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**TUNISIA:
POPULATION STRATEGY
FOR THE 1990s**

by

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Glossary

A.I.D.	Agency for International Development
ANE	Asia, Near East, and Europe (A.I.D. Bureau)
ATPF	Tunisian Family Planning Association (<i>Association Tunisienne de Planning Familial</i>)
AVSC	Association for Voluntary Surgical Contraception
CIP	Commodities Import Program
CREPF	Regional Center for Education and Family Planning (<i>Centre Régional d'Éducation et Planning Familial</i>)
CSM	Contraceptive social marketing
DCCG	Division for Coordination and Control of Management (ONFP)
DHS	Demographic and Health Survey
EDS	<i>Enquête Démographique et de Santé</i> (Demographic and Health Survey)
ETF	<i>Enquête Tunisienne sur la Fécondité</i> (Tunisian Fertility Survey)
ETPC	<i>Enquête Tunisienne sur la Prévalence Contraceptive</i> (Tunisian Contraceptive Prevalence Survey)
FHMS	Family Health Management Services
FPLM	Family Planning Logistics Management project
FPMD	Family Planning Management Development project
GOT	Government of Tunisia
HPN	Health, population and nutrition
IEC	Information, education and communication
INS	<i>Institut National de la Statistique</i> (National Statistical Institute)
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
LT	Tubal ligation (<i>ligature des trompes</i>)
MCH	Maternal and child health

MCH	Maternal and child health
MIS	Management information system
MOPH	Ministry of Public Health
MSA	Ministry of Social Affairs
MWRA	Married women of reproductive age
NGO	Nongovernmental organization
ONFP	<i>Office National de la Famille et de la Population</i> (National Office for the Family and Population)
OYB	Operating year budget
PAC IIb	Family Planning Training for Paramedical/Auxiliary/Community Personnel
PIO/T	Project Implementation Order/Technical
PL-480	Public Law 480
PVO	Private voluntary organization
RNI	Rate of natural increase
S&T/POP	Bureau for Science and Technology/Office of Population (A.I.D.)
TFR	Total fertility rate
TIPPS	Technical Information on Population for the Private Sector
TRG	Training Resources Group
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VSC	Voluntary surgical contraception
WHO	World Health Organization

Acknowledgments and Overview of Assignment

Overview of This Assignment

The purpose of this assignment was to help Tunisia's National Office for the Family and Population (ONFP) to elaborate further its strategy for the 1990s, develop more detailed plans for implementing that strategy, examine resource requirements, and identify areas for A.I.D. support. The immediate goal was to produce a strategy statement that would serve as a basis for future support for population activities in Tunisia by A.I.D. and other donors.

The team began with briefings at A.I.D./Washington with key personnel, including Office of Population staff monitoring centrally funded projects potentially able to assist the ONFP. During three weeks in Tunisia the team reviewed documents, engaged in intensive analytic discussions with the ONFP, interviewed other government officials, met with key USAID personnel, made field visits, and participated in a conference bringing together major actors in the population and family planning field. Team conclusions were thoroughly discussed at several junctures with the ONFP and with USAID/Tunis.

Acknowledgments

The members of the team express their sincere appreciation for the active participation of all the staff of the ONFP in this important planning effort. Special thanks go to Dr. Hedi M'Henni, President Director General of the ONFP; Mr. Ahmed Beltaief, Director of the International Cooperation Division; Dr. Ridha Chadi, Director of the Medical Division; and to all the other staff members who worked hard to make this activity a success. The team especially appreciated the frank expression of opinion during the excellent strategy planning sessions, the extensive documentation provided, the comprehensive and well-planned schedule, and the facilitation of meetings with others involved in population and family planning.

Appreciation is also expressed to staff of USAID/Tunis for their thoughtful analysis as well as their understanding of the need to continue support for Tunisia's national family planning program during the program's crucial transition period. Thanks go to Mr. George Carner, Mission Director; Dr. Diana Putman, Project Development Officer with oversight for the Tunisia Family Planning and Population Development Project; Ms. Nancy Tumavick, Assistant Director for Project Management; and Mr. Hafid Lakhthar, Assistant Project Officer for Health and Population.

Finally, the team also expresses its sincere gratitude for the insightful analysis and facilitation of this planning process by Mr. Anwar Bach Baouab and Ms. Suzanne Reier, Co-Directors for RONCO Consulting Corporation, which is providing technical assistance to USAID's Tunisia Family Planning and Population Development Project.

Executive Summary

Background

Since independence in 1956, the Government of Tunisia (GOT) has been in the lead among developing countries in recognizing the crucial role that demographic balance plays in economic development and the need to integrate population considerations into national socioeconomic planning. As a result, since 1966 the GOT has been providing free family planning services to the Tunisia public. While some family planning services are now provided in the private sector and by the Ministry of Public Health (MOPH) itself, the great bulk of all family planning activities are handled by the National Office for the Family and Population (ONFP, *Office National de la Famille et de la Population*), a semiautonomous agency of the Ministry of Public Health.

Given Tunisia's progressive policies and vigorous family planning program, it now has the highest level of contraceptive use in the Near East and Africa. Tunisia has also become a training ground and important model for other countries in the Near East and Africa, especially francophone Africa.

The U.S. Agency for International Development (A.I.D.) has been the primary donor supporting family planning activities in Tunisia since the mid-1960s, providing approximately \$32 million of assistance during this period. An \$8.2 million bilateral project, the Tunisia Family Planning and Population Development Project is in its sixth year, scheduled to end December 31, 1990. This project provides \$7.5 million for population-related activities.

Purpose of This Assignment

The purpose of this assignment was to help the ONFP to elaborate further its strategy for the 1990s, develop more detailed plans for implementing that strategy, examine resource requirements, and identify areas for A.I.D. support. The immediate goal was to produce a strategy statement directed toward the Tunisia government, USAID/Tunis, A.I.D./Washington, and other interested collaborating organizations. This strategy statement is to serve as the basis for future A.I.D. support for population activities in Tunisia as well as for support by other donors.

Major Conclusions

1. Demographic achievements in context. Despite current high contraceptive use, the job is by no means done. The total fertility rate remains high (4.3, according to the 1988 Demographic and Health Survey), and the population is growing at the rate of 2.4 percent per year. Although total contraceptive prevalence is now about 50 percent, 10 percent is for less effective, traditional methods. In many ways, the challenge ahead is more difficult than in the past. The number of couples to be provided with family planning services will be much greater in the next decade than during the past two decades, in part a consequence of the large number of women just reaching childbearing age. To meet demographic goals, the number of users will have to double by the year 2000. To achieve this it will be necessary to proceed promptly with family planning program restructuring, cost containment, and privatization measures that are now just in their infancy. Tunisia is becoming more urban, but half of the population continues to live in rural areas, some of

which are hard to reach and where contraceptive use remains low. A continuing challenge throughout the 1990s will be to increase prevalence in these areas while seeking to reduce the costs of service provision.

2. Economic and political concerns. Reducing the population growth rate is essential for achieving the GOT's economic and political goals, which A.I.D. supports. The GOT has embarked on a politically high-risk structural adjustment program, seeking to transform its economy from one that is state controlled to a market-driven, private-led economy able to provide jobs for the large numbers coming into the work force. This massive transformation will not be easy. Unemployment is high and, given the youthful and still growing population, will remain high during the near future -- a potential challenge to social and political stability. In 1991, the structural adjustment program will enter a second and more difficult phase, causing negative effects on many people. Employment is thus the foremost challenge facing Tunisia as it enters the 1990s. For most Tunisians, jobs will be the measure of success. This is not only an economic but also a political concern. Evidence is clear throughout the Near East that unemployment, especially among young people, is a major contributor to Islamic fundamentalism, a force that is undeniably present in Tunisia too.

3. GOT population policy for the 1990s. Reducing population growth will remain a high priority of the Tunisia government. Political commitment to family planning remains firm from the presidential level on down. The interrelations between population change and all sectors of the economy will figure importantly in the GOT's Eighth Plan (covering the years 1992-1996). Ambitious demographic targets have been set. Evidence of GOT commitment is the fact that its contribution to the ONFP budget has increased steadily in recent years and now totals 73 percent of direct costs and nearly 90 percent of overall costs.

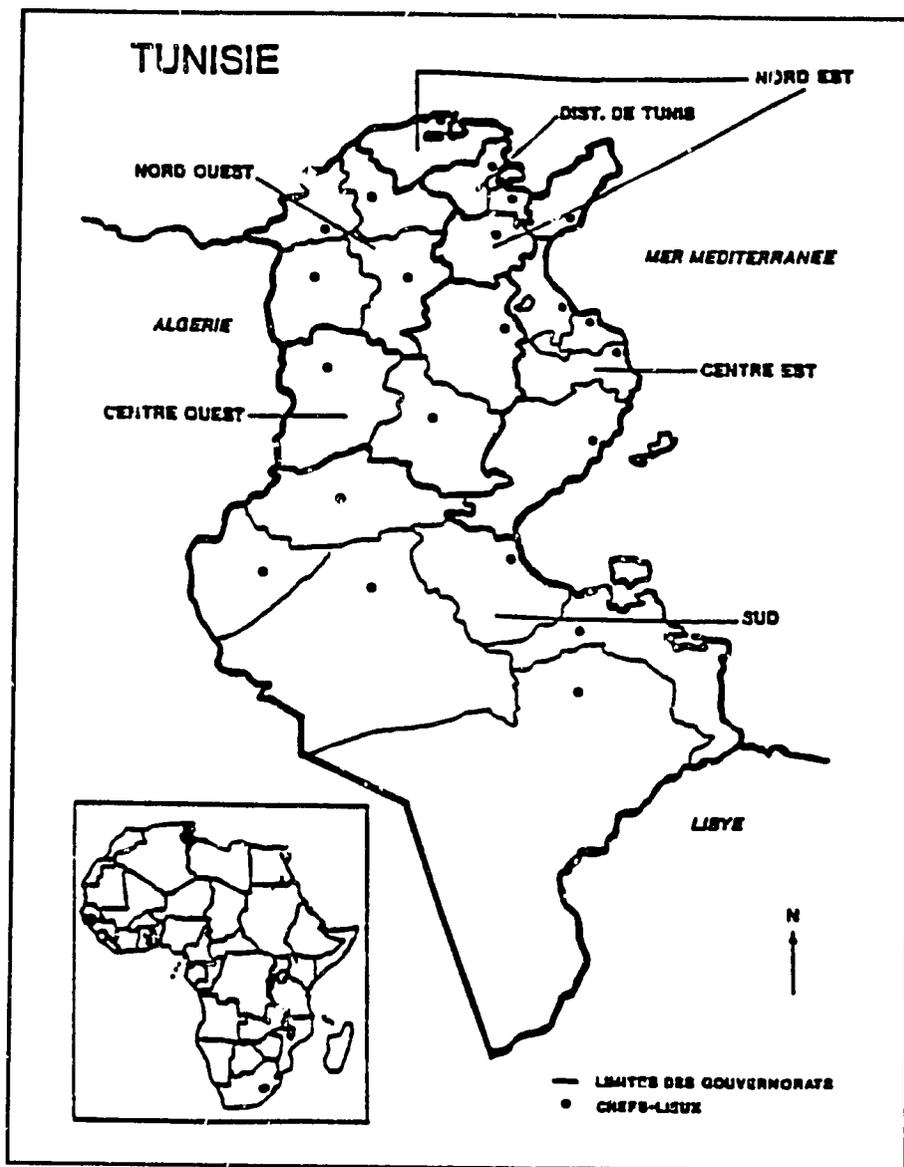
4. ONFP family planning strategy for the 1990s. The ONFP has developed an appropriate but ambitious strategy for the 1990s. The overall goal of this strategy is to transform the ONFP from a government monopoly providing free family planning services into a coordinator of services provided in large part through the marketplace and paid for increasingly by consumers. Not only is the ONFP strategy consistent with the overall GOT strategy for economic transformation, but more significant, the ONFP may be in the forefront among GOT agencies in attempting this transition and may well become a trailblazer for others. The three key elements of the ONFP strategy are as follows:

- Privatization -- transferring much of the burden of service provision to the private for-profit sector (physicians, pharmacists, and employers) and of costs to consumers able to pay for them.
- Integration -- integrating family planning into the basic health care services of the Ministry of Public Health (and further into education and social service programs administered by other GOT ministries).
- Transformation of the ONFP itself -- administrative, management, and program reform to transform the ONFP
 - (a) from a government monopoly into a coordinator of activities undertaken by others and, simultaneously,
 - (b) into a more cost-efficient and self-sufficient entity able to diversify its sources of support and to market its training and research capacities and other services in the domestic and international marketplaces.

5. **Need for assistance.** Despite growing capacities, the ONFP will continue to need some external assistance, especially technical, to implement its new strategy and achieve self-sufficiency. The ONFP has developed an appropriate strategy but, given the radical departure this represents from traditional "business-as-usual" programming, it needs external assistance to figure out precisely how to reach its objectives.
6. **Congruence with A.I.D.'s policy.** The ONFP strategy is consistent with A.I.D.'s overall priorities and with those of USAID/Tunis in particular. The assistance strategy of USAID/Tunis for the period 1992-1996 (coinciding with the GOT's Eighth Plan) aims at sustainable growth and employment based on an "improved match of labor supply and skills with market demand." The ONFP strategy is also congruent with the priorities of the Health, Population and Nutrition Office of the Bureau for Asia, Near East, and Europe (ANE/HPN).
7. **ONFP as a model for A.I.D. assistance.** Tunisia offers some of the best possibilities in Asia and the Near East, and the ONFP some of the best possibilities in Tunisia, for A.I.D. to achieve the private sector and market-related objectives it has set for itself, especially in assistance to countries moving into the category of "advanced developing country."

Major Recommendations

1. **The ONFP should proceed vigorously with the general strategy it has developed.** This should be further developed along the lines outlined in this report.
2. **USAID/Tunis should support the two key elements of the ONFP strategy that conform most closely with A.I.D. priorities and with USAID/Tunis objectives.** These are (1) privatization and (2) transformation of the ONFP itself.
 - USAID/Tunis should begin immediately to develop an institutional grant to the ONFP to support activities in the above two areas.
 - A specific purpose of this grant should be to enable the ONFP to take charge of meeting all its technical and financial needs and diversifying sources of support, without dependency on or direct supervision by A.I.D.
 - Funds provided by this grant must be substantial enough to encourage and help the ONFP through the difficult transformation envisioned.
 - The grant should make it possible for the ONFP to receive additional support from A.I.D./Washington, both from the ANE Bureau's regional projects and through buy-ins to Office of Population centrally funded projects. The most critical technical assistance needs are in (1) expanding the successful contraceptive social marketing program, (2) supporting new ventures with private enterprises and private physicians, and (3) strengthening ONFP program management and efforts to achieve self-sufficiency.



Tunisia Facts and Figures at a Glance

Population (1990)	8.2 million
Infant mortality rate	57
Total fertility rate	4.3
Population growth rate (RNI)	2.4%
Doubling time	31 years
Percent population under age 15	40
Percent urban	53
GNP per capita	1,140
Total contraceptive practice among married women	50%
Modern contraceptive practice among married women	40%
Estimated unemployment rate	16.2%

Sources: National Office for the Family and Population; Demographic and Health Survey, 1988; and Population Reference Bureau, World Data Set, 1988.

1. Background

1.1 Country and Policy Context

1.1.1 Political Commitment to Demographic Balance

Tunisia is a country of approximately 8 million people, a forward-looking Arab nation lying between Libya and Algeria.¹ Since independence in 1956, the Government of Tunisia (GOT) has been in the lead among developing countries in recognizing the crucial role that demographic balance plays in economic development and the need to integrate population considerations into national socioeconomic planning. The GOT has strongly supported the development of population policies and officially promoted family planning as an integral part of national economic and social development policy. It has also placed high priority on the improvement of women's status, with attention to the legal status of women. Measures have included encouraging female education, establishing a minimum legal marriage age, legalizing divorce, banning polygamy, and promoting greater involvement of women in the modern economic sector. In 1989, in the face of high unemployment and to encourage smaller families, the government reduced from four to three the maximum number of child subsidies per family. It is significant that the GOT has been able to implement such measures in this Islamic country, despite the position of Islamic fundamentalists elsewhere in the region and even within Tunisia.

1.1.2 Program and Institutional Accomplishments

Since 1966 the GOT has been providing free family planning services to the Tunisia public. Launched as a small pilot project in 1964, the Tunisia family planning program was the first national family planning program to be established in the Near East or Africa. Today, it is the broadest and most advanced program in Africa and the Near East, offering family planning information, education, and services, free of charge, in over 1,000 facilities throughout the country. Planning, programming, coordination, and evaluation of all family planning activities are handled by the National Office for the Family and Population (ONFP), which was created in 1973 as a semiautonomous agency of the Ministry of Public Health (MOPH).

With broad political, religious, and legislative support, the national family planning program has been able to overcome important obstacles and achieve a dramatic transformation in family planning knowledge, attitudes, and practice. With a dedicated staff, the ONFP has developed policies, a nationwide administrative structure, and a broad range of programs -- family planning services, information, education, training, research, and evaluation. It has planned and coordinated the extension of comprehensive family planning services throughout the country, maintaining a broad mix of contraceptive methods. This is done through a humanistic approach aimed at the harmonious development of the population, the stability and well-being of the family, and maternal and child health (MCH).

The family planning service delivery system created by the ONFP includes, in each of Tunisia's 23 governorates, a Regional Center for Education and Family Planning (CREPF), which provides family planning services and training as well as gynecological and pre- and postnatal exams. The ONFP also provides family planning services on an ongoing basis in 240 public health facilities (hospitals, MCH centers, and basic health care centers). This is complemented by 67 mobile teams and 10 mobile clinics, which provide outreach services to the 25 percent of the Tunisia population who live in dispersed rural areas. (The mobile teams bring family planning

¹Tunisia's population is growing at the rate of 2.4 percent annually. About 53 percent of the population is now classified as urban. About 25 percent of the total population, however, still lives in dispersed, hard-to-reach rural areas.

services to some 800 small public health facilities whose personnel do not regularly provide family planning services. The 10 mobile clinics bring services to remote areas where no health facility exists.) The ONFP service system also includes three model clinics and a training center. Countrywide, a staff of approximately 1,200 works to provide these free services and commodities, which the population of Tunisia has come to expect as a right owed them by the government.

1.1.3 Demographic Achievements

As a result of its progressive policies and vigorous family planning program, Tunisia now has the highest level of contraceptive prevalence in the Near East region and on the continent of Africa. As of 1988, 40 percent of married couples of reproductive age were using a modern contraceptive method. Adding the 10 percent who use a traditional method, the total contraceptive prevalence is now about 50 percent of married couples of reproductive age. Tunisia has also achieved the lowest fertility rate (a total fertility rate of 4.3) of all countries in the Near East and Africa.²

1.1.4 Tunisia as a Model for the Region

For obvious reasons, Tunisia serves as a training ground and important model for other countries in the Near East and for all francophone Africa. Even Central American and anglophone African countries have looked to Tunisia for training and as a model. The accomplishments of the Tunisia family planning program and its leadership role in the region and on the continent have been officially recognized through the awarding to the ONFP of the International Humanitarian Medal by the United Nations Educational, Scientific, and Cultural Organization in 1978 and the United Nations' Population Award in 1989. As Tunisia now embarks on a family planning privatization strategy, it promises to offer guidance also in privatization to other A.I.D.-assisted countries.

1.2 The Role and Impact of A.I.D. Assistance

1.2.1 A.I.D.: The Principal Donor Providing Financial and Specialized Technical Assistance

A.I.D. has been the primary donor supporting family planning activities in Tunisia over the past 25 years, providing approximately \$32 million of assistance to population and family planning during this period, through bilateral and centrally funded programs. As the largest single foreign donor, A.I.D. has played a key role in both the development and expansion of the Tunisia family planning program.

While financial support from A.I.D. has been important, A.I.D. is moreover the principal donor offering specialized technical assistance. Significantly, this specialized technical assistance has made an important difference in helping the Tunisia family planning program become the success and model that it is to date.

Initially, A.I.D. assistance was used to develop an infrastructure, followed by extension of services to rural areas. Subsequent A.I.D. assistance included measures to expand and improve the quality of services, such as strengthening educational and administrative structures in all governorates; specialized training of medical and paramedical personnel; creation of a national training center; establishment of a model clinic with a national and international training program in voluntary surgical contraception (VSC; laparoscopy); establishment of regional clinics providing

²*Demographic and Health Survey in Tunisia, 1988.*

laparoscopic sterilization; expansion of informational and educational activities; testing and evaluation of experimental community-based contraceptive delivery systems; and a strengthened data collection system and research and evaluation program, including national demographic and health surveys. Up to this time, A.I.D. provided free contraceptive commodities, along with medical and audiovisual equipment.³

Most recently, A.I.D. assistance has aimed at transferring some of the costs of service provision to the private sector and the public. Under A.I.D.'s current bilateral project (the Tunisia Family Planning and Population Development Project), the ONFP has launched a social marketing program, which marks the first efforts in Tunisia to involve the private for-profit sector in family planning and to transfer costs to individual consumers.⁴

1.2.2 Other Donors Supporting Family Planning in Tunisia

Two other donors have also played important roles in Tunisia. The United Nations Population Fund (UNFPA) has provided valuable support for a broad range of population and family planning activities. The World Bank has also provided important support to help the GOT develop its integrated health delivery system, including family planning.

Two other international donors have provided more limited assistance. The World Health Organization (WHO) has extended valuable support in the area of research. The International Planned Parenthood Federation (IPPF) has its regional office in Tunis and provides support for the program of its local affiliate, the Tunisia Family Planning Association (ATPF).

A.I.D. is the only bilateral donor supporting population-related activities in Tunisia. Other international organizations are virtually all A.I.D.-supported cooperating agencies, through which A.I.D. provides technical assistance: the Association for Voluntary Surgical Contraception (AVSC), Family Planning International Assistance (FPIA), the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), The Population Council, RONCO Consulting Corporation, and Save the Children Federation.⁵

1.2.3 A.I.D.-GOT Funding Shares Now Reversed

In the youth of the Tunisia family planning program, A.I.D. paid the major share of all costs, including provision of free contraceptives. Now, significantly, the A.I.D.-GOT inputs are reversed. The GOT currently meets 73 percent of direct program costs and nearly 90 percent

³Elizabeth Maguire and Melvyn Thorne. *GOT/USAID Mid-Term Evaluation of the Tunisian Family Planning Program, 1980*. Washington, D.C.: American Public Health Association, 1980. Shelley Ross-Larson, Effat Ramadan, Charles Tilquim, and Josep Ma Via-Redons. *Midterm Evaluation of Tunisia Family Planning and Population Development Project, 1988*. Arlington, VA: Population Technical Assistance Project, 1989.

⁴The Tunisia Family Planning and Population Development Project (No. 664-0331) was to run for a four-year period, August 1985 to June 1989, with a total USAID grant of \$7.7 million (of which \$725,000 was for diarrheal disease management). The project is being implemented by the RONCO Consulting Corporation under a contract for \$3.012 million. An 18-month extension added \$500,000 and extended the project completion date to December 31, 1990.

⁵United Nations Population Fund, *Inventory of Population Projects in Developing Countries Around the World 1987/88*, 1989, pp 577-581.

of overall costs.⁶ Consistent with the priority the Tunisia government places on a demographic balance for economic growth, the amount of its contribution to program financing has increased steadily over the years while A.I.D. subsidization has decreased proportionately (see Figure 1).

Further, the ONFP is beginning to assume partial financial responsibility for purchasing contraceptives used in Tunisia. As of 1990, the ONFP will pay for contraceptives USAID used to finance. As in all other countries accustomed for many years to receiving free donor-provided contraceptives, this was not an easy step to take. The ONFP is now prepared, however, to take on this cost and logistics burden and is trying to determine how to do so in the most cost-efficient manner.

During the past quarter century, A.I.D. has developed a very close and warm relationship with the GOT through its collaborative partnership in the area of population and family planning. A.I.D. and the GOT stand poised now to begin an important new phase in this partnership.

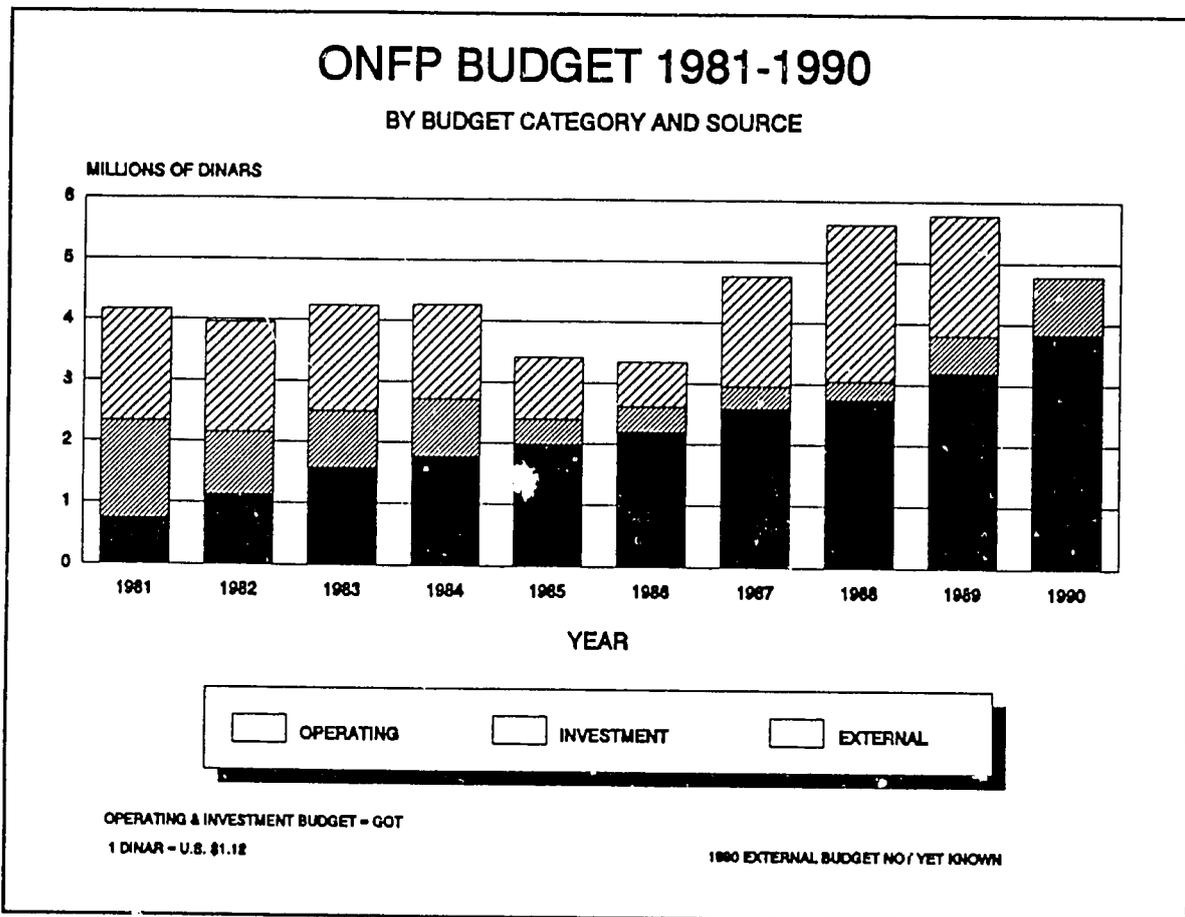


Figure 1 - Evolution of ONFP Budget

⁶Overall costs include both direct and indirect costs. Direct costs include the salaries of MOPH personnel assigned to the ONFP. Indirect costs are for such things as MOPH facilities, transport, and supplies, as well as MOPH personnel involved in family planning service delivery, who are paid by the MOPH.

Note that the budgetary data included in Figure 1 pertain to direct costs only. Indirect costs are not included (see footnote 6). When direct and indirect costs are taken together, the GOT's share of the overall cost of the national family planning program, as noted, is approximately 90 percent.

The ONFP operating budget and investment budget are provided by the GOT. The operating budget (also known as "title 1") includes expenditures for personnel and supplies. The investment budget ("title 2") includes capital costs (e.g., buildings and vehicles). "External budget" includes all donor funds. Figures are not readily available to compare donor contributions over time.

In 1990 the ONFP succeeded in obtaining very significant budget increases from the GOT over 1989 levels. It received an increase in its operating budget of 19.8 percent and an increase in its investment budget of 57.5 percent, and this at a time of considerable GOT austerity due to overall budgetary constraints.

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2. Tunisia and A.I.D. Policy Goals: The Challenge Ahead

2. Tunisia and A.I.D. Policy Goals: The Challenge Ahead

2.1 Population Growth, Unemployment, and Economic Reform

Although Tunisia now has the highest level of contraceptive use in the Near East, the job is by no means done. With an annual growth rate of 2.4 percent, Tunisia still suffers from a burgeoning population. With nearly 60 percent of the population under the age of 25, rapid population growth is expected to continue over at least the next 10 to 15 years. Major challenges thus remain, both at the macro level, in terms of the constraints that population increase will continue to place on economic growth, and at the level of family planning service provision.

2.1.1 Unemployment

Despite relatively rapid economic growth during earlier decades, Tunisia's endemic employment problem has worsened in recent years (see Table 1, below). This is due both to a decline in economic growth and the virtual halt in emigration of Tunisia labor to Europe and to other Arab countries. Unemployment is high and threatens to remain so, given the youthfulness of the population. Over 380,000 of Tunisia's 2.4 million labor force participants were unemployed in 1989, with an open unemployment rate of 16.2 percent. The unemployed tend to be young, mostly uneducated, largely urban, and without work for extremely long periods of time. The underemployed (those working less than six months), although not reported in the 1989 sample survey, made up an estimated 27 percent of the employed labor force in the 1984 census. Underemployment is likely to have worsened since then, given the trends in open unemployment.

The youth unemployment rate (ages 15-24) in 1989 was over 30 percent and it constituted over half (54 percent) of the total unemployed. The female unemployment rate rose to a record level of 21 percent, double the 1984 level. Although unemployment rates in urban and rural areas have largely equalized since 1975, this has been of small comfort since the convergence was at the expense of significantly higher urban unemployment. Two out of every three persons unemployed were located in urban areas in 1989.

There are ominous signs that the unemployment problem has deepened since 1984. Higher unemployment rates now extend to older, prime working-age adults (ages 25-44), and the average duration of unemployment has significantly increased, with at least 41 percent (perhaps as many as 58 percent) of the unemployed without work for two years or longer. Even for the hard-core working-age group of 18-59, the unemployment rate rose from 13.1 percent to 15.3 percent between 1984 and 1989. Unemployment is not only an economic but also a major political concern given the threat to stability that a large unemployed population poses.

2.1.2 Demographic and Family Planning Challenges

In many ways, the challenges of the decade ahead are considerably more difficult than in the past, both programmatically and financially, for family planning service delivery. There remains a large unmet demand for family planning services and also a high level of ineffective use. Quantitatively, the total number of couples to be provided with family planning services will be much greater in the next decade than during the past two decades, in part a consequence of the large number of women just reaching childbearing age (see Figure 2, below).

Table 1

Evolution of Population, Employment, and Unemployment in Tunisia, by Governorate 1984-1989

GOUVERNORATS	----Population----		-Growth Rate-		---Labor Force Participation 15+---				---Employed 15+---		-----Unemployed 18-59-----			
	----(000)----		----(%)----		----(000)----		----(%)----		----(000)----		----(%)----			
	1984	1989	75-04	04-09	1984	1989	1984	1989	1984	1989	1984	1989	1984	1989
Tunis	774.4	815.8	1.2	1.0	277.0	275.6	52.4	48.3	233.9	225.8	32.3	45.3	12.8	17.6
Ariana	374.2	517.8	6.9	6.3	120.2	161.7	52.4	50.7	104.0	134.0	11.3	22.7	10.5	15.6
Jen Arous	246.1	297.1	5.5	3.6	84.0	102.7	52.7	52.4	71.0	85.8	9.4	15.3	12.3	15.9
DIST. TUNIS	1,394.7	1,630.7	3.2	3.0	481.2	540.0	52.7	49.5	408.9	445.6	53.0	83.3	12.2	16.7
Habeul	461.4	520.8	2.5	2.3	152.1	168.7	53.4	51.7	136.0	147.9	10.6	16.8	8.0	11.3
Zaghuan	118.7	127.9	2.1	1.4	30.0	35.7	54.1	46.6	32.3	29.6	3.8	4.6	11.6	15.8
Bizerte	394.7	439.6	1.5	2.1	125.8	138.8	51.3	49.0	101.6	113.9	17.7	21.2	16.0	17.6
NORTH EAST	974.8	1,088.3	2.1	2.1	315.9	343.2	52.9	50.0	269.9	291.4	32.1	42.6	11.7	14.3
Sousse	322.5	300.3	2.7	3.2	100.0	126.9	50.0	52.8	85.6	105.8	9.9	16.9	11.2	15.3
Monastir	278.5	320.1	2.5	2.7	88.2	110.0	51.1	54.6	74.9	100.4	8.8	8.0	11.6	8.3
Madhia	270.4	305.0	2.4	2.3	83.6	88.2	52.0	48.1	71.7	77.2	7.2	8.5	10.3	11.6
CENTRAL EAST	871.4	1,005.4	2.5	2.8	271.8	325.1	51.0	52.2	232.2	283.4	25.9	33.4	11.5	11.9
SFAX	578.0	651.1	2.2	2.3	173.8	200.3	47.8	48.4	152.6	175.8	15.1	20.0	9.8	11.3
Gabes	240.0	270.1	2.9	2.3	66.8	78.4	44.0	49.2	53.6	67.9	9.1	8.5	15.7	12.8
Medenine	295.9	340.3	3.3	2.7	72.8	81.0	44.7	41.4	64.9	70.6	5.1	7.9	8.2	11.7
Tataouine	100.3	115.2	3.6	2.7	24.7	22.5	45.6	37.1	21.7	20.3	2.0	1.8	9.6	9.1
SOUTH EAST	626.2	725.6	3.2	2.5	164.3	181.9	45.6	43.7	140.2	158.8	16.2	18.2	11.5	11.9
TOTAL EAST	4,455.1	5,101.1	...	2.6	1,407.0	1,590.5	50.7	49.2	1,203.8	1,355.0	142.3	197.5	11.5	11.5
Beja	274.7	295.8	1.1	1.4	90.0	100.1	52.9	51.8	72.7	86.5	11.8	11.8	15.2	13.6
Jendouba	359.4	396.5	2.0	1.9	114.2	106.3	52.0	42.7	81.3	81.8	23.2	20.0	23.7	21.0
Le Kef	247.7	266.4	0.7	1.4	75.0	69.2	45.9	40.2	57.7	56.3	12.2	11.0	19.1	18.5
Silliana	222.0	239.6	1.6	1.5	65.6	66.9	51.1	45.7	52.1	50.9	9.2	12.3	16.5	22.2
NORTH WEST	1,103.8	1,198.3	1.4	1.6	341.8	342.5	51.7	45.0	263.8	275.5	56.4	55.1	19.1	18.7
Kairouan	421.6	479.3	2.5	2.5	122.6	143.6	51.8	52.3	105.6	122.0	11.3	16.9	10.9	14.0
Kasserine	298.0	345.7	2.5	2.9	82.2	79.8	50.6	41.6	65.9	64.5	11.9	12.3	16.9	19.3
Sidi Bouzid	288.5	328.8	3.1	2.5	77.3	100.7	49.6	54.0	64.2	81.8	9.1	14.0	13.8	17.8
CENTRAL WEST	1,008.1	1,153.8	2.7	2.6	282.1	324.1	51.0	49.6	235.7	268.3	32.3	44.0	13.5	16.2
Gafsa	235.7	270.1	2.7	2.6	60.9	63.0	45.5	40.1	47.0	45.2	10.0	15.5	18.4	26.9
Tozeur	67.9	75.1	2.	1.9	19.1	19.4	46.0	42.5	16.2	16.2	1.9	2.5	11.7	14.8
Kebili	95.7	111.2	3.	3.0	23.3	21.1	44.7	34.4	19.9	18.6	2.3	2.0	11.6	11.1
SOUTH WEST	399.3	456.4	2.	2.6	103.3	103.5	45.7	39.2	83.1	80.0	14.2	20.0	15.7	21.6
TOTAL WEST	2,511.2	2,808.5	...	2.2	730.2	770.1	50.4	45.9	582.6	623.8	102.9	119.1	16.5	18.1
All TUNISIA	6,966.3	7,909.6	2.5	2.4	2,137.2	2,360.6	50.5	48.1	1,786.4	1,978.8	245.2	316.6	13.1	15.3

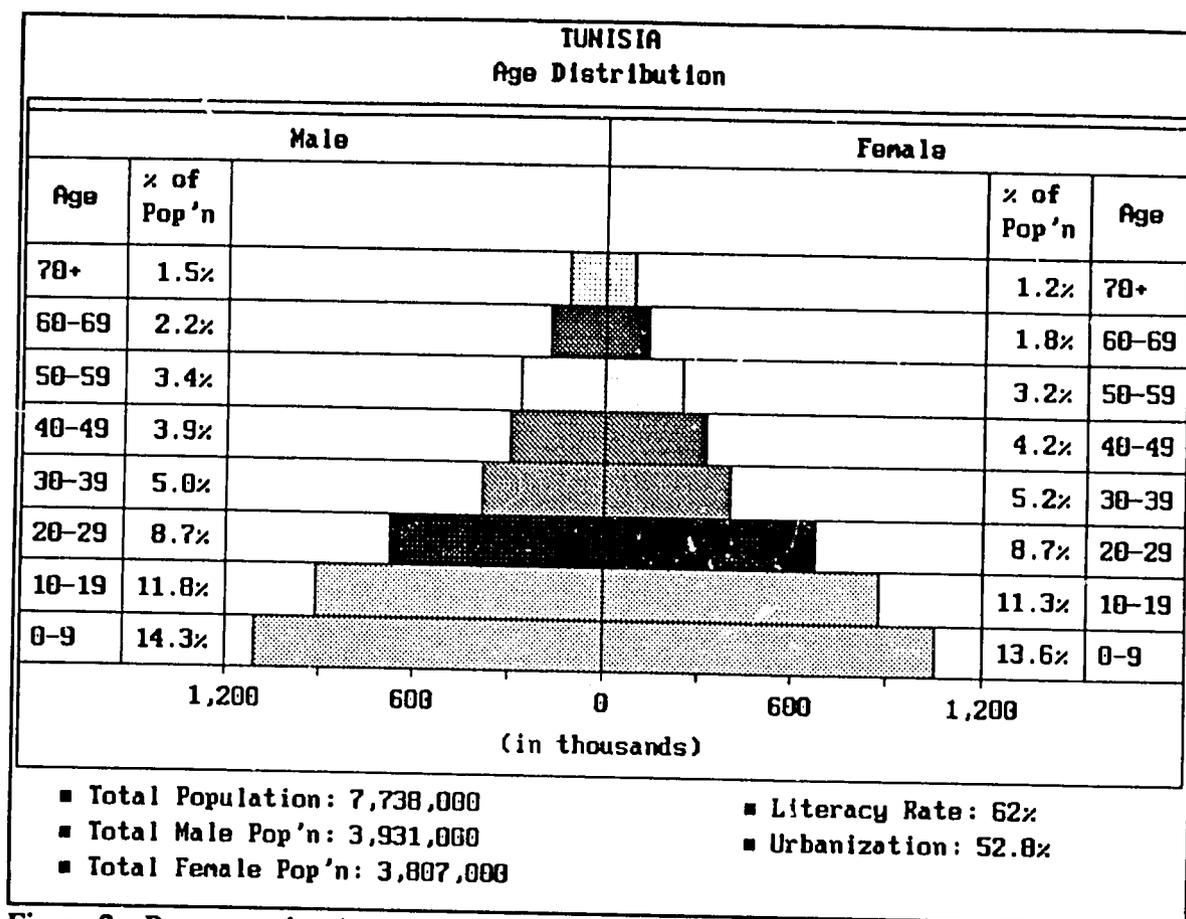


Figure 2 - Representative Age Pyramid for Tunisia

To meet demographic goals, the number of contraceptive users will have to double by the year 2000. To achieve this it will be necessary to proceed promptly with program restructuring, cost-containment, and privatization measures that are now just in their infancy. Although the Tunisia population is becoming increasingly more urban, one quarter of the population continues to live in hard-to-serve rural areas, where contraceptive use remains low. A continuing challenge throughout the 1990s will be to increase prevalence in these areas while seeking to reduce the costs of service provision.

Social and policy changes, such as those that have contributed to improvements in the status of women, have helped lower fertility levels and will continue to do so. Continued vigorous provision of family planning information and services, however, will remain essential for permitting couples to follow through on their desires for child spacing and smaller families.

2.2 GOT and A.I.D. Strategy for the 1990s

2.2.1 GOT Program and Priorities for the 1990s

The GOT is in the midst of a difficult five-year structural adjustment program initiated in 1986, when the government was on the brink of insolvency. An objective is to transform Tunisia's economy from one which is state controlled into a private-led economy. Specifically, the government's strategy is to transform the economy into a dynamic market-driven,

export-oriented economy able to provide jobs at home and compete effectively abroad, both within a Maghreb economic union and vis-a-vis an integrated European Economic Community after 1992.

Such massive transformation is not easy. Much remains to be done to implement the reforms and spur sustainable economic growth. The adjustment program thus cannot be accomplished within only five years. Realistically, it will require another eight years or more to complete a comprehensive adjustment program. Thus, in 1992 Tunisia will enter a second and more difficult phase of economic transformation. This will be the focus of the GOT's Eighth Plan period, covering the years 1992-1996. Shifting from a state-controlled, import-substituting economy to a private-led outward-looking one will call for new approaches, new skills, new attitudes, new capacities, new technologies, and new institutions -- along with stepped-up private investment. Although Tunisia ranks as a middle-income developing country in terms of per capita income, so long as these gaps remain, it can only aspire to becoming an advanced developing country.

As USAID/Tunis has recognized, structural adjustment is a high-risk, fragile process.⁷ Restructuring of the economy inevitably causes stresses, strains, and negative impacts on the more vulnerable lower income groups. Negative impacts will also occur for formerly protected industries and the 25 percent of the labor force that has depended on public sector employment.

As noted, unemployment is not only an economic concern. It is also a political concern. November 1987 marked a turning point in recent Tunisia history. Since the mid-1980s, Tunisia had faced a serious economic downturn, growing unemployment, and a government in paralysis. The peaceful assumption of power in 1987 by Prime Minister Zine El Abidine Ben Ali generated renewed hopes.

During the structural adjustment process, however, the new government of President Ben Ali remains vulnerable, given the significant proportion of the population that will be displaced from work or suffer other adverse changes in social and economic status. The government will continue to remain vulnerable until such time as the economic benefits begin to outpace the social costs of reform. This will take time. A related concern is the fact that, among Tunisia's neighbors and throughout the Near East, unemployment is a major contributor to Islamic fundamentalism. This is a force that remains an omnipresent threat in Tunisia, too. Employment thus is the foremost challenge facing the country as it enters the 1990s. For most Tunisians, jobs will be the measure of success.

The GOT's political commitment to reduction of population growth is clearly linked to concern about employment issues. Commitment to family planning remains firm from the presidential level on down. The interrelations between population change and all sectors of the economy are reflected in current development plans and are certain to figure importantly in the Eighth Plan.

2.2.2 USAID/Tunis Strategy for the 1990s

The USAID/Tunis strategy for the 1990s seeks to support measures being taken by the GOT in the areas indicated above. The mission has proposed a new assistance strategy for 1992-1996 which aims at sustainable growth and employment. At the base of this strategy is an "improved match of labor supply and skills with market demand."⁸ This is central in the mission's 1990 *Action Management Plan*.

⁷USAID/Tunis. *Tunisia: Action Management Plan*. April 1990.

⁸USAID/Tunis. *Tunisia - A Strategic Option for the '90s*. February 28, 1989, p. 2.

2.2.3 Safeguarding A.I.D. and GOT Investment to Date

It is evident that achievement of USAID objectives will depend greatly on continued progress in lowering fertility rates. To suggest that efforts to reduce population growth are no longer needed would be shortsighted. Fortunately, USAID/Tunis has indicated its intent to continue work on reducing the long-term size of the labor force through investment in the national population program, at least during the critical transition period of the early 1990s.

Continued investment in achieving a population balance is in fact essential to safeguarding all A.I.D. investment, past and present, in Tunisia. Given the priority the GOT places on achieving this balance, for A.I.D. to retain influence in Tunisia, it must also consider this a high priority.

**3. Family Planning Program Objectives and Strategies:
The 1990s**

3. Family Planning Program Objectives and Strategies: The 1990s

3.1 Demographic and Program Targets

As Tunisia positions itself for an intensified effort in family planning during the remaining decade of this century, the country seems determined to maintain its status as the leader in the Arab world and in Africa in terms of demographic and family planning program achievements. Nowhere else on the continent of Africa or in the Middle East have family planning programs yet achieved the level of sophistication and impact they have in Tunisia, nor has political commitment -- at all levels -- been as high and as sustained.

As indicated, however, the challenges ahead may be even more difficult than in the past. This is due to several factors:

- First, Tunisia has chosen very ambitious demographic and program targets (see discussion below).
- Second, moving from relatively high contraceptive prevalence levels (50 percent overall, 40 percent modern methods) to even higher levels is far more difficult than was the job of reaching current levels:
 - "Easy acceptors" have been reached.
 - Urban prevalence is already quite high.
 - Rural prevalence, especially in the Center and the South, will have to be markedly increased in areas where infrastructure is limited and where costs of service delivery are high.
 - The very large number of women moving into peak reproductive years during the 1990s will tax service delivery capabilities.
 - Progressively younger couples will have to become family planning users.
 - Males must be reached with effective motivational programs.
- Third, achievement of the targets will require a reorientation of ONFP activities, in fact, a deliberate restructuring of goals, relationships, and program activities of the ONFP itself. Family planning must evolve from an ONFP monopoly to a full partnership between all appropriate elements of the public and the private sectors. This means that the ONFP, as the lead agency, must evolve from the principal service-providing agency to a self-reliant organization capable of providing effective leadership and technical support to all agencies and individuals involved in family planning in both the public and the private sectors.

Fortunately, the ONFP and the GOT appear to be committed to moving rapidly and effectively in these new directions. It is clear that, given a suitable transition period as described below, these ambitious goals and targets can be achieved.

3.1.1 Demographic Targets

All available evidence suggests that the demographic target for the Seventh Plan period (1987-1991) will be met and may be significantly surpassed. The goal was to reduce the

number of births in 1991 from an expected level of 277,000 to no more than 240,000 births. In fact, it appears that the number of births has been falling each year since 1986, with the estimated number in 1989 at just over 200,000. This phenomenon (falling numbers of total births) is itself a rarity in the developing world.

Although targets established for the Seventh Plan period extend into the 1990s, no new targets have yet been established for the Eighth Plan period (1992-1996). However, key documents and statements by the ONFP, the Ministry of Plan and Finance, and the Ministry of Public Health indicate that Tunisia is intent on stepping up the pace of demographic transition as an essential prerequisite for economic development, recognizing that the road ahead may be more difficult than ever, taking into consideration the growing number of women of childbearing age.

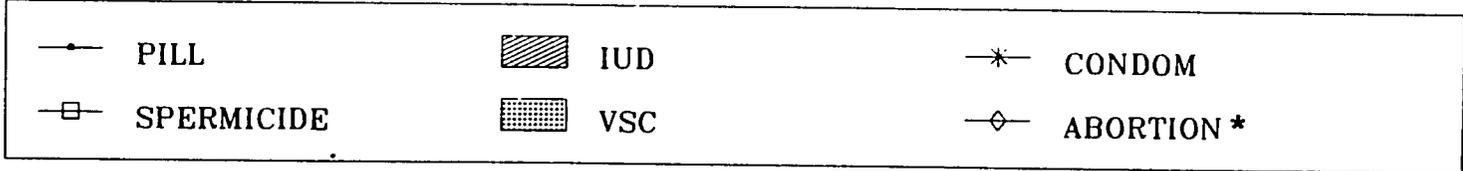
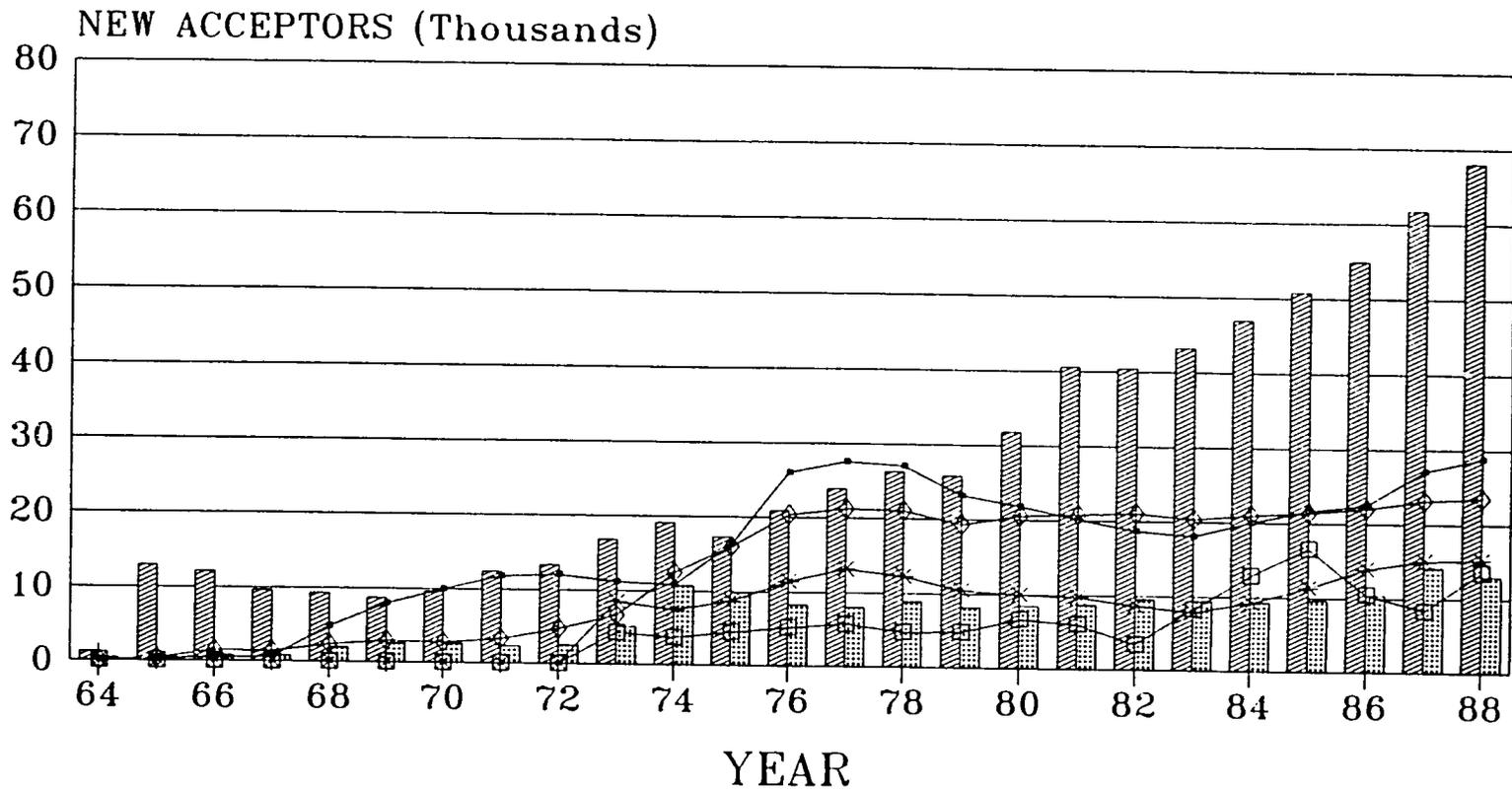
In developing a strategy with respect to meaningful demographic and program targets for the next decade, it is important to take account of past performance of the program and of the current status of affairs. Fortunately, this is not difficult because the Tunisia program has been well studied and documented for many years.

Figures 3 and 4 trace overall ONFP family planning performance for past years in terms of the evolution of numbers of acceptors by method.

YEAR	Method				
	Pill	IUD	Condom	Gelee*	LT**
1964	0	1,154	0	0	293
1965	343	12,832	0	0	384
1966	350	12,077	0	0	766
1967	591	9,657	0	0	742
1968	4,780	9,304	0	0	1,927
1969	7,867	8,696	0	0	2,513
1970	9,959	9,638	0	0	2,539
1971	11,778	12,381	0	0	2,280
1972	12,026	13,250	0	0	2,459
1973	11,194	16,790	8,406	4,237	4,964
1974	10,795	19,084	7,432	3,683	10,757
1975	16,310	17,307	8,678	4,426	9,896
1976	25,987	20,830	11,385	5,100	8,269
1977	27,567	23,879	13,125	5,727	7,987
1978	27,017	26,273	12,304	4,674	8,832
1979	23,108	25,755	10,442	4,736	8,141
1980	21,768	31,792	9,938	6,517	8,460
1981	20,137	40,597	9,694	5,968	8,719
1982	18,707	40,400	8,613	3,384	9,564
1983	18,073	43,234	7,842	8,285	9,319
1984	19,919	47,005	9,168	12,887	9,315
1985	21,550	50,699	11,368	16,579	9,638
1986	22,386	54,891	13,863	10,513	10,394
1987	27,028	61,641	14,975	8,336	14,132
1988	28,731	67,958	15,196	13,542	13,043
Total	387,971	677,124	172,429	118,594	165,333

*Gelee = spermicides **LT = voluntary surgical contraception (VSC)

Figure 3 - ONFP New Acceptor Statistics 1964-1988



*not a family planning method

Figure 4 - ONFP Family Planning Activity, New Acceptors for Period 1964-1988

Figure 5 shows historical changes in Tunisia's population growth rate (RNI, rate of natural increase) since 1921. It can be seen that the rate was generally increasing from 1931 to 1975. Then, the ONFP's program began to reduce fertility sufficiently to offset improvements in the mortality rate, thereby reducing the overall population growth rate.

Although the population growth rate has started to slow, Figure 5 projects overall population growth through 1994. Throughout this period, growth is still above 2 percent per annum, higher than desired by the GOT and higher than is commensurate with the social and economic planning objectives of the country.

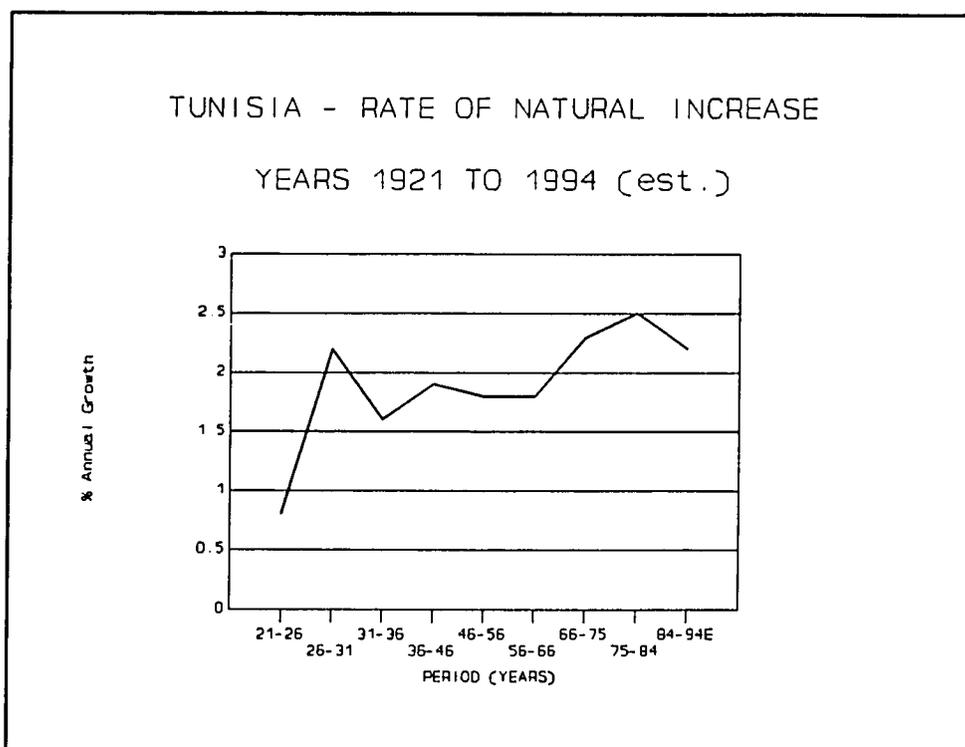


Figure 5 - Historical Population Growth Rate

Source: M'Henni, Hedi, *La Planification Familiale en Tunisie: Hier, Aujourd'hui, et Demain*, Tunis, December 1989.

3.1.2 Total Fertility Rate (TFR) and Cost Implications

Fertility in Tunisia has declined steadily from a TFR of 5.84 in 1978 to 4.3 in 1988. Fertility has declined in all age groups, but the major decline has taken place in the 30-49 age groups. This suggests that the program needs to reach younger couples in the future (see Figure 6, next page).

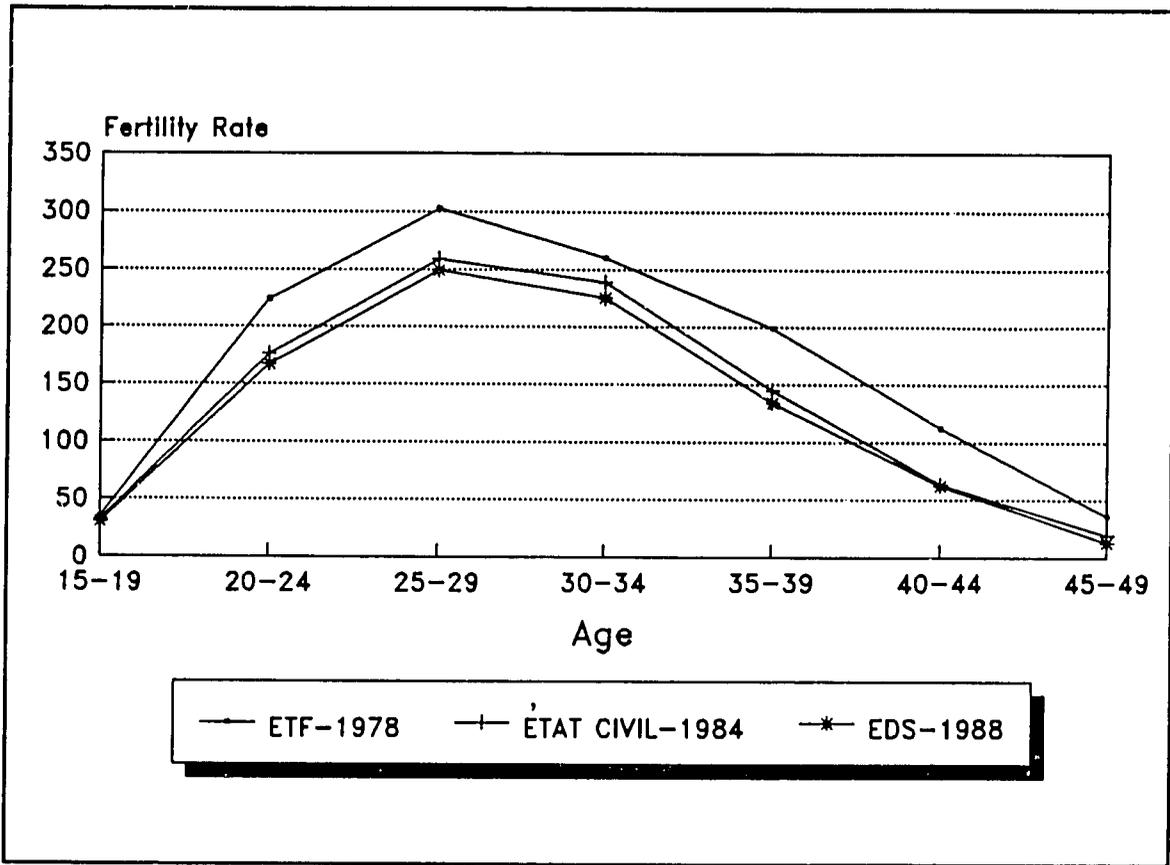


Figure 6 - Changing Age-Specific Fertility Rates According to Three Surveys in Tunisia
Source: Demographic and Health Survey in Tunisia, 1988.

While Tunisia has made considerable progress in lowering fertility, especially in comparison with other Near East and African countries, the TFR is still high. Tunisia still has not reached the lower fertility levels of such countries as Indonesia, Thailand, Sri Lanka, Brazil, Colombia, Mexico, and the Dominican Republic (Figure 7, below).

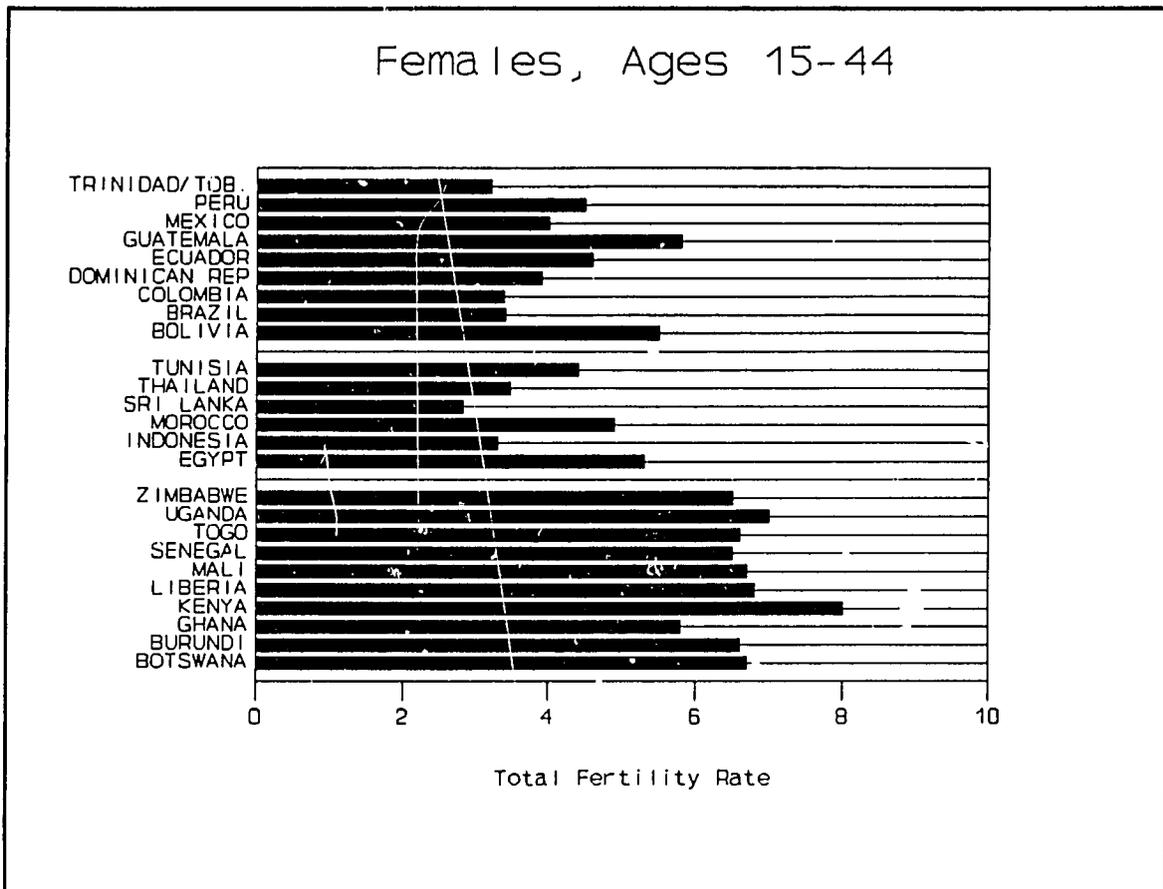


Figure 7 - Comparative Fertility Rates, Selected Countries

Figure 8 provides some clues as to why Tunisia's fertility rate remains high. Although fertility has fallen everywhere in Tunisia since 1966, the most important declines have occurred in the urban and most heavily populated areas, those with greatest access to family planning services. In three major regions, the Center, the Sahel, and the South, fertility decline has been far less rapid, however (see Figure 8, below). These areas contain well over 40 percent of the total population, much of which is rural and often dispersed. People in these regions must be included in the overall program if demographic targets are to be met. This means more outreach, more motivational activities, more service provision, and higher program costs per acceptor.

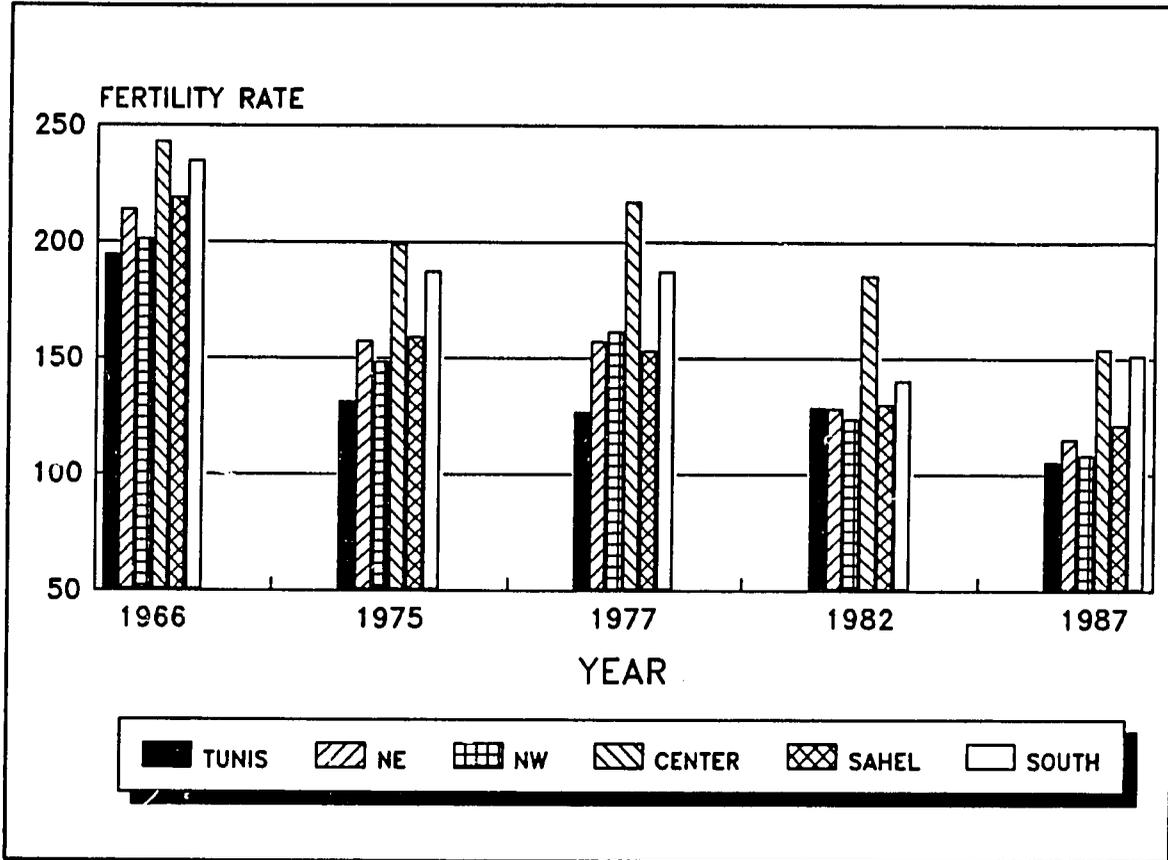


Figure 8 - Tunisian Fertility Decline, by Region (1966-1987)

Source: *Institut National de la Statistique*

3.1.3 Knowledge and Practice

The 1988 Demographic and Health Survey (DHS) results indicate that knowledge of modern contraception is virtually 100 percent throughout the country (Figure 9, below). Practice of contraception (both modern and traditional!), as noted earlier, is almost 50 percent for all methods, and about 40 percent for modern methods (Figure 10, below). This is most impressive and places Tunisia, as noted, ahead of all other countries in Africa and the Near East (Figures 11 and 12, below).

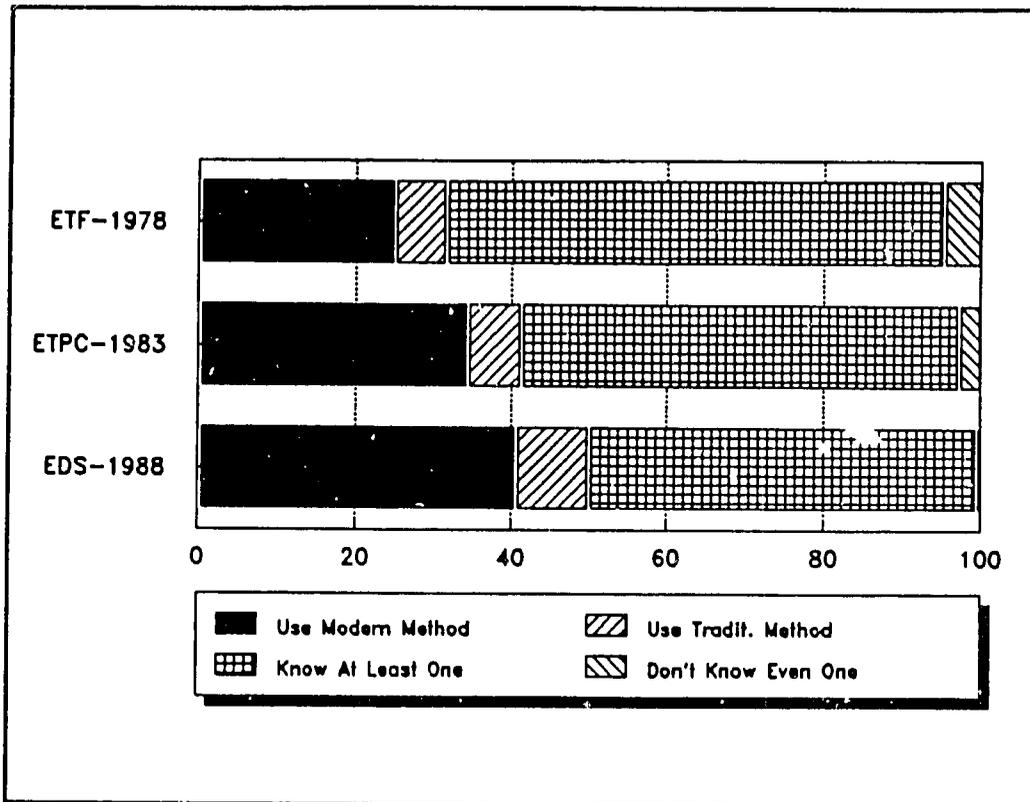


Figure 9 - Contraceptive Knowledge and Use Among Married Women, Tunisia
Source: Demographic and Health Survey in Tunisia, 1988

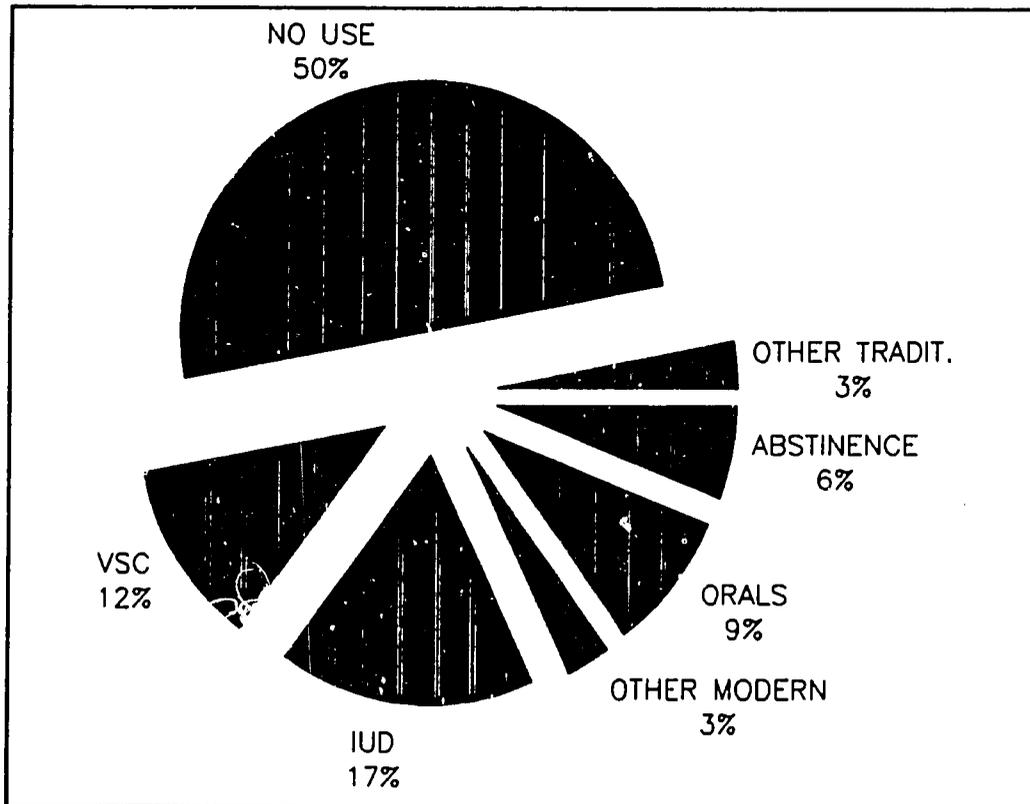


Figure 10 - Current Contraceptive Use, by Method, Tunisia
Source: Demographic and Health Survey in Tunisia, 1988

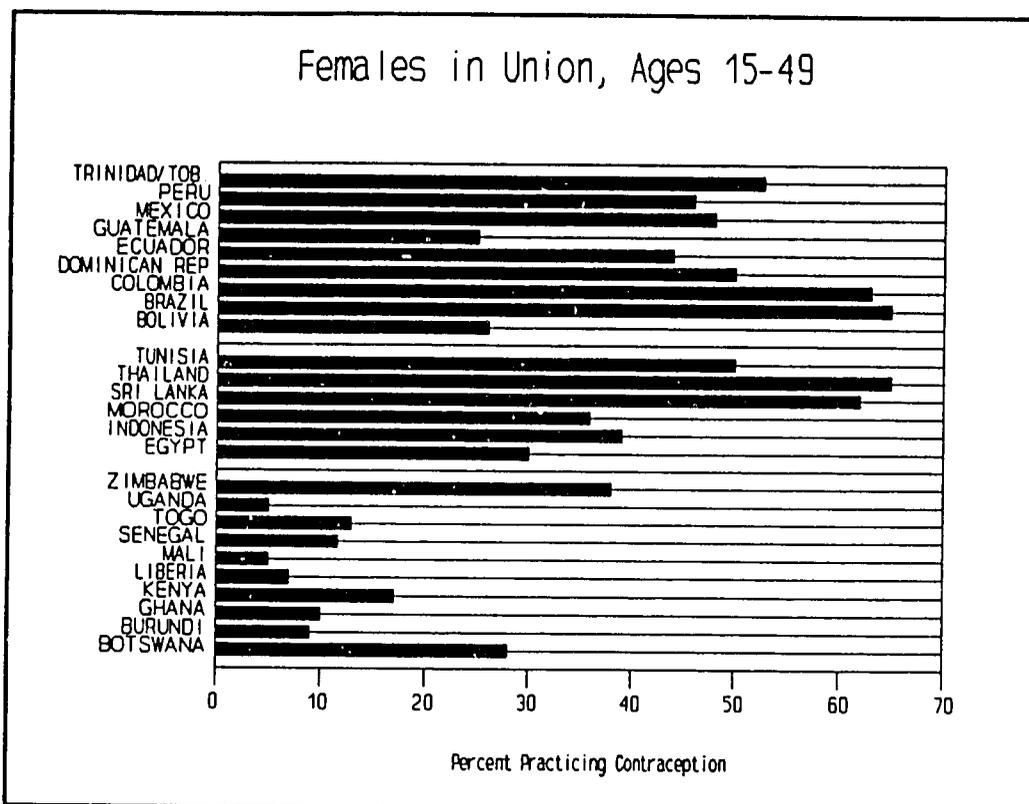


Figure 11 - Comparative Contraceptive Prevalence Levels, Selected Countries

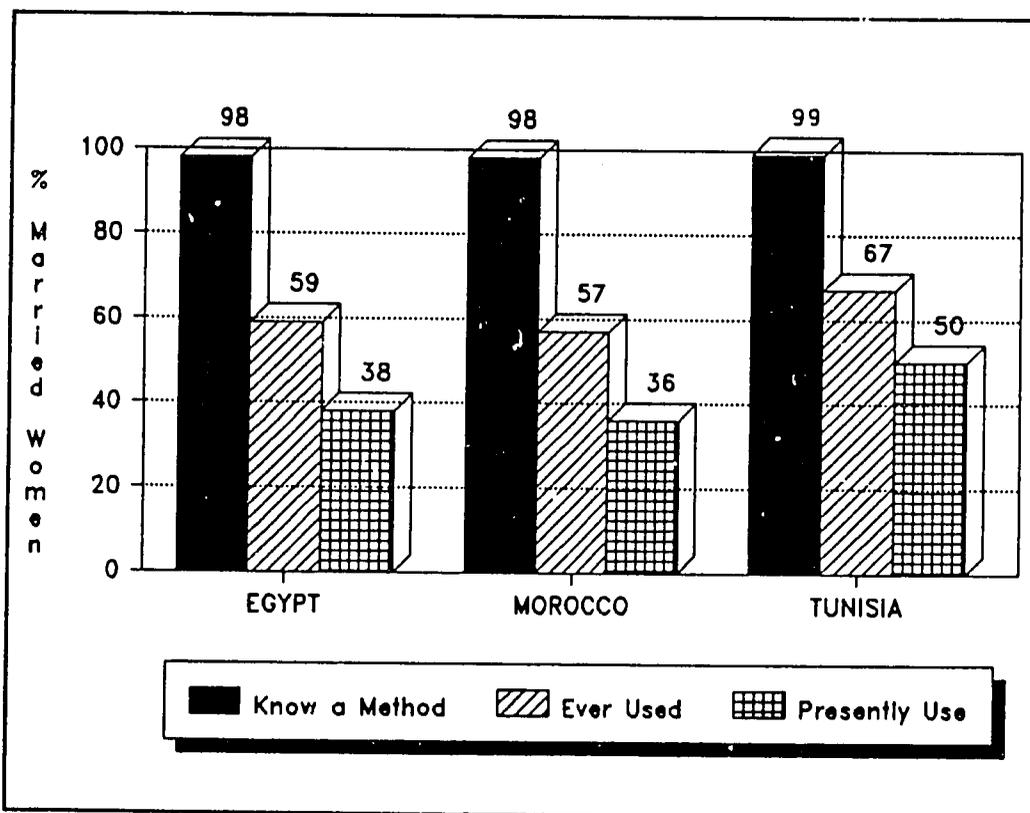


Figure 12 - Contraceptive Knowledge and Use, Egypt, Morocco, Tunisia

There are significant rural-urban differences in level of practice, as well as differences that seemingly are related to level of education (see Figures 13 and 14). This is not surprising. It is disquieting, however, because it is precisely the rural, hard-to-reach population among which the lowest level of schooling is found and among which family planning practice is the lowest. It is also this population that serves as the engine for rural-to-urban migration with its attendant social, economic, and ultimately, political consequences.

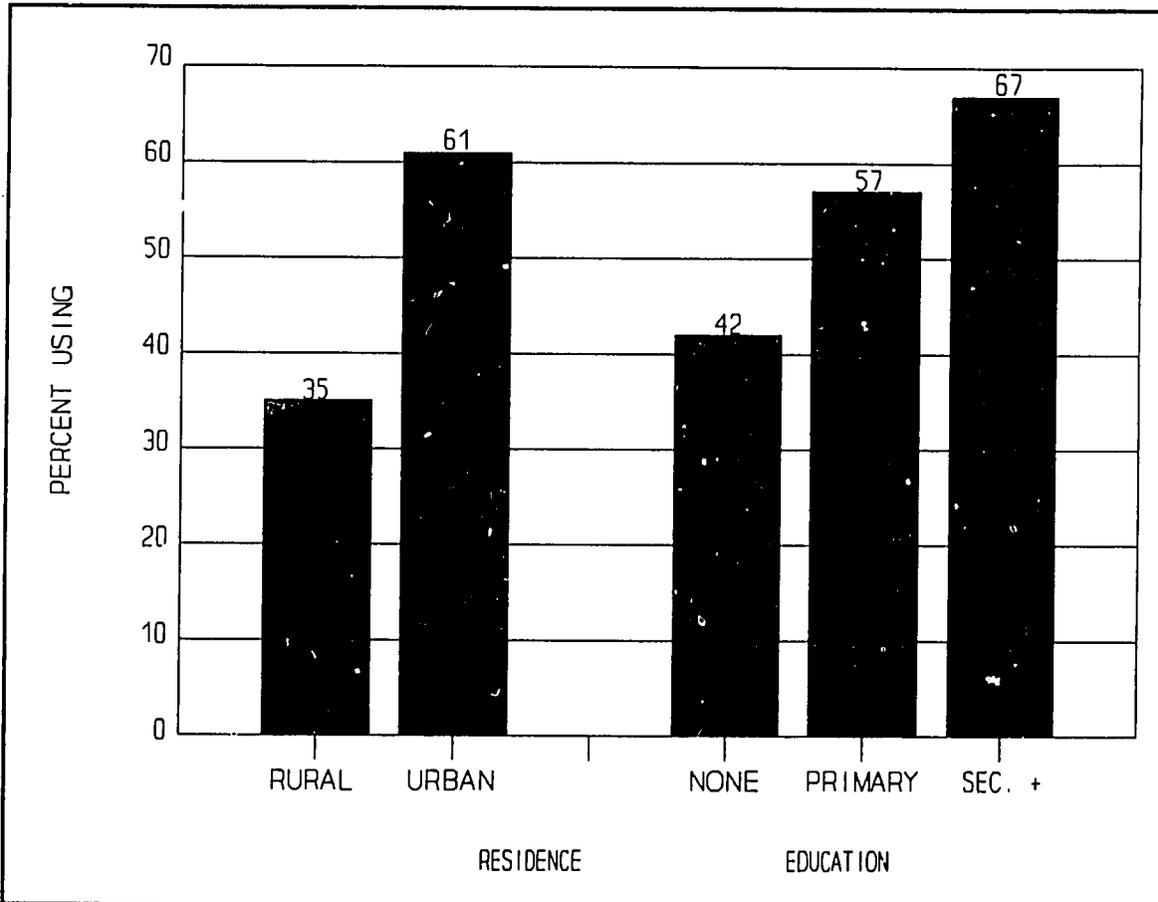


Figure 13 - Residence and Education as Contraceptive Use Factors
Source: Demographic and Health Survey in Tunisia, 1988

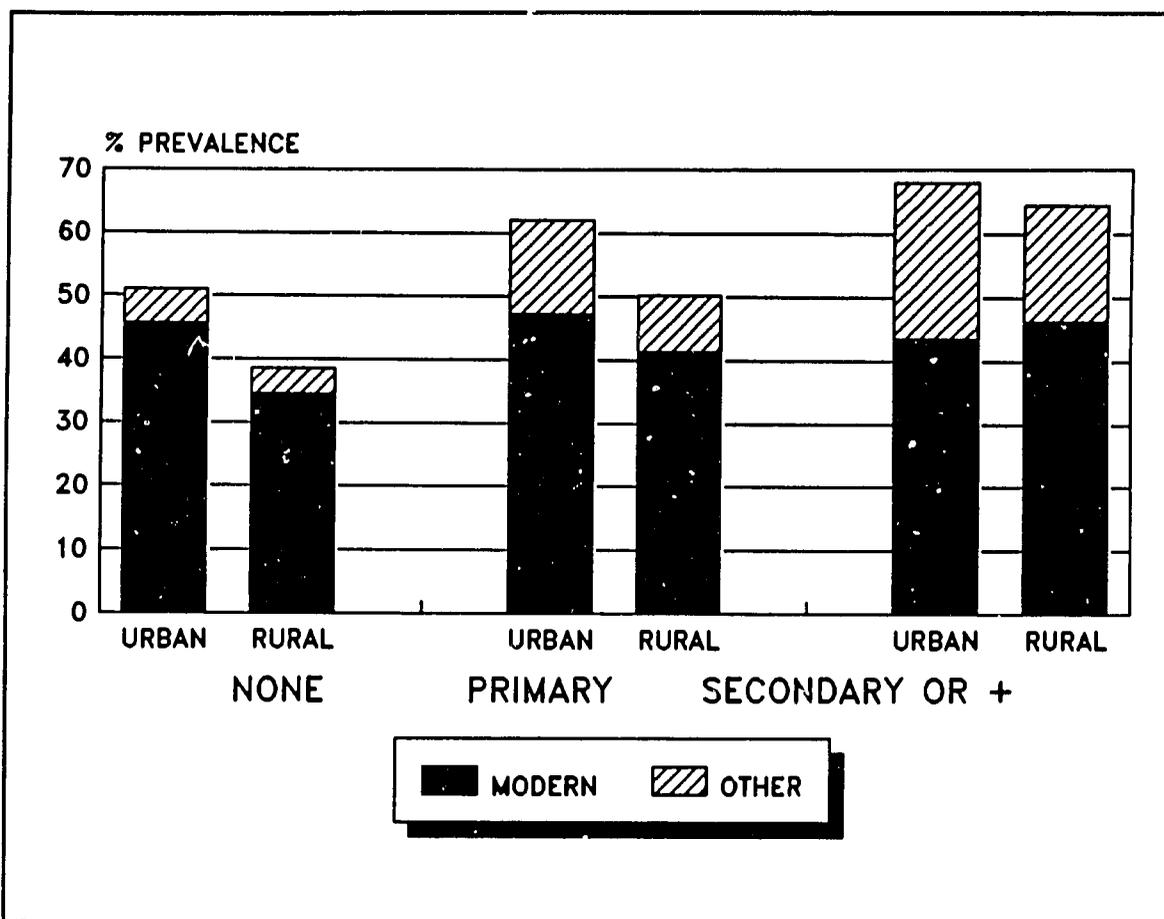


Figure 14 - Residence, Education, and Use of Modern Contraception

Figure 14 also shows that use of non-modern ("other") methods is highest among urban groups. This has important implications for ONFP programming and suggests the need for service-related research and more targeted information, education and communication (IEC) programs.

3.1.4 Demand for Contraception

The DHS results document the existence of a large unmet demand for contraceptive services, despite the existence of a national program for over 20 years (see Figure 15). Eighty-one percent of all Tunisia women in 1988 expressed the desire either to halt childbearing completely (59 percent) or to delay the next birth for at least two years (22 percent).

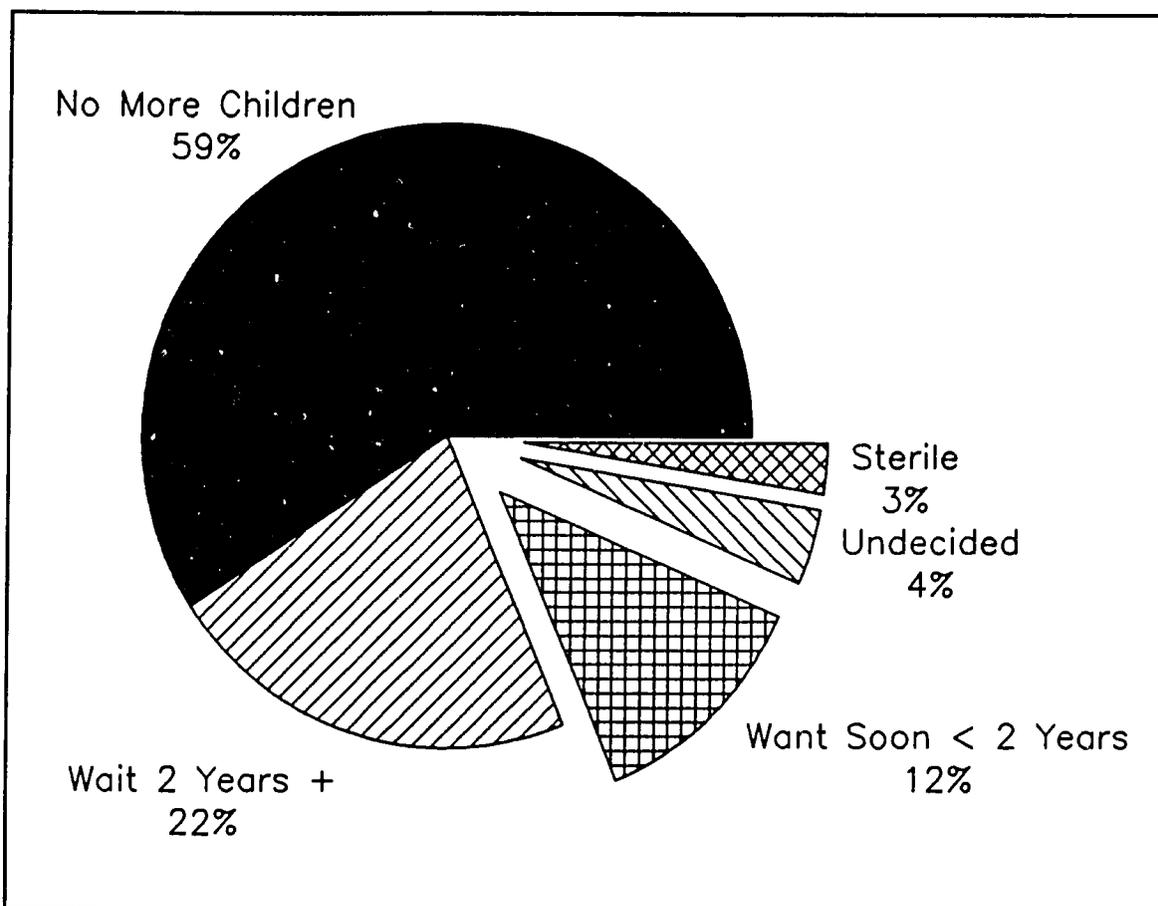


Figure 15 - Desire for Additional Children Among Tunisian Married Women, 1988
Source: Demographic and Health Survey in Tunisia, 1988

The existence of unmet demand is further attested to by the differences between current use of contraceptives and "ever use." Fully 60 percent of married women of reproductive age (MWRA) have used a modern method in the past, but only 40 percent are now using a modern method. This is a high dropout rate. Reasons given for discontinuation suggest that there is a need for better and more specific information pertaining to the use of each method. Clearly, knowledge of a modern method and even use of that method do not constitute adequate knowledge as to how the method should be used or what side effects might be expected.

In addition, demand for contraception will grow dramatically over the next decade as the result of three interrelated factors:

- the large number of women reaching childbearing age (see Figure 2);
- the introduction of new contraceptive methods (e.g., injectables) that have proven elsewhere to be extremely popular; and
- improvements in service availability and service quality and the resulting better "contraceptive use knowledge."

Finally, economic and social phenomena -- including higher educational levels -- will further contribute to increased demand for contraception (both modern and traditional), challenging both the public and the private sectors to keep pace.

3.1.5 Program Implications

In trying to predict the evolution of family planning in Tunisia over the next decade, a computer model developed by The Futures Group proves useful.⁹ This model, based on the work of John Bongaarts, includes both demographic and program information. It attempts to estimate the number of acceptors and users required to reach a chosen demographic target and the associated contraceptive inputs (and therefore the cost). Results are given by year, by contraceptive method, and by public and private sector activity.

For illustrative purposes we have chosen an ambitious, but not unreasonable goal: a total fertility rate of 2.5 by the year 2005, which represents a decline of 1.9 points over a 15-year period. We emphasize that this is illustrative only, because official GOT targets are still under discussion. The computer model has been given to the ONFP as an aid to its planning for the Eighth Plan and beyond.

In using the model, we built in the following assumptions:

- The private sector will play a much greater role in service delivery.
- Injectable contraceptives (a new monthly injectable, distinct from Depro Provera) will be very popular and will be widely available through the public and private sectors within two to three years.
- As the program moves to attract younger couples, nonclinical and other temporary methods (especially injectables) will gain a greater share of the market.
- IUDs and sterilization will represent a slightly lower percentage of the overall contraceptive mix, though their numbers will remain high.
- Vasectomy will begin to gain popularity, but very slowly.

The model yields detailed estimates, by year, for the years 1988 through 2005. For illustrative purposes, in the following paragraphs we have chosen two years, 1989 and 2000. The results are striking:

⁹Monique Barrere, *Niveau de Prévalence Contraceptive Requis pour la Poursuite de la Baisse de la Fécondité en Tunisie: 1988-2005 (Tableaux) et Niveau de Prévalence Contraceptive Requis pour la Poursuite de la Baisse de la Fécondité en Tunisie: 1988-2005*, The Futures Group, Washington, D.C., 1990.

<u>All Tunisia</u>	<u>1989</u>	<u>2000</u>
% MWRA contracepting	51.3	65.4
# users all methods	562,500	976,000
% MWRA using injectables	0.8	9.3
# users of injectables	9,000	139,000
# new acceptors of injectables	3,700	42,300
# acceptors of orals	31,900	44,300
# cycles of orals required	1,378,500	1,903,200

The results of the model for the private sector alone are very impressive:

<u>Private Sector</u>	<u>1989</u>	<u>2000</u>
% MWRA contracepting	16.3	24.8
# users in private sector	179,200	370,500
# IUD new acceptors	11,500	31,600
# IUD users in private sector	24,600	102,400

The figures above are illustrative of the greatly increased level of activity required, particularly in the private sector, to reach the demographic target (TFR of 2.5 by the year 2005) chosen for this exercise. Achieving results of this magnitude will require carefully formulated strategies and purposeful, dynamic implementation over the remaining years of this century.

3.2 Program and Organizational Strategies

To reach the ambitious demographic targets chosen for the Seventh Plan and envisioned for the Eighth Plan, the ONFP has chosen a set of strategies that represent a departure from the past. As noted, the new strategies clearly coincide with, and are directly supportive of, the overall GOT and USAID objectives: revitalization of the private sector, marketable skills development, public/private sector partnership, and sustainable growth with expanded employment opportunities.

3.2.1 ONFP Organizational and Institutional Strategies

The ONFP's strategy is to lower fertility rates through its private sector initiatives, its technical skills transfer to both the private sector and selected elements of the public sector, and through its own metamorphosis during the next 5 to 10 years from a monopolistic service provider to an orchestrator and facilitator of family planning motivation and service delivery activities in the fee-for-service private sector as well as the public sector. Each of the three strategic components

(*les trois grandes lignes* -- private sector, public sector, and ONFP transformation) is described in Section 4.

The ONFP's strategy is truly exciting in that it offers the real prospect of reaching a level of sophistication, impact, self-sustainability and independence -- within a very few years -- that is beyond that of almost all other family planning programs in the developing world.

3.2.2 Program Strategies

Several emphases cut across the ONFP's three strategic components (private sector, public sector, ONFP transformation):

- Concentration on the underserved population --
 - young married couples,
 - peri-urban poor,
 - rural couples, especially in the Center, West, and South, and
 - males.
- Improved quality of services through technical skills transfer to the private sector and to the MOPH.
- Greatly expanded number of service delivery points, using private sector and MOPH facilities.
- Expanded and more balanced method mix (introduction of injectables, expansion of NORPLANT® use, more emphasis on oral contraceptives).
- Self-reliance in contraceptive procurement and logistics management.
- Improved management and cost-effectiveness.
- Cost recovery and self-sustainability.

The importance of these themes and their meaning in the context of each major program strategy are discussed in the following sections.

**4. From Monopoly to Coordination with Partners:
Three Strategic Components**

4. From Monopoly to Coordination with Partners: Three Strategic Components

Within the next 5 to 10 years the ONFP plans to move out of service delivery activities (with the exception of the CREPFs as family planning centers of excellence, research, and specialized training and technical activities), turning the job over to the paying private sector and to the Ministry of Public Health, which will expand the provision of family planning services through its extensive health infrastructure. The goal is to improve the ONFP's capabilities to achieve a more efficient and more effective overall program.

To accomplish this the ONFP has defined a three-part strategy:

- (1) transfer many of its responsibilities to the private sector,
- (2) integrate family planning services into the public health infrastructure, and
- (3) transform the ONFP structure itself in order to assume a new role as a self-sufficient coordinator ("orchestrator") of actions in family planning rather than being a service delivery organization.

By this means the ONFP will be able to liberate financial and other resources from certain current programs and to redirect them to underserved geographic areas and population sectors. The ONFP has designed the strategy and has already drafted specific action plans in many areas.

After detailed analytic discussions with ONFP staff, the team has developed additional, concrete ideas for implementation of this strategy. These are not presented as separate recommendations but are incorporated below.

4.1 Development of the Private Sector

Almost one-fourth (23.3 percent) of all Tunisians using modern contraceptive methods currently receive services through the private sector. When one considers the number of Tunisians using nonclinical modern methods (pills, condoms, and vaginal spermicides), the proportion served by the private sector is even higher: 60.5 percent (1988 DHS). The ONFP seeks to increase these proportions. It has chosen three areas of the private sector as the primary foci of its efforts: pharmacies, private physicians, and the organized sector.

4.1.1 **Pharmacies and Contraceptive Social Marketing**

The pharmacy sector is well developed in Tunisia and has many years of experience in contraceptive distribution. There are 1,000 pharmacies in the country, which are served by 33 wholesalers, who work with the Central Pharmacy (*Pharmacie Centrale*). Pharmacies provide 46 percent of all nonclinical contraceptives.

For the past few years, the ONFP has implemented, with USAID support, a contraceptive social marketing (CSM) project. CSM has proven a very efficient mechanism for achieving higher prevalence for nonclinical modern contraceptives. Initially the CSM project focused on (1) utilization of mass media to promote family planning, (2) development of a distribution network using established pharmacies as points of purchase for oral contraceptives and condoms, and (3) establishment of realistic prices for contraceptives.

The ONFP was able to air three mass media campaigns for the first time on Tunisian television and radio; contraceptives are now available in almost every pharmacy in the country; and there has been a slow increase in prices, closing the gap between real costs and market prices. The 1988 DHS shows that 48.7 percent of oral contraceptives were provided by pharmacies as well as 47.1 percent of condoms and 58.5 percent of vaginal foaming tablets. If there is a decision to increase prevalence of these methods, the primary effort should be developed through the pharmacies, the distribution channel that serves the most users.

The ONFP will continue its CSM activities as a basic means of developing its private sector strategy. A new phase will be implemented in which activities will be undertaken in the following areas.

- Introduction of new products and development of new markets

About 9 (8.8) percent of married women of reproductive age are currently using oral contraceptives. Pharmacies, as noted, provide almost half (48.7 percent) of these pills. The ONFP's CSM activities will increase efforts in pill distribution. Special emphasis will be given to pharmacies in rural areas. Efforts will also be targeted to young women (among whom use of oral contraceptives is lower than among women over 30 and should be increased).

The ONFP will also develop studies to assess the feasibility of introducing a triphasic oral contraceptive in the commercial market. This product will be introduced at a commercial price and will be targeted to consumers with medium and high incomes.

The Tunisia family planning program will introduce new contraceptives as a means to increase prevalence. The ONFP has been distributing a vaginal spermicide tablet, Conceptrol™, in its programs. This product will also be made available through the commercial sector. Although the use of this method is low, 65.9 percent of all vaginal spermicides (foaming tablets and other) are provided by pharmacies.

Under WHO sponsorship, the ONFP is developing an acceptability study on a monthly injectable. After the study is completed, this product will be introduced in phases over the next several years in all programs, including CSM activities. This injectable shows a very high potential to contribute to the increase of overall contraceptive prevalence. According to many sources, this injectable will be a particularly attractive product in rural areas and among low socioeconomic classes.

The IUD is today the most accepted contraceptive in Tunisia. In 1988, 42.7 percent of Tunisians using modern family planning methods were IUD users. The great majority (88 percent in 1988) of IUD users are served by the public sector, especially by the ONFP system (1988 DHS). To achieve the objective of transferring responsibilities to the private sector, the ONFP will start commercial distribution of the IUD. This will be part of the effort (described below) to transfer family planning services to private physicians.

- Communication strategy

The communication strategy for Tunisian CSM activities was designed to be developed in three phases. The objective of the first phase was to open mass media channels for family planning messages. Three general family planning TV spots were developed and aired and were supported by radio spots and posters, the predominant advertising media. The airing of the TV spots was the first time any kind of advertising appeared on Tunisian television and as such accomplished the basic objective of the CSM communications strategy.

For the second phase, a method-specific campaign was developed and aired. Three method-specific TV spots were produced, complemented by radio spots and posters. These were expected to be highly sensitive and did meet with some adverse reactions among certain opinion leaders, but they were generally well received by the population. The third phase, now on the air, has been developed to meet an ONFP general communication objective: to sensitize men in general as well as parents of potential contraceptive users to the value of family planning.

Until now, communication efforts have been aimed at general ONFP objectives and not at supporting specific social marketing interventions. It is now time to focus a communication effort on providing better specific information to users. For example, the 1988 DHS showed that, when asked about reasons for abandoning the pill as a contraceptive method, over 30 percent of the interviewees gave "method failure" as the reason. This figure does not match the usual method failure statistics for oral contraceptives. Although no additional research has been conducted, it is very possible that one cause for such a high dropout rate for oral contraceptives is incorrect use. This means that a communication effort should be focused on providing better information to users.

The DHS survey also showed that contraceptive prevalence among women under 30 years of age was lower than among older women. Communication interventions in this third campaign will therefore focus on child spacing as a rationale for contraception.

The ONFP will develop its new communication efforts with a social marketing emphasis, taking into account the need for a more consumer-focused approach. Communication interventions will be implemented to address specific audiences on specific issues according to marketing objectives. Special attention will be given to information and education on correct use of the available methods. The campaigns will also concentrate on targeting new market segments, such as young couples and men, and will include information on availability of nonclinical methods in pharmacies. The communication strategy will be consistent with the ONFP's privatization strategy, directing consumers to pharmacies and private sector physicians.

An organizational change is to take place within the ONFP in order to accomplish the outlined tasks. Currently CSM activity management is part of the Communications Division at the ONFP. This means that social marketing is viewed as a part of IEC. However, in order to implement a maximally effective social marketing approach, CSM as a whole must be an independent unit within the ONFP. A social marketing manager with full responsibility for project planning and implementation at all levels will be recruited by the ONFP.

- Pharmacies and distribution strategy

The CSM project will take full advantage of the existing pharmacy network by strengthening cooperation with the pharmacies. Social marketing interventions will include pharmacist training and the development of point-of-purchase promotional materials that will support ONFP's effort to increase contraceptive continuation rates among nonclinical method users. By recognizing the pharmacist and pharmacy clerk's role in providing information to contraceptive users, the CSM project will be able to increase correct use of the products distributed by the commercial sector.

Under the CSM project, the medical detailers (*délégués médicaux*) will be providing additional information and promotional materials to doctors in order to increase private sector prescriptions for nonclinical contraceptives. In all, the distribution strategy will be based on trade promotion as a means of achieving greater private sector participation in delivering family planning services. Special attention will be given to information and education efforts needed for introducing new products.

The distribution strategy will be supervised at two levels: wholesalers and pharmacies. For pharmacy supervision, "mystery shopper" promotions (with emphasis on the quality of

counseling) will be implemented. The ONFP will design and implement a retail audit system to follow up on sales of CSM products to consumers.

- Commodities procurement and price strategy

For the past 25 years the Tunisian family planning program has been distributing donated commodities free of charge, or at a minimal price. It is clear that in order to achieve some degree of self-sufficiency, a program must address commodity and price issues. The ONFP is, in fact, seeking to establish competitive prices for contraceptives and, through its CSM activities, has been able to introduce some increases in the prices of nonclinical contraceptives. It is now putting together a long-term price strategy.

Also as part of its self-sustainability strategy, the ONFP will in 1990 begin purchasing its own contraceptives in the international marketplace. These two lines of action will be coordinated in order to ensure affordable prices for contraceptives while eventually eliminating all subsidies. To achieve this, the ONFP will design and implement procurement mechanisms that will permit the establishment of a price structure according to margin regulations that will maintain contraceptives at an affordable price for most of the population, while reserving some subsidies for the lowest socioeconomic classes.

A plan for collaboration in contraceptive procurement between the ONFP and IPPF is under study by both organizations.¹⁰ This would allow the ONFP to have access to the IPPF contraceptive procurement system, which ensures lower commodity prices for their projects. If the ONFP-IPPF plan does not work out, the Central Pharmacy should be able to find low-price contraceptives from pharmaceutical companies that already support social marketing programs elsewhere. The UNFPA will apparently continue to supply most brands of pills in 1990 and 1991, and some contraceptives in 1992, but the ONFP must develop a longer term procurement plan.

4.1.2 Private Physicians

The ONFP is also developing plans to increase the participation of private physicians in providing family planning information and services. The basic goal is to transfer some responsibility for service delivery to private physicians, enabling them to serve the population that can afford to pay for family planning and thus eliminating nonessential subsidies by the ONFP and the Tunisian government. The ONFP will then be able to focus on underserved areas. Currently, private physicians provide only 8.8 percent of modern contraception; with the exception of gynecologists, their training has not included family planning. The ONFP has developed family planning modules (see below) to be included in the training of future physicians and is examining ways of providing training to physicians already in practice.

The ONFP has identified the various categories of physicians to be involved. It has also identified some actions that could create a real opportunity for private physicians' involvement in family planning. Nevertheless, it will be necessary to define a clearer strategy in this area. The following strategy is proposed.

- Commodities

As with CSM, the price of commodities should be established at a level at which commodity costs, including transportation and distribution costs, are recovered and a normal margin is realized. As the ONFP assumes its role as a coordinator of all family planning activities, the

¹⁰In January 1990, discussions were initiated between ONFP and the Tunisia Family Planning Association, an IPPF affiliate. Subsequently, an arrangement between Family Health Management Services (FHMS), an arm of IPPF/London, has been under discussion for 1990-1991.

organization may for a time retain its role as importer and provider of contraceptives. CSM is proposed as the intervention that will facilitate this process. Contraceptives, including IUDs, will be available in the pharmacies, at "social" prices. The ONFP will determine jointly with the medical and pharmacist associations the regulations concerning prescriptions and other important issues. Ultimately, the ONFP's role will focus on quality control, product selection, and needs forecasting.

- Quality of service

The quality-of-service issue is to be addressed from the outset. This is crucial, especially for IUD insertion. The ONFP, in coordination with the medical associations, will provide training to interested physicians. The ONFP has proposed a plan for this process. Although the plan is being debated, the idea is to develop a self-instructional module to be distributed to interested physicians. They would then have a short practical training, focused on IUD insertion, in selected ONFP facilities and subsequently receive a certificate.

As private family planning services become more available, it is likely that the market will establish its own quality control, provided that sufficient information is available to ensure free and informed choice. To achieve this, the communication strategy must have as one of its major objectives, as stated above, the provision of information on contraceptive methods and their correct use. Printed materials, with simple and complete information on all methods and their correct use, will be made available to pharmacies as well as to doctors.

- Fees and regulations

To prevent abusive practices, the ONFP has presented to the Ministry of Public Health a proposal for regulation and codification of family planning services. This proposal will be followed by a request-for-fee regulation that will establish the maximum fees to be charged in the private sector for family planning services. It will also be important to address at some time the issue of fees to be charged in the public sector. If eventually, fees are charged in the public sector, there would be no need for regulatory procedures, as the public sector would serve as the market regulator. This issue is further discussed below (see Section 4.2). Also, as the issue of prepaid medicine or health insurance is discussed, reimbursement for family planning services will be proposed.

- Inclusion of family planning in medical curricula

The ONFP has developed 13 family planning modules to be included in the medical education curricula of physicians and nurse-midwives as well as social workers. These should be ready in late 1990. This will ensure that new practitioners have the basic knowledge for providing counseling and services in family planning. This will be particularly important for general physicians and pediatricians.

4.1.3 Organized Sector and Work-Based Family Planning

Labor regulations in Tunisia require that every organization with more than 40 employees provide preventive medical care to its employees. The larger companies have work-based medical services; smaller ones in some cases share services and in other cases refer their employees to private practitioners. These work-based medical services (*services de médecine du travail*) currently total 256 and employ 70 full-time practitioners as well as many part-time personnel. This system is supported by enterprise councils (*conseils des entreprises*), in which management and labor are equally represented.

Tunisia's labor force is close to 2.4 million people, of whom 23 percent are women (most of whom are of reproductive age and married). According to current statistics and assuming

that this population lives in urban areas, where prevalence is about 60 percent, there are still 180,000 women who are not contracepting. There are also 1.54 million men in this category. Using the organized sector's medical facilities to provide information, services, and referrals for family planning will thus contribute significantly to meeting ONFP objectives. The proposed actions to integrate family planning into the organized sector's medical facilities include the following:

- The ONFP and the Secretary General for Occupational Health Services (*Direction Générale de la Médecine du Travail*) will, in coordination, present the benefits of family planning to the UTICA (management) and the UGTT (labor) unions. Both will be shown how family planning cuts health care costs.
- For work-based medical services, special emphasis will be given to training in family planning. The objective is to develop a service referral system in which family planning is considered a preventive health measure. Among women, special emphasis will be given to maternal-child health and family planning. The organized sector will also develop activities to involve men in family planning, one of the key objectives of the ONFP for the coming years. The ONFP will coordinate with the enterprise councils and with the Secretary General for Occupational Health Services to develop this program, including training and IEC. The ONFP is planning to train 80 physicians per year by holding two seminars, each for 40 physicians. Ideally, some means will be found to increase this number.
- Work-based health care is a specialization in the Tunisia medical education system, and the ONFP will coordinate with educational authorities to include family planning in the curriculum for this specialization. This will ensure that new practitioners will have basic knowledge on how to provide counseling and services to their clientele.
- ONFP's mobile clinics will visit the work places with a high proportion of female employees to provide family planning services. Information and counseling, however, will be carried out by the medical staff in charge of the workplace.
- Contraceptives will be made available for work-based medical care units at the same price as for wholesalers. It is proposed, however, that all contraceptive distribution take place through commercial channels (pharmacies).

4.1.4 Health Insurance and Reimbursement Systems

Health insurance and reimbursement systems exist in Tunisia. Many employers provide, besides social security, additional health insurance or reimbursement to their employees. The ONFP will develop a public relations effort to convince decision makers in the health insurance sector of the importance and cost-effectiveness of including family planning among the medical services covered by insurance. The basic argument will be that family planning cuts costs in maternal and child care that otherwise must be borne when fertility is high and births are not well spaced.¹¹ Here again the ONFP will support the IEC efforts to be developed. It is important to note that the fee regulation discussed above will contribute to the acceptance of reimbursement by insurance companies.

¹¹The practical experiences of A.I.D.'s Enterprise and TIPPS projects, in Egypt, Zimbabwe, and elsewhere, in seeking to have family planning services covered by health insurance, should be reviewed as a valuable source of lessons learned.

This intervention is expected to have a major impact in stimulating the widespread provision of family planning services by private physicians. As health care costs are reimbursed, users tend to go to private practitioners; except for the high- and middle-income classes, most women will still use the public sector if the alternative is paying the full cost of a private doctor.

4.1.5 Nongovernmental Organizations

In Tunisia there has not been a tradition of nonprofit nongovernmental organizations (NGO) working in social services. There are nevertheless a small number of organizations working in the social and health sectors that could and should contribute more to family planning efforts. There is an IPPF affiliate, the Tunisia Family Planning Association, which receives some support from the ONFP. A second family planning NGO, the Tunisian Society for Fertility and Sterility, has just been created and is planning to initiate some activities. The Union of Tunisian Women (*Union des Femmes Tunisiennes*) is also involved in family planning education and referral. As part of its new strategy of seeking partners for service provision, the ONFP will increase collaboration with these and other NGOs that may become involved in family planning.

The ONFP will also encourage moves by other parts of the GOT to promote development of nonprofit private sector organizations that can play greater roles in provision of social services. Structures do not currently exist in Tunisia, as in many other countries, that encourage NGO activity, but there appears to be some interest in creating incentives to stimulate such activity. Such moves might include the following: restructuring legal and tax systems to encourage formation and growth of not-for-profit foundations, service organizations, and constituency groups; creating or strengthening national umbrella organizations that can organize, support, and finance local NGOs; developing income-generating strategies and assets to finance NGO programs; and seeking support from U.S. and other international PVOs to assist Tunisian counterparts in developing sustainable, independent organizations.¹²

4.2 The Public Sector: Integration

In Tunisia, family planning has been since the beginning a public sector responsibility. The ONFP, created as a vertical program outside the regular structure of the MOPH, is nevertheless a governmental organization under the authority of this ministry. According to the 1988 DHS, 76.7 percent of all contraceptive users, including 97.6 percent of sterilization clients and 89 percent of IUD users, are served by the public sector. Because the GOT is highly committed to family planning, various other ministries also engage in population and family planning activities.

To achieve the GOT's ambitious demographic objectives, the ONFP will give special attention to the full integration of family planning information and services into other appropriate government organizations, particularly the Ministries of Public Health, Education, and Social Affairs. This plan has formally received full support of all the concerned decision makers.

4.2.1 Inclusion of Family Planning as a Priority within Basic Health Services

Although there has always been a close relationship between the MOPH and the ONFP structures, family planning and MOPH services will become more integrated at the service delivery level. The goal is to achieve a more efficient health care structure while also increasing

¹²From the A.I.D. perspective, such moves are all part of the ANE Bureau's current emphasis on democratic pluralism, economic freedom, and social service reform.

contraceptive prevalence. Currently, about half (49.5 percent, according to the 1988 DHS) of modern method users are served by MOPH health units. At present, ONFP mobile teams and clinics provide family planning counseling and services in a portion of the various facilities of the basic health care system (*service des soins de santé de base*).

The basic health care system of the MOPH consists of 1,466 health care centers (fixed facilities). Family planning services and counseling are provided in 240 of these MOPH centers by a permanent team; 800 additional MOPH centers are visited by the mobile teams and mobile clinics of the ONFP. Of the 1,466 centers, 426 do not provide any family planning at all. In addition, there are MOPH mobile nurses (*infirmiers itinérants*), all men, who visit some 2,200 gathering places (*points de rassemblement*) but do not currently provide any family planning services or information. This structure has great potential for the expansion of family planning and could make an important contribution to the extension of family planning to underserved areas. The ONFP has, as a result, developed the following strategy for proceeding with this integration.

- Training

The Training Division at the ONFP has developed a complete training program that will support the integration efforts. Public sector doctors will receive theoretical and practical training in seminars held at the five decentralized training centers of the ONFP. The training modules have been developed. This training program will reach an estimated 70 doctors per year.

- Basic education of health personnel

Since 1989, nurse-midwives have received family planning training as part of their college curriculum. The ONFP has now developed family planning modules for physicians to be included in the curriculum of medical schools, as described. This will ensure that new practitioners in the public as well as in the private sector will be better able to offer family planning services and counseling.

With well-trained personnel, family planning service delivery responsibilities will be progressively transferred from the ONFP to the existing MOPH system. The MOPH facilities and mobile nurses serve many rural areas, where availability of family planning services will contribute to increasing rural prevalence in years to come. This will enable the health structure to increase coverage while utilizing more efficiently the existing structures, thus making possible a more extended program with little cost increase.

Two types of health care providers will play a key role in this process -- the nurse-midwives and the mobile male nurses. Nurse-midwives have always been crucial to family planning programs in Tunisia and if they receive strong support from the MOPH structure, their participation will increase.

As for the mobile male nurses, there is still a cultural constraint against their providing family planning counseling and services, especially because IUDs are one of the principal methods. It is expected that with the introduction of an injectable contraceptive, these male nurses will be able to play an important role in the extension of family planning, especially in underserved rural areas, where their presence is reflected in the very high vaccination coverage, their principal responsibility. To support these developments, the ONFP will complete acceptability studies on the new monthly injectable, with the support of WHO, and make it available in rural areas in a phased plan beginning in 1990. The only additional cost for this intervention will be that of the commodities, which can nevertheless be a significant burden for the ONFP and the MOPH. Injectables will also be available in all the other basic care centers, such as "*dispensaires*" and "*salles de soins* (health rooms)," as well as in pharmacies.

- Postpartum family planning

In many countries, postpartum programs play an important role in family planning. Tunisia, however, has no nationwide postpartum family planning program, despite the fact that the MOPH has a large number of maternity units at many levels. During the five-year period 1983-1988, 69 percent of births were attended by physicians or nurse-midwives. Five maternity hospitals account for 50 percent of all births in hospitals, yet they have no postpartum family planning program. This represents many lost opportunities for counseling and service provision.

In the near future, the ONFP will place special emphasis on developing a postpartum program. The personnel working in the (*maternités*) will be trained and contraceptives as well as equipment will be made available in these units. Here again, nurse-midwives, who attend 53 percent of deliveries, will play a key role in the expansion of family planning.

- Cost and supervision issues

Although this integration process should contribute to a more efficient service delivery structure, cost questions must still be reviewed. It will be necessary to review the existing policy of free family planning services within the public sector. The high prevalence of clinical methods, especially IUDs in urban areas (21.9 percent), plus the fact that close to 90 percent of all IUDs are inserted by public sector providers, show that there are a large number of urban users who are receiving free contraceptive services when they should be able to pay for part or all of the cost. If the extension of family planning through the MOPH structures is to be cost effective, the population will have to assume at least part of the financial burden of contraceptives. It is then necessary for the ONFP to study different alternatives and to assess various approaches to the establishment of fees for family planning services in the public sector, at least initially in urban areas.

Because the ONFP has the government's mandate to implement its population policy, it will continue to be the "guardian of standards." It will ensure, first, that quality and other performance standards are being met before responsibilities are transferred to the MOPH. Thereafter, the ONFP will still continue systematic supervision to determine whether desired standards are being met; where performance falls short, the ONFP will decide upon corrective measures, including in-service training of staff. The ONFP will retain this supervisory oversight role until such time as it is absolutely clear that standards are being achieved throughout the system. Once agreed standards are being regularly met, it should be possible to verify achievement on a statistical basis.

4.2.2 Ministry of Social Affairs

The Ministry of Social Affairs (MSA) also has a widespread structure that covers almost the whole country. There are 916 social workers who visit households, in most cases upon request, to assist families with all kinds of social issues. Within this structure the (*Division Générale de la Prestation de Services*) has within its scope of work, population and family planning education. The ONFP and the MSA have already developed strong cooperation in this area, both at the level of program design and implementation as well as in the field.

Basically, social workers discuss family planning with the families they visit and refer users to the different service delivery facilities. Also, when special education or literacy campaigns take place, family planning is included. The educational curriculum of social workers has a family planning component developed by ONFP's training center.

The ONFP and the MSA are currently developing an operations research project in an urban marginal area to measure the impact of different approaches to family planning by

social workers. The results of this study will form the basis of new MSA activities in support of family planning. It is also recommended that the ONFP and the MSA develop a follow-up mechanism to assess the contribution and impact of social workers in family planning. A referral form is needed to track new family planning users coming through this channel.

4.3 Transformation of the ONFP

4.3.1 Organizational Strategy

The ONFP faces an important challenge in the decade ahead. With Tunisia's ambitious demographic objectives, the family planning program must work efficiently to reach the required contraceptive prevalence and fertility rates. The ONFP will also have to achieve autonomy from foreign donors during this decade as external aid for population programs becomes less available due to competing demands from other countries. Consequently, the ONFP must develop new relations with the international donor community, starting with USAID, with whom a new institutional agreement should be in place in 1991 (see Chapter 7). Efficiency, cost recovery, and extended coverage are three key elements of ONFP's strategy.

The ONFP acknowledges that management reform will be critical to the fulfillment of its new role. As discussed, the ONFP will modify its role from a service delivery oriented organization to a policymaking and coordinating institution by transferring service delivery responsibilities both to the private sector and to other structures within the public sector. At the same time the ONFP will still be responsible for monitoring and supervision of family planning activities, for maintaining the quality of services provided, and for the extension of family planning coverage to the entire population of the country. Last, but not least, the ONFP and Tunisia will be an example for other institutions and countries that will face the same challenge in the near future. The 1990s will be a period of change for both the ONFP and for other organizations involved in Tunisia's family planning program. To meet the challenge, the ONFP will undertake a careful revision of its management and organizational structure and also some changes in its legal and administrative framework.

4.3.2 Organizational Structure

Under A.I.D.'s current bilateral project, the ONFP has started a review of its management structures and legal framework. The ONFP must assume a different organizational structure to achieve its objectives and to implement its new strategy. Issues like personnel management, salaries, job descriptions, and decentralization will be addressed to complete the transformation. The ONFP will also propose a modification of its legal framework. At present, the ONFP has contracted local technical assistance to review its organizational structure. Also through the bilateral project, management training needs will be assessed and a management training program designed and implemented. Special attention should be given to this area in the new institutional grant to be developed between the ONFP and USAID.

Within this organizational structure, new strategies will imply new responsibilities for different areas of the organization. The new strategic areas, private sector and integration, will require full attention and high priority by management. This means that new divisions will assume new responsibilities. Until now, service delivery has been the most important objective. When the transformation is achieved, coordination and communication will be as important. For example, social marketing is to play a key role in the private sector efforts. At present CSM management is a unit within the Communications Division, which is essentially an IEC unit. If social marketing objectives are to be accomplished, a high-level marketing manager will have to take charge of planning and implementation responsibilities within the ONFP.

4.3.3 Organizational Objectives

The proposed transformation of the ONFP has the following objectives:

1. Strengthening management information and accounting systems

The ONFP has contracted local technical assistance to design a management-oriented cost accounting system that is to ensure the monitoring of cost-effectiveness within its programs. But as the transference of programs takes place the need for a more interactive management information system (MIS) will become greater. The ONFP will be then able to monitor effectiveness of its program partners (the public sector), and its business partners (the private sector). At the public sector level, program statistics are to be gathered and processed in order to support planning and supervise implementation. At the private sector level, a more business-oriented monitoring system is to be instituted. This means that sales and distribution data, data on distribution and use of promotional materials, and program statistics are to be obtained and analyzed.

The ONFP will need additional computer equipment and software to improve its management and organizational framework. The ONFP has subcontracted with a local firm for the design of a computerization plan (*plan informatique*) to support its new needs for data processing and analysis. The additional equipment should be supported with a more targeted technology transfer through training and technical assistance.

ONFP's Population Division (research and statistics units) will play a very important role in this area and will redefine its mandate so that it focuses much more on program monitoring and evaluation. Research will focus on specific actions to orient the decision-making process. Tasks such as targeting new audiences and market segmentation will require different and creative research approaches.

Finally, the ONFP has been proceeding with a decentralization process. This is to be strengthened so that, at the regional and local level, the CREPFs will be able to provide effective coordination and monitoring of activities undertaken by ONFP's partners. Management training at this level will be developed through the five regional training units.

2. Cost recovery and revenue generation

As the ONFP undertakes a true social marketing approach in support of activities in the private sector, cost recovery and revenue generation will become important organizational objectives. The cost-accounting system being developed will serve as a base for the definition of cost-recovery policies. In addition, income generated by contraceptive marketing will be reinvested in the strengthening of CSM in order to achieve self-sustainability and to contribute to the general revenue generation policies. As the ONFP transforms its organizational structure and strategy, marketing of other capabilities -- such as market research, operations research, production of audiovisuals, and training -- will contribute to revenue generation. At a certain point, the issue of fees for family planning services will have to be addressed. Based on its improved management information and accounting systems, the ONFP will be able to establish cost-recovery fees to be charged for services to users who can afford them. As the ONFP moves toward a more self-financing operation, units like its printing shop and audiovisual center will need additional equipment to become competitive in the market and contribute to revenue generation.

3. International marketing: diversification of financial support

The ONFP will also have to develop new relationships in the international donor community. Until now, the ONFP has been highly dependent upon USAID financial support

(although this dependency has been declining, as noted earlier). Its new strategy aims not only at a more efficient and financially self-sufficient organization, but also at development of the ONFP capacities to market its knowledge and experience as a way to obtain financial and technical cooperation from multiple institutions in the international donor community, including A.I.D. and its cooperating agencies.

Given Tunisia's laudable achievements in terms of relatively high contraceptive prevalence and good program performance, it is becoming more difficult for USAID and other donors to direct scarce population resources to Tunisia on the basis of absolute need (in contrast, for example, to sub-Saharan countries). The Tunisia family planning program does have strong attributes, however, that make Tunisia potentially attractive to donors for other reasons. Given its overall program capacity, and the likelihood of showing measurable results in a relatively short period of time, Tunisia should be a very attractive site for family planning organizations seeking to test innovative or targeted approaches -- for example, in areas such as quality of care or factory-based family planning.

Special efforts will be made to develop proposal writing and grant management capabilities within the ONFP. The ONFP will also develop its ability to obtain effective technology transfer from each technical assistance and training activity. Under the proposed strategy, USAID will support the ONFP efforts in this area, including provisions for the ONFP to contract for local technical assistance.

4. Forging new relationships with partners

As discussed, to achieve a more efficient and expanded family planning program, the ONFP will transfer many responsibilities to the private sector and will cooperate with the MOPH and other entities within the public sector to integrate family planning services in their structures. Private sector and integration strategies will imply a new and different type of relationship with ONFP partners. Supervision, technical support, and communication will play a major role in this new relationship.

The ONFP will become more involved in information exchange with its partners (an area in which it is currently very weak). This implies setting up systems for gathering, processing, analyzing, and disseminating information. It also implies defining communication channels within the ONFP and with its partners to ensure a more efficient decision-making process both at the ONFP and by the partners.

As the ONFP embarks on this institutional transition, USAID should give special attention and support to the proposed organizational changes. Specific technical assistance, both local and external, will be essential to success. The overall objective will be, as stated, for the ONFP to achieve autonomy by the end of the decade. This does not mean an absence of financial or technical support from outside organizations but rather that the ONFP will be self-reliant, able to assess its needs and to negotiate with the GOT and international donors to meet them, independent of any single donor organization.

5. Resources

5.1 Available Resources

5.1.1 GOT Resources

The GOT currently underwrites 73 percent of the direct costs of the national family planning program. This includes the salaries of MOPH personnel assigned to the ONFP, but does not include the amortized cost of MOPH facilities, transport, equipment, and personnel involved in family planning service delivery. Thus the real contribution of the GOT far exceeds 73 percent of overall program costs. Figure 1 traced the development of GOT and external donor funding over the past decade, documenting the dramatic growth in GOT funding responsibility.

Despite periodic setbacks and worrisome day-to-day problems, the ONFP has evolved into a technically and functionally strong organization capable of implementing a government-led national family planning program. It has amassed a wealth of experience in all aspects of family planning: communication, demography, service provision, research, policy, training, institutional development, and social marketing. It has a mandate, emanating from the highest level of government, to intensify family planning program effectiveness throughout the country. It has developed a vision and overall strategies that are appropriate, forward thinking and innovative, and that promise to lead toward a new private/public sector partnership in family planning that is unparalleled in the developing world.

The following is a sketch of the existing the ONFP family planning delivery system in the 23 governorates (provinces) in Tunisia:

23	regional family planning centers (CREPFs)
240	public health facilities (MOPH hospitals, MCH centers, and basic health care centers) where family planning is available
67	mobile teams (bringing family planning services to some 800 small public health facilities whose personnel do not regularly provide family planning services)
10	mobile clinics (bringing services to remote areas where no health facility exists)
3	model clinics
1	national training center
1,200	total staff countrywide
936	MSA social workers (who reached 68,637 families for family planning counseling in a recent three-month period).

The following are the resources that the ONFP plans to include in its strategies in the private and public sectors:

1,000	pharmacies countrywide
70	full-time industrial health physicians
215	part-time industrial health physicians
200	additional MOPH facilities (in addition to the 800 that are to be phased over to the MOPH for family planning)
2,200	"gathering places" served by visiting MOPH nurses at least once every month
1,000	private physicians (generalists and pediatricians)
5	large maternity hospitals, which account for 50 percent of all MOPH-assisted births
1	Tunisia Family Planning Association (its role and programs to be strengthened)
1	Tunisia Fertility Association (its role and programs to be strengthened).

The full involvement of these private and public sector entities will greatly expand the availability of information and services during the coming decade.

5.1.2 External Resources

USAID, the UNFPA, and (prospectively) the World Bank are the principal providers of external assistance in family planning in Tunisia.

USAID has supported the Tunisia family planning program since the mid-1960s and is in the final year of an \$8.2 million bilateral program (see Chapter 1). Assistance has been running at just over \$1.0 million, but will decline considerably over the next few years as the ONFP assumes even greater financial responsibility for its activities. Contraceptives, until now provided mostly by USAID, will no longer be provided. The ONFP has already obtained a \$300,000 1990 budgetary provision for contraceptive procurement. This is insufficient to meet current need, but is a good start. Intensive discussions are under way to find creative ways to ensure an adequate level and range of contraceptives without USAID financing.

The UNFPA's programs of assistance began in the mid-1970s and have usually provided about \$3.5 to \$4 million each over 3-1/2 to 5 years (to projects in family planning; maternal and child health; population information, education and communication; and women, population and development). The UNFPA also provides contraceptives. Most oral contraceptives for 1990 and 1991 will continue to come from UNFPA.

The next UNFPA assistance program is scheduled to start in 1992. The UNFPA sent a mission to Tunis in spring 1990, following this USAID assignment, to discuss with the ONFP its planned strategy and to plan for UNFPA support. Although the funding level remains to be determined, it appears that the new program might be funded at a similar if not slightly higher level.

The UNFPA will probably concentrate in the Central and South regions, aiming for better targeting to the underserved populations. There may also be more emphasis on maternal health care. The UNFPA will almost certainly continue to provide some support in contraceptives. This will probably be limited to what it is doing now, although it may add support for injectables or NORPLANT.

Aside from the Tunisia program, a UNFPA-supported "international training program in family planning," previously housed in Belgium, was moved to Tunis as of early 1990. This provides practical training in contraceptive methods to intermediate-level staff (e.g., nurse-midwives) from francophone countries throughout the world. The first course, two months in duration, began in March 1990. This is the only course to be offered in 1990; two courses are planned for 1991. The training is provided by the ONFP, the Faculty of Medicine of the University of Tunis, and the University of Brussels.

The World Bank has provided assistance through two projects. The most recent, the Bank's second health and population project, begun in 1982, was to provide an \$8.5 million loan to help the GOT develop its integrated health delivery system, including family planning, by strengthening the planning and management capabilities of the MOPH and extending decentralization.

The World Bank is currently developing a Population and Family Health Project, a loan that would help finance the full "integration" of family planning services in the MOPH basic health services facilities. This project, as preliminarily envisioned, would support (a) refurbishing and equipping of 400-600 MOPH basic health care facilities and selected referral centers; (b) mobile clinics serving areas without fixed health facilities; (c) strengthening training in family

planning and MCH; and (d) equipment purchases, technical assistance, scholarships, and studies. Also under preparation is a Health Management Project designed to support health sector reform. The exact levels and timing of these two loans have not yet been finalized.

5.2 Required Resources

Pursuance of the ONFP's strategies in the public and private sectors will require the infusion of resources over and above those now available, especially over the short term. Increasingly, as the ONFP shifts service delivery responsibility to the MOPH and to the private sector, its own resources can be freed to concentrate on the hardest-to-reach groups, operations research, overall planning, program monitoring and evaluation, and other activities appropriate to its evolving role as an orchestrator of family planning in the country.

One such activity -- a critical one -- involves the marketing of ONFP skills and products that have been developed over the past two decades: the transfer of ONFP "know-how" to the private sector and to the MOPH. Another activity involves the development of new and diversified sources of external assistance: other bilateral donors (e.g., Canadians, Germans, Japanese); private foundations (e.g., Hewlett-Packard, Ford Foundation, MacArthur Foundation, The Population Council); and multilateral sources (e.g., European Economic Community). Development of these relationships will ensure not only an increased institutional maturity and independence but will provide a measure of insurance against the changing policies of individual donors.

In terms of overall levels of required assistance, it is difficult to set a precise figure at this time. What can be said with conviction, however, is that the required levels are surprisingly low, given the excellent performance of the GOT in assuming financial responsibility for family planning. Though the level required may be low (in relation to the overall size of the program), external assistance can play a major role, particularly over the next four to five years, in facilitating the implementation of ONFP's strategies as well as its own metamorphosis. The level of required resources will very likely exceed that which can be provided by A.I.D. Thus, it will be doubly important to assist the ONFP to "package" its needs in such a way as to attract funds from other external sources.

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6. The Role of A.I.D.

6. The Role of A.I.D.

6.1 USAID/Tunis

USAID/Tunis has a crucial role to play in the further development and implementation of ONFP's overall strategy despite declining levels of A.I.D. financial and technical support compared with past years under bilateral projects. A.I.D. is viewed by the ONFP as a valued partner and counsel in family planning matters. It is clearly understood by all, however, that the nature of the ONFP-USAID relationship is changing and that this change will necessitate the development of new assistance modalities that better reflect the mature status of the ONFP and that will focus on those activities that make the greatest difference.

A.I.D. support will be especially critical over the next two years while the ONFP further refines its strategies and individual work plans and begins to implement them. This is also the period during which the ONFP will be developing new relationships both with its implementing partners in the public and private sectors and with USAID and other potential donors. A.I.D. can play an important role in assisting the ONFP to "market" itself, that is, to develop discrete proposals that are consistent with its overall strategy and to "sell" them to USAID and to other potential donors: bilateral, multilateral, and private foundations. Additionally, the ONFP has developed technical skills that are very marketable in Tunisia and the region, including the full range of technical family planning skills, social marketing, materials development and production, and research (demographic, operations, and market). A.I.D. can assist the ONFP in identifying and in "marketing" these skills in Tunisia as well as internationally.

In short, A.I.D. has a major role to play in assisting the ONFP to complete its transformation and to pursue aggressively its private sector initiatives, which represent the wave-of-the-future in this relatively advanced developing country.

6.1.1 Sources of USAID Financing

With the termination of the bilateral project in December 1990, and with the prospect of diminishing operating year budget (OYB) levels in the future, USAID/Tunis will be hard-pressed to find sufficient resources to finance agreed-upon, high priority, *avant-garde* family planning activities. Although it is beyond the purview of the strategy team's scope of work, in view of the importance of maintaining adequate financial support during the critical transition period, USAID should be creative in exploring both sources and modalities.

Sources of funding from USAID/Tunis should include

- other ongoing or planned bilateral projects,
- deobligations from the ongoing population project,
- other deobligations/reobligations, and
- local currency, including generations from the Commodities Import Program (CIP) and PL-480 programs.

The modalities through which these funds are made available should include

- sector or "institutional" grants,
- buy-ins to S&T/POP activities (either using Project Implementation Orders/Technical (PIO/Ts) or OYB transfers as appropriate), and
- PIOs under other appropriate projects (e.g., Technology Applications Project and Private Sector Project).

USAID/Tunis should also endeavor to obtain as much assistance from S&T/POP cooperating agencies (organizations funded by S&T/POP) as possible.

6.2 A.I.D./Washington

6.2.1 Office of Population: Projects That Could Help Meet ONFP's Technical Assistance Needs

A variety of projects funded by S&T/POP can be used to help meet the specialized technical assistance needs of the ONFP during the transition period 1990-1991 and during the Eighth Plan, 1992-1996. Funding for these projects would come from three sources: (1) mission buy-ins; (2) ANE buy-ins; and (3) S&T/POP funds.

The following are the priority areas for targeted technical and financial assistance to the ONFP:

- (1) social marketing and private sector initiatives;
- (2) training
 - management, including assistance in transforming the ONFP into a self-reliant, independent institution,
 - commodities and logistics management,
 - in-country training activities (limited support); and
- (3) operations research.
 - Support for social marketing and private sector initiatives

When the RONCO contract ends in December 1990, continuing support to the ONFP to strengthen and expand its social marketing program should be provided under the S&T/POP Contraceptive Social Marketing (CSM II) project, through a buy-in from USAID/Tunis. Social marketing will be the centerpiece of the new institutional grant to the ONFP. The CSM II project with The Futures Group runs until September 1993 and should have enough ceiling to be able to accept mission buy-ins over the next three years. Limited additional support will likely be available from S&T/POP and ANE funds.

The S&T/POP Family Planning Enterprise Project is designed to increase the delivery and use of family planning services through the private sector. The Enterprise project is currently being implemented under a contract with John Snow, Inc., which ends in 1991. This will be followed by a new five-year contract, with the implementing firm selected on the basis of competitive procurement. Limited technical and financial support to Tunisia private sector family planning initiatives could be made available under the new project beginning in 1991, although the project's emphasis will be on large developing countries where the for-profit, market-based channels are well developed.

The S&T/POP Family Planning Service Expansion and Technical Support project is another vehicle that may be able to provide some assistance in support of private sector family planning initiatives, including integration of family planning into work-based health services.

- Support for training management

The most important training needs for the ONFP are in the area of management. The appropriate S&T/POP project to provide the necessary technical and financial support in this

area -- beginning in late 1990/early 1991 -- is the Family Planning Management Development (FPMD) project. The current Family Planning Management Training project, being implemented by Management Sciences for Health, is in its final year. A new five-year contract, selected on the basis of competitive procurement, will begin by September 1990. Under the new agreement, technical and financial assistance can be provided to improve the overall program effectiveness, management capabilities, and sustainability of ONFP.

Assistance could be targeted to strengthen the following areas:

- strategic planning;
- organizational development;
- financial management;
- management information systems for monitoring, controlling, and evaluating program efficiency and effectiveness at headquarters and in the field (the CREPFs);
- personnel and supervisory systems;
- development and implementation of work plans;
- decentralization of strategies, financial planning, and management;
- development of financing strategies combining cost-containment approaches with revenue-generation strategies;
- marketing of ONFP materials and services;
- development of grant proposal and management capabilities to enable the ONFP to negotiate directly with and to seek funding from multiple sources -- including the cooperating agencies of S&T/POP, other bilateral donors, multilateral sources, and private organizations and foundations; and
- public-private sector partnerships.

Assistance in a few of the areas listed above is currently provided by the Training Resources Group (TRG) under a subcontract with RONCO. If desirable and feasible, there could be some continuing involvement of TRG under the new FPMD project.

Under the new FPMD project, S&T/POP is hoping to allocate at least \$100,000 per year over a period of several years to assist the ONFP in improving program management and sustainability. The new FPMD project will also have ample ceiling over the next five years to accept buy-ins from the mission.

- Commodities procurement and logistics management

To help the ONFP achieve, during 1990-1991, self-sufficiency in the area of contraceptive procurement and logistics management, continued A.I.D. assistance is required. A comprehensive plan of action has been developed and the necessary technical assistance can be provided under the Family Planning Logistics Management (FPLM) project, funded by S&T/POP. The current FPLM project ends in 1990 and a new agreement will be in place by September 1990.

It is unlikely that mission buy-in funds will be required to meet the technical assistance needs in this area. However, a substantial amount of technical assistance is needed during the remainder of 1990 and into 1991.

- In-country and regional training

Under the PAC IIb project, Development Associates is interested in providing targeted technical and financial assistance to the ONFP. Development Associates would be able to provide, during 1990-1991, technical assistance to the National Training Center using S&T/POP funds (under \$100,000). Any additional support of national or international training activities would have to come from a mission or ANE buy-in. The current PAC IIb project continues through September 1993 and has sufficient ceiling to accept mission buy-ins.

JHPIEGO and AVSC have enjoyed a long and productive working relationship with the ONFP. They would like to continue a modest level of technical and financial support to the ONFP over the next several years.

- Support for operations research

Limited support for operations research could be provided to the ONFP under the new ANE Operations Research contract. This will be competitively bid in spring 1990. The new contract will have a ceiling to accept mission and regional bureau buy-ins.

6.3 A.I.D./Washington: ANE Bureau

In Washington, the ANE Bureau has also been a source of some modest support for special population/family planning needs in Tunisia beyond what the bilateral project provides.¹³ Two regional projects may be able to assist the ONFP during the coming transitional period.

6.3.1 The Asia/Near East Regional Population Project

The Asia/Near East Regional Population Project (No. 398-0048) awards small sums of money in response to proposals submitted by USAID missions. As of early 1990, two years remain in this project. The ANE Bureau began to evaluate proposals in March 1990 for the next round of funding. Among the topics likely to be given the highest priority for funding are three that coincide with needs of the ONFP:

- Activities to ensure that social marketing projects in the region are well institutionalized and continue to move into private sector control insofar as possible with less and less reliance on A.I.D.-financed contraceptives.
- Efforts to increase contraceptive prevalence beyond 30-35 percent by specifically targeting men for information and service delivery. (Examples are the Bangladesh social marketing program, which has used IEC to target men, and Turkey, which has many factory-based programs reaching men.)
- Support for analyses/surveys clarifying or defining family planning/population program needs.

¹³Throughout the 1980s, "ANE" stood for Asia and the Near East. Following 1989 developments in Eastern Europe, commitments there have been added to the Bureau's responsibilities. ANE now means "Asia, Near East, and Europe."

In addition to the above priorities, activities are to be selected in 1990 based upon the following priority order:

- activities in countries without current bilateral programs,
- activities of regional or multinational interest, and
- activities in countries with bilateral programs but which are difficult to fund under those programs.

6.3.2 The ANE Regional Health Financing Project

This project will also provide modest sums to countries in the Near East and Asia. A major purpose of this project is to provide technical and financial assistance for activities designed to make the provision of health care services more cost-efficient.

It would be appropriate for the ONFP to seek support from this project for activities aimed at making family planning costs reimbursable through Tunisia's health insurance systems. This project is not intended to focus on family planning per se, however. Thus, it will be important that ONFP efforts to make family planning services reimbursable be linked to a broader set of actions designed to rationalize Tunisia's overall health insurance systems.

**7. Next Steps:
Priority Actions for a Smooth Transition**

7. Next Steps: Priority Actions for a Smooth Transition

7.1 Immediate Steps During 1990

The immediate objective should be to ensure adequate resources for a suitable transition period, which will be about four to five years. As A.I.D.'s bilateral project ends in December 1990, resources must be available for early 1991.

7.1.1 USAID/Tunis

This means that USAID/Tunis must immediately begin work to develop the modality for assistance -- an institutional grant or some sector grant-like mechanism. It will be important to pursue this immediately because the arrangement is new to USAID/Tunis as well as the ONFP and will thus take time to develop.

The funding level should be kept as high as possible. A level for this grant of \$600,000 per year is recommended for each of the first two years, to include buy-ins to S&T/POP projects and to be supplemented by S&T/POP-financed activities and by ANE regional projects.

In view of resource constraints in the mission, and in view of the resource needs of the ONFP to develop and implement the new activities, USAID/Tunis should explore every opportunity available for ensuring an adequate level of support to the ONFP. This is especially critical in the first years of the transition. Sources to explore include those mentioned in the preceding chapter.

Since much of the ONFP's need is in local currency, and to reach the needed levels, USAID should seriously examine the potential for local currency (PL-480 and CIP) generations. USAID/Tunis should explore this with the ONFP and the Ministry of Plan and Finance.

The ONFP's print shop (materials production center) is in need of equipment and spare parts. These are essential to ensure that the ONFP will be able to market itself as envisioned. USAID/Tunis could conceivably address this need with a Project Implementation Order/Commodity under the existing bilateral project, provided that sufficient funds remain.

The ONFP also needs increased computer capability for MIS and other management purposes. These needs appear modest in U.S. terms but are far more costly if the ONFP has to make purchases on the open market in Tunisia, where costs are reportedly approximately three times those in the United States. A.I.D. should consider an MIS package (hardware, software, and training) not to exceed \$100,000, including technical assistance. The exact components of this package should be determined through a technical assistance visit. This could be achieved through one of the S&T/POP centrally funded projects, which might also be able to handle the procurement.

The technical assistance that is already scheduled with TRG and the FPLM project is highly appropriate to ONFP's current needs, is eagerly anticipated by the ONFP, and should proceed promptly as planned.

7.1.2 RONCO

The RONCO Consulting Corporation, A.I.D.'s contractor on the current bilateral project, should begin immediately to assist the ONFP in identifying and "packaging" segments of its overall strategy, some of which are to be included in the A.I.D. grant.

7.1.3 ONFP

The ONFP should write a marketing plan for 1991, taking into account the role that social marketing will play in the development of the ONFP's private sector strategy.

The ONFP should also identify specific technical assistance needs for 1991 in all areas. The ONFP should specify very clearly the expected outcomes of each technical assistance input and should establish priorities among the requests.

7.1.4 Other Steps for 1990-1991

Institutional constraints should be examined in the context of individual plans of action.

A.I.D. should assist the ONFP in making appropriate contacts and approaches to other funding sources -- bilateral, multilateral, and private foundations.

7.2 Steps for the Eighth Plan Period (1992-1996)

As the ONFP finalizes its planning for the next five-year period, and as the process of "transformation" and intensification of activities in the private sector begins, the necessary actions for the next five years will become more evident. What is clear at this time is that the basic strategies outlined above will, in all likelihood, remain appropriate and of high priority throughout the next decade.

Appendices

Appendix A
Scope of Work

Appendix A

Scope of Work USAID/Tunis

BACKGROUND:

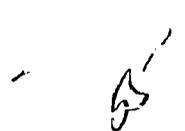
A.I.D. has been the primary donor supporting family planning activities in Tunisia since the early 1960s, providing approximately \$46 million of assistance to the sector during this period. Despite this, legal and administrative restrictions continue to hinder the organizational and structural development at Tunisia's national family planning office, the Office National de la Famille et de la Population (ONFP). In addition, collaboration between the private sector and the Government of Tunisia in the delivery of family planning services has not met expectations. Finally, although Tunisia has long standing laws and policies encouraging child spacing as an integral element of social and economic development, strengthened policies and legislation promoting slower population growth during the next decade are needed.

The Mission's Action Plan was reviewed and approved in A.I.D./Washington in March 1989. The strategy focuses on development of a market-led, export-based economy. The Mission and the Government of Tunisia recognized that slowing population growth is key to the success of this strategy. The Mission plans to continue to allocate a portion of its Operating Year Budget (OYB) to population, with an emphasis on increasing the role of the private sector, strengthening Non-Governmental Organization (NGO) capabilities, conducting contraceptive research, and for training programs. At the same time, USAID/Tunisia believes it is time to sever the longstanding donor-client relationship with the ONFP, and to develop a new relationship reflecting the ONFP's maturity as an organization.

OBJECTIVE:

The Contractor shall assist the Mission and the ONFP to strategize and plan future population programs for Tunisia for the 1990s.

SCOPE OF WORK:

- 1) Examine, with the ONFP: Tunisia's demographic objectives for the year 2000; national population policies; and available national, bilateral and multilateral resources currently directed toward population-related programs.
 - 2) Review potential actions necessary to achieve stated sector objectives, with a special emphasis on increased government contributions, incentive measures such as tax deductions, and the introduction of fee for service.
 - 3) Assess the current legal and administrative framework under which the ONFP operates, and make recommendation for reforms or revisions which would enable the ONFP to respond to the challenge of the 1990's.
 - 4) Using the Mission's approved Action Plan as a frame of reference, review current strategic directions for the 1990s being proposed by the ONFP, and define an appropriate role for A.I.D. in this sector over the next decade.
 - 5) Identify and analyze constraints constituting impediments to increased integration of government-sponsored family planning services, as well as constraints to private sector participation in family planning programs.
 - 6) Assess the progress of the contraceptive social marketing program, opportunities for expansion and future technical assistance needs.
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- 7) Examine opportunities for expanded privatization of family planning services and increasing the self-sustainability of ONFP programs.
- 8) Based on these reviews of policy, resources and proposed strategies, recommend interventions for A.I.D. assistance, specifying whether Mission or central funding is most appropriate for each.
- 9) Recommend innovative approaches for implementing the recommended interventions, taking into consideration Mission management constraints.
- 10) Identify potential institutional relationships which the ONFP could establish with research, training and other institutions, as an alternative to the traditional A.I.D. project assistance mode.
- 11) Define the elements of a comprehensive, future-oriented management plan for the ONFP, addressing the skills mix, staff development, and procedural changes required to meet the challenges of the 1990s.
- 12) Facilitate the ongoing Mission-ONFP dialogue concerning new directions in family planning programs worldwide by providing insights from activities in other countries with more established programs.
- 13) Based on the above, prepare a strategy statement directed towards the host government, USAID/Tunis and A.I.D./Washington, and other interested organizations, which will form the basis of future direction for the USAID in support of population activities in Tunisia.

Appendix B
List of Persons Contacted

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List of Persons Contacted

MAJOR CONTACTS

IN TUNISIA:

USAID/Tunis

Mr. George Carner	Mission Director
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Mr. Ahmed Beltaief	Director
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Mlle. Samira Zghal	Pharmacist

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Mr. Abdelhamid Smida	Division Chief for Programming

Population Division

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Mr. Habib Fourati	Researcher
Mr. Touhami Aloui	Statistics Division

Communications Division

Ms. Saida Agrebi	Director
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Appendix C
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