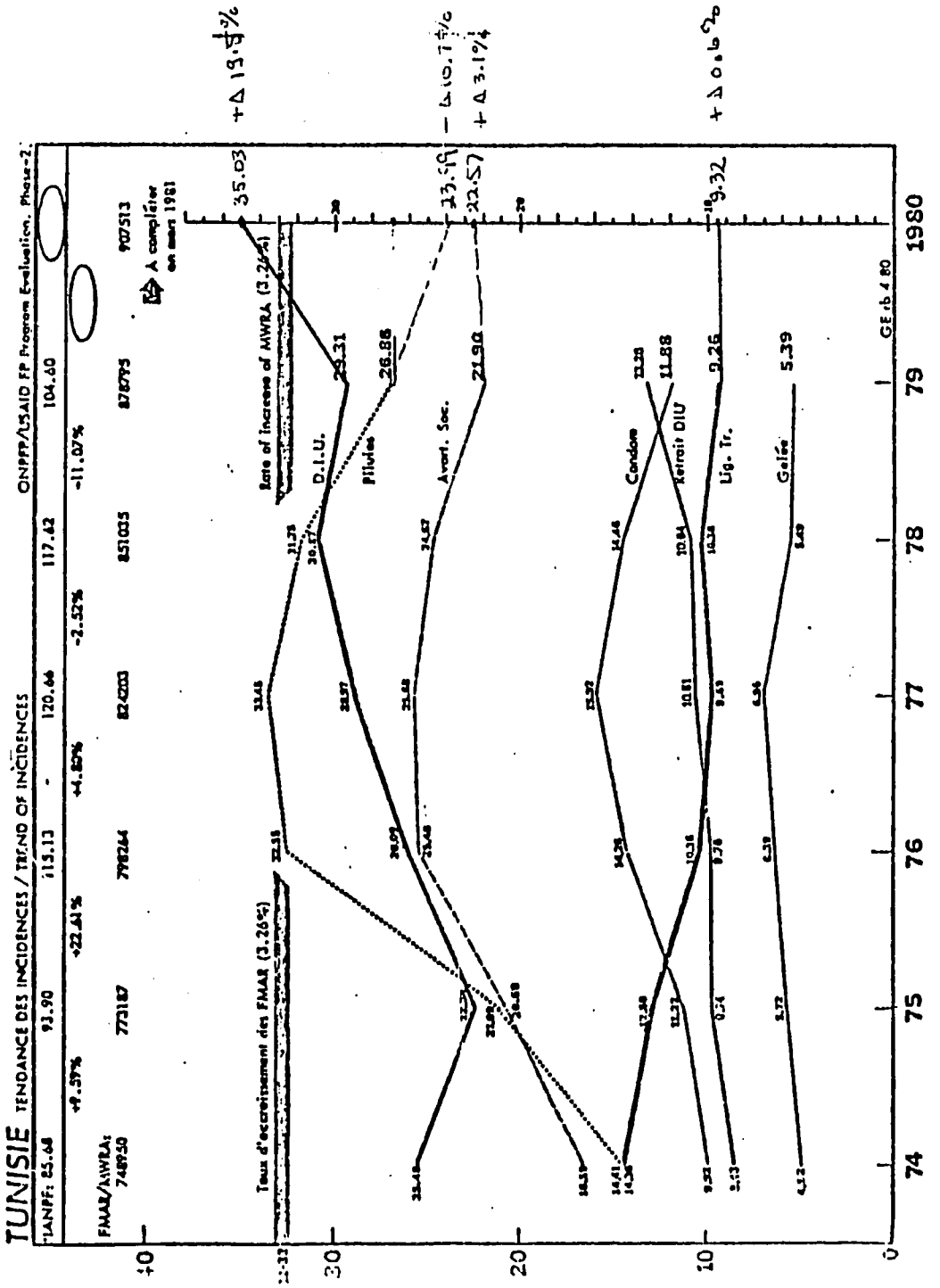
** Lowest annual incidence for years 1974-1980.

Appendix E

GRAPH OF TRENDS IN INCIDENCE OF TUBAL LIGATIONS
(1974-1980)

Appendix E

GRAPH OF TRENDS IN INCIDENCE OF TUBAL LIGATIONS
(1974-1980)



IANPF: Index d'Activité Nouvelle en Planning Familial. C'est la somme des 6 taux à l'exclusion du taux des retraits de DIU.

PFPAI: Primary Family Planning Activity Index. This is the sum of the six input rates, excluding the rate of IUD removal.

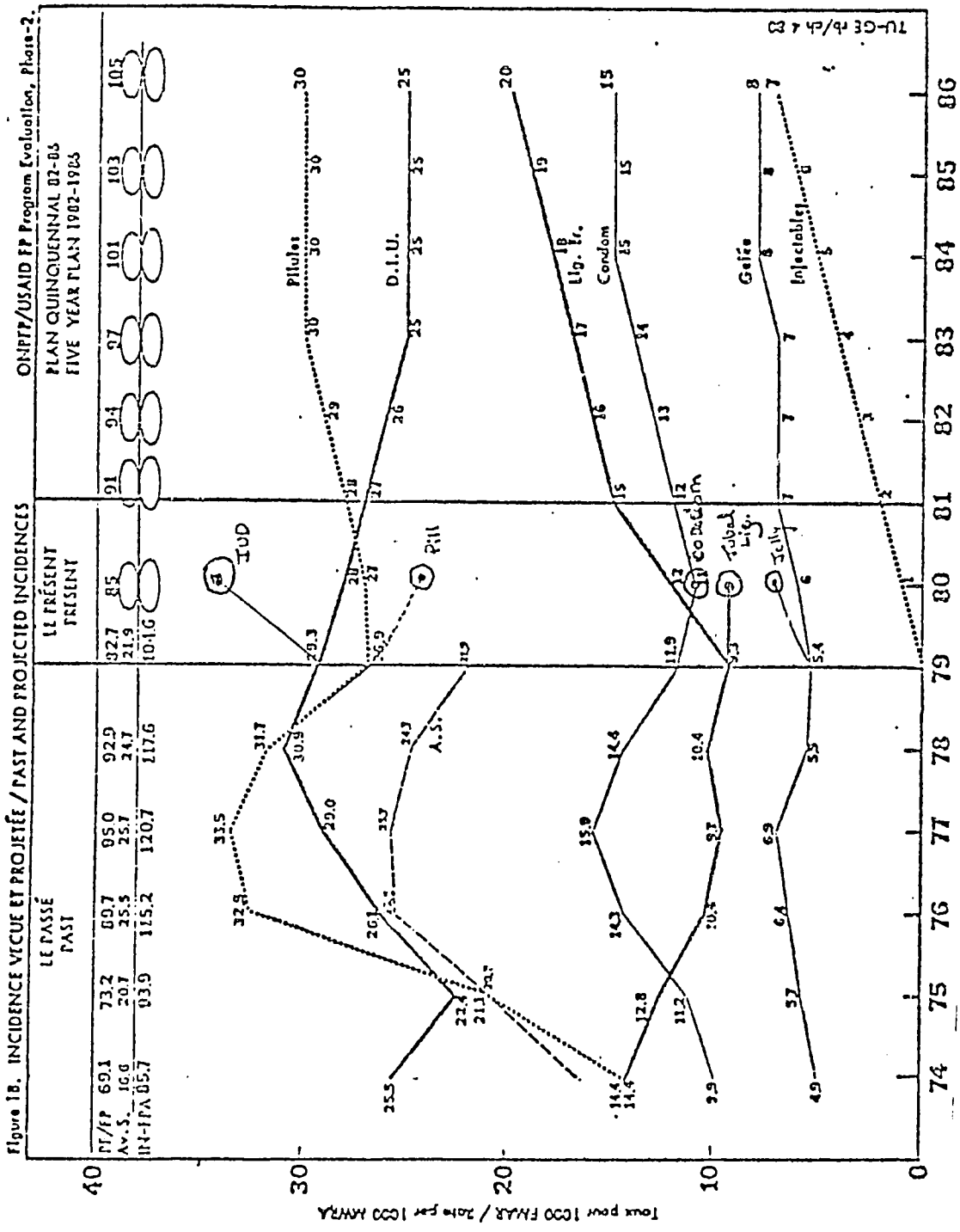
Source: Bernard and Charfeddine, Family Planning Monitoring (FPM) in Tunisia (1973-1979): Findings and Implications for the Next Five-Year Plan (1982-1986), April 1980, p. 24.

Appendix F

PAST AND PROJECTED INCIDENCES OF FAMILY PLANNING METHODS

Appendix F

PAST AND PROJECTED INCIDENCES
OF FAMILY PLANNING METHODS



Source: Bernard and Charfeddine, Family Planning Monitoring (FPM) in Tunisia (1973-1979): Findings and Implications for the Next Five-Year Plan (1982-1986), April 1980, p. 48.

Appendix G

PROCES VERBAL
(February 1981 Meeting Between Regional Delegates and PDG)

République Tunisienne

OFFICE NATIONAL DU PLANNING
FAMILIAL ET DE LA POPULATION

Tunis, le

PROCES - VERBAL

DE LA REUNION DES DELEGUES REGIONAUX DE L'OFFICE NATIONAL DU PLANNING FAMILIAL ET DE LA POPULATION.

Cette réunion a eu lieu les 11 et 12 Février 1981 au Centre de Formation et de Recyclage de l'Ariana .

Présidée par Madame Souad CHATER, Président Directeur Général ,cette réunion a groupé les Délégués Régionaux et les cadres des Services centraux .

SEANCE D'OUVERTURE :

Ouvrant la réunion, Madame le Président Directeur Général a noté l'importance de cette rencontre qui se tient à la veille du VIè Plan et de la nouvelle Decennie. Elle revêt ainsi un caractère particulier puisqu'elle va permettre aux cadres régionaux et centraux de l'Office de faire le point de la situation à partir du bilan de l'année écoulée et de se concerter sur la stratégie d'action de l'Office pour l'année 1981 et de la prochaine décennie de développement économique et social.

Elle est la première d'une série de réunions qui permettront de donner une impulsion continue au programme de l'Office en conformité avec la réalité de la société tunisienne et les mutations qui s'y opèrent .

Le Président Directeur Général a insistés sur l'importance du rôle des délégués régionaux et les a invités à présenter la situation du planning familial chacun dans sa région en mettant en relief les difficultés rencontrées afin d'aboutir à une évaluation objective de l'action entreprise, à trouver les solutions adéquates aux problèmes enregistrés, favorisant ainsi le développement de l'action.

Dans leurs interventions les délégués régionaux ont notamment souligné ce qui suit :

.../...

BEST AVAILABLE DOCUMENT

Appendix H

LIST OF CONTACTS

Appendix H

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Office National de Population et Planning Familial

Mr. Mongi B'chir, Adviser to the ONPFP

Mr. Benzarti, Chief, Information, Education and Communication Section

Mr. Hamadi Betbout, Bilateral Cooperation

Mr. Yahia Bousnina, IEC Section

Mr. Charfeddine, Research and Evaluation Section

Mrs. Souad Chater, President Director General

Mr. Rafaat Dali, Chief, Medical Section

Mr. Mourad Ghachem, Director of International Cooperation

Mr. Taoufik Kilani, Research and Evaluation Section

Dr. Farouk Ben Mansour, Medical Inspector

Mr. Abderrazak Thraya, Chief of Training

Ministry of Health

Dr. Habib Rejeb, Chief, Central Tunisia Project

Dr. Taoufik Nacef, Head, Ecole des Cadres; Chairman, Department of Social and Preventive Medicine, University of Tunis

Population Council

Dr. George Brown

Ms. Peggy McEvoy

USAID/Tunis

Mr. William Gelabert, Director

Mr. Allan Getson, Population Officer