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PROJECT ASSISTANCE COMPLETION REPORT (PACR)

FAMILY PLANNING AND POPULATION DEVELOPMENT

PROJECT NO. 664-0331

I. INTRODUCTION

This Project Assistance Completion Report (PACR) for the Tunisian Family Planning and Population Development (FPPD) Project relies heavily on two written sources of data: 1) the final semi-annual report of the contractor, RONCO Consulting Corporation (Dec 1990); and 2) a review of the institutional capacity of the National Office of the Family and the Population (ONFP) (Echols and Trayfors - Dec 1990). Information on the Diarrheal Disease Management component, provided in a separate section, is derived from the Catholic Relief Services final report. This report was prepared by the USDH and FSN project officers who worked on the project for three and six years, respectively.

II. PROJECT DATA

A. Title and Number: Family Planning and Population Development Project No. 664-0331

B. Grant Agreement Date: 8/30/1985
RONCO Contract Date: 6/06/1986
Mid-Term Evaluation Date: 6/12-7/8/1989
PACD: 12/31/1990
TDD: 9/30/1991
EOP Evaluation: None planned

C. Funding: $8,317,000
Expenditures: $7,315,351

D. Implementation/Organization: National Office of the Family and the Population (ONFP).

E. Project Status: Bilateral support terminated 12/30/1990.

III. EXECUTIVE SUMMARY

Since independance 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, created in 1973.

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.

In August 1985, USAID began its bilateral Family Planning and Population Development Project (664-0331), which has a LOP funding of $8.317 million of which $0.7 million was for a Diarrheal Disease Management component. The original PACD was June 30, 1989. This was extended, at no extra cost, an additional 18 months in March 1989 to 12/31/90. Technical assistance was provided to the National Family Planning and Population Office (ONFP) by RONCO.

MID-PROJECT EVALUATION (June 12 - July 8, 1988)

PURPOSE OF EVALUATION: The purpose of the midterm evaluation of the USAID bilateral Tunisia Family Planning and Population Development Project was twofold: (1) to examine the project activities undertaken to date and to evaluate their contributions to attaining the project's intended purpose while documenting any impediments to their implementation; (2) to assess the contribution of this project in enhancing the ability of the Office National de la Famille et de la Population (ONFP) to translate family planning objectives and stategies into action programs.

OVERVIEW: In Tunisia, prior to this bilateral project, USAID's 24-year involvement with family planning efforts helped achieve a contraceptive prevalence rate (CPR) in the mid-range (34 percent). The present USAID family planning project is seeking to achieve close to another 10 percent gain by increasing the institutional capacity of the National Family Planning Office (ONFP), shifting some of the responsibility for service delivery to the private sector (through contraceptive social marketing [CSM]), and strengthening the Ministry of Public Health (MOPH) in its ability to provide services (training and operational research [OR]). Due to a combination of a late project start, plus constraints within each component, more emphasis has been placed to date on achieving outputs than on technology transfer. Nonetheless, thanks to cumulative efforts over the past two decades, contraceptive prevalence continues to increase. At the same time, acceptable progress has been achieved in most project components,

justifying a two-year extension of the project that would compensate for the late start date.

The achievements in CSM, training, and OR can be ascribed in part to the following implementation factors:

- The willingness of project personnel to apply lessons learned during the curriculum development subcomponent to the in-service training was commendable and has resulted in the addition of an innovative post-graduate training component to the project.

- ONFP management's willingness to follow through on project specifications in the areas of method-specific advertising, training of medical detailers and instituting improvements in the distribution system, and putting into effect some commodity price increases have given a good start to the CSM component.

- Full staffing of the Communication Department, coupled with a good understanding by ONFP of the purposes of information, education, and communication (IEC), have enabled this component to be the project's most successful.

- Host country midwifery, nursing and medical schools have developed an appropriate and relevant family planning curriculum, followed by a methodical course of action (including analysis of professional needs, development of educational objectives, creation and testing of teaching modules and final evaluation). It has also involved in the process, all relevant personnel including professors, representatives of the family planning program and outside academic experts skilled in curriculum development.

TUNISIA CONTEXT AND ACCOMPLISHMENTS:

CONTEXT: The Government of Tunisia (GOT) has long been aware of the important role demographic balance plays in socioeconomic development, and since the early 1960s, has supported family planning. Measures have included authorizing importation of contraceptive products, encouraging female education, legalizing divorce, declaring a minimum legal marriage age (17 years for women, 20 for men), banning polygamy, and most recently, reducing from 4 to 3 the maximum number of child subsidies per family.

The GOT has been providing free family planning services to the Tunisian public since 1966. In 1973, the Office National du Planning Familial et de la Population (ONPFP) (the name was changed in 1984 to ONFP) was created as a semiautonomous agency of the Ministry of Public Health (MOPH). The decision to establish this vertical program was taken with the support of international donors, who believed that demographic gains would be more rapid if Tunisia had an agency devoted exclusively to family planning. The donors also were reluctant to channel large sums of family planning monies through the over-burdened public health system (which itself was in need of capital investment

to maintain its infrastructure). The ONFP enjoys financial autonomy, relative administrative autonomy, and has the authority to recruit and contract.

The ONFP, under the direction of its headquarters, has built a system that parallels that of the MOPH. This system includes a regional training center (CREPF) in each of the 23 governorates. The CREPFs are situated next to MOPH maternity hospitals or clinics and provide family planning services and education, as well as offering gynecological and pre- and post-natal services. The system also includes 3 model clinics, 61 mobile teams, 8 mobile clinics, and a staff of 1,070 (of whom 379 or 35 percent are seconded from the MOPH).

The project's long-term goal is the reduction of fertility in Tunisia. The stated project purpose is to increase the contraceptive prevalence rate (modern methods) from 34.1 percent in 1983 to 42.7 in 1989. The Project Paper also called for development of greater institutional capacity within the ONFP, to enable it over the long-term to sustain its programs with less external support.

Project activities designed to achieve the stipulated goals include improved program planning and management; contraceptive social marketing (CSM) and information, education and communication (IEC); training, both institutionalization of family planning training in medical and paramedical curricula and provision of in-service staff training; and research (more than 50 percent of which is to be operational research).

Of these elements, the most important for increasing the capacity of the ONFP to sustain its programs with reduced levels of external support is the CSM component, which should enable ONFP to generate income through the sale of contraceptive commodities.

ACCOMPLISHMENTS: With respect to the project's demographic targets, good progress is being made, albeit due in large part to the considerable efforts made over the past decades by the GOT, with significant assistance from USAID, as well as from other donors. By 1987, the crude birth rate had decreased to 29.3 (from 31.6 in 1983), and in 1988 the contraceptive prevalence had risen to 40.9 percent (Demographic and Health Survey (DHS) 1988). Thus, the project's goal is being achieved, and the project purpose is within 2.2 percentage points of being met.

Progress has also been made in the area of developing self-sufficiency. After being almost totally donor-dependent, today even in a time of budget austerity, the ONFP has assumed major responsibility for its operating expenses. Program costs are still financed largely by donors, however.

Progress has been made in each project subcomponent, but five accomplishments warrant special mention: a) pre-service training, which is resulting in the integration of family planning into the academic curriculum for midwives, nurses, doctors, social workers and

which should eventually lead to institutionalization of training; b) an increase in the price of the CSM low-dose oral contraceptives, which should increase revenues; c) method-specific promotion in the media and in pharmacies, which should increase contraceptives sales; d) a medical detailers' program that has placed in the field five detailers and which is likely to generate considerable demand for CSM products; and 3) the launching of research that should provide some insights in how to make service delivery more efficient. These accomplishments are particularly noteworthy for their potential to increase the institutional capacity of ONFP to run its programs with less donor asssistance.

TUNISIA: POPULATION STRATEGY FOR THE 1990s

In January 1991, a POPTECH team has been sent by AID/W Office of Population 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 AID support. The immediate goal was to produce a strategy statement directed toward the Tunisia Government, USAID/Tunis, AID/Washington and other interested collaborating organizations. This strategy statement is to serve as the basis for future AID support for population activities in Tunisia as well as for support by other donors. The following brief conclusions and recommendations are presented pursuant to the above mentioned strategy.

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, 10percent 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.

Economic and political concerns. Reducing the population growth te is essential for achieving the GOT's economic and political goals, which AID 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 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 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 goals of this strategy is to transform the ONFP from a government monopole 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 AID's policy. The ONFP strategy is consistent with AID'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 AID 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 AID, 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."

RECOMMENDATIONS

1. The ONFP should proceed vigorously with the general strategy it has developed.

2. USAID/Tunis should support the two key elements of the ONFP strategy that conform most closely with AID priorities and with USAID/Tunis objectives. These are (1) privatization and (2) transformation of the ONFP itself.

-- USAID/Tunis should try 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 AID.

-- 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 AID/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.

IV. PROJECT DESCRIPTION

A. Background

A.I.D. has provided assistance to the Tunisian family planning and population programs since 1965, with bilateral assistance through 1981. Between 1982 and 1985, assistance was provided through centrally funded programs with no appreciable decline in population growth rates. The FPPD Project, therefore, was designed to work with the technically competent Office National de la Famille et de la Population (ONFP), which still had weak elements as noted below. The program had been characterized by inadequate planning, management, monitoring and feedback, and lack of focus on the alleviation of constraints to increased contraceptive prevalence. Contraceptive distribution had been falling off and contraceptive prevalence appeared to have been declining.

The ORT (Oral Rehydration Therapy) component was added based on emerging interest on the part of the Ministry of Health to tackle fundamental child survival issues such as Diarrheal Disease Management (DDM).

B. Project Goal and Purpose

The project goal was "to reduce Tunisia's fertility rate by 1988 (later amended to 1990), and thereby provide the potential for achievement of the country's economic and social development objectives. The project purpose was "to increase contraceptive prevalence by 9 percent through: 1) targetted and evaluated IEC activities; 2) contraceptive social marketing; 3) targetted and evaluated training; and 4) program focusing, including demographic and operations research and identification of alternative public sector delivery mechanisms." The purpose was achieved prior to project extension in March 1989.

The project was amended in July 1987 to add an Oral Rehydration Therapy (ORT) sub-project. The additional goal and purpose were as follows: Goal: To reduce morbidity and mortality resulting from diarrheal disease in children under 5 years of age. Purpose: To promote effective ORT management of Diarrheal Disease (DD) and dehydration associated with DD.

C. Project Implementation

The project was implemented by the ONFP with the vast majority of Technical Assistance provided by RONCO Consulting Corporation. Much

of the description which follows is taken from RONCO's final semi-annual report.

1. RONCO's Contract and Scope of Work

RONCO's original contract with USAID/Tunis, signed June 6, 1986 was for three years, or until June 1989. It was subsequently amended to continue through December 31, 1990.

Project activities were initially grouped under four project components: (a) Information, Education, and Communication (IEC) activities; (b) Contraceptive Social Marketing (CSM); (c) Training; and (d) Program Resource Targeting, including demographic and operations research and identification of alternative public sector delivery mechanisms. The first two components were combined into one, IEC/CSM, during the project life since two separate discrete activities never evolved. A fourth activity, management, is described briefly.

RONCO's responsibilities consisted of coordinating activities in all project components and providing technical assistance. RONCO was required to make arrangements for short-term training and observational tours, consultancies, and procurement under the contract and was also mandated to assist the ONFP in preparation of documentation for proposals for funding under the Resource Targeting component.

RONCO was also required to coordinate activities with those of centrally funded cooperating agencies that provide assistance to the Tunisian program and to ensure that there was no overlap between its activities and those provided by cooperating agencies.

The level of effort for the performance of the RONCO contract (as amended) was established at 250 person months of direct employee, consultant, and subcontract labor, composed as follows:

- Project Management	72 P/Month
- Short-term Consultations and Sub-Contractors	124 P/Month
- Administration	54 P/Month
TOTAL	250 P/Month

2. Key Project Dates

Because of the slow progress in activating the bilateral agreement between USAID/Tunis and the ONFP that was signed August 30, 1985, the effective execution of activities programmed under the project did not start until the technical assistance contract with RONCO was signed on June 6, 1986. Even then, some of the conditions precedent to project implementation, such as those related to management interventions and to pricing levels of contraceptive sales in the private sector, were not met until well into the project life.

Following the June 1988 mid-term project evaluation and a review of the program and budget conducted in October 1988, a determination was made by USAID/Tunis to extend the project.

On March 17, 1989 an agreement was reached between USAID and the ONFP to extend the Project Assistance Completion Date from June 30, 1989 until December 31, 1990. Subsequently, the RONCO Consulting Corporation technical assistance contract was amended to cover the above extension. By mutual agreement with USAID, some budgetary adjustments were made to the contract to reflect additions in RONCO technical assistance, particularly in the areas of management training and cost-effectiveness analysis. Additionally, the RONCO project management structure was revised. It should be noted that no additional funds were required for the extension of the RONCO Consulting Corporation contract in spite of the above-mentioned additions and revisions.

In January 1990, a high-level technical assistance team provided through the POPTECH project participated with the ONFP and RONCO in the development of a population strategy for the 1990s (see POPTECH Report No. 89-041-108). A strategy statement directed toward the Tunisian government, USAID/Tunis, A.I.D./Washington, and other interested collaborating organizations was produced. This strategy statement served as a basis for shaping future A.I.D. support for population activities in Tunisia.

During the sumnmer and fall of 1986, which coincided with the inception of the project, Tunisia underwent several significant political and economic changes. Among those that had most direct impact on project implementation were:

(1) The dismantling of the ONFP's sponsoring ministry, the Ministry of Women and Social Welfare (July '86), and the consequent shift of the ONFP sponsorship back to the Ministry of Public Health;

(2) A change of government and the introduction of major cuts in government spending (August '86);

(3) Legislative elections (October '86); and

(4) The nomination of a new Director General of ONFP (December '86).

Later, Tunisia underwent further political and economic changes with the removal of President Bourguiba (November '87) and the adoption of a Structural Adjustment Program (October '88).

In March 1990, a new Director General was appointed to the ONFP following the nomination of the previous Director General to the position of Secretary of State to the Ministry of Health.

3. Project Organization and Monitoring Procedures

A full-time in-country Project Manager was assigned to RONCO's regional office in Tunis (early 1986). RONCO also provided administrative and logistics support to backstop its field effort in Tunisia as well as direction and administrative support from its Washington, D.C. office. A non-resident long-term Training Advisor was also assigned to coordinate the project's training activities. With the departure of the Washington-based Project Director in June 1989, USAID/Tunis and RONCO agreed not to recruit a new Director but to appoint the Project Manager and the long-term Training Advisor as Co-Directors of the project. A direct impact of this decision was that no disruption occurred in project implementation and monitoring, or in the coordination work with USAID and the ONFP, despite this major change in RONCO's project management structure.

Regarding monitoring procedures, semi-annual Steering Committee meetings were held during the project. The Steering committee meetings were always chaired by the ONFP's Director General and attended by the USAID Project Officer and RONCO's Project Director(s) as well as heads of the various technical departments at the ONFP. In addition to reviewing progress and issues, the Steering Committee meetings were used as a forum to approve or modify discrete elements of the regular annual plans developed for each component of the project.

RONCO's semi-annual progress reports followed the Steering Committee meetings and incorporated their results and recommendations. In addition, written trip reports were submitted by RONCO to USAID and the ONFP, each time a consultant visited the project.

The combination of Steering Committee meetings, semi-annual reports, and consultants' reports proved to be the most adequate mechanisms for monitoring the progress of the project. This combination of interventions was extremely helpful in addressing issues and constraints that surfaced during the life of the project.

D. PROJECT ACTIVITIES

1. Information, Education, Communication (IEC)/Contraceptive Social Marketing (CSM)

The project provided technical assistance to the ONFP to develop and strengthen its capacity to plan, implement, and evaluate a comprehensive contraceptive social marketing program including a media-focused communication strategy. Objectives were:

(1) Improve the quality and targeting of IEC activities to meet the family planning information needs of the population; and

(2) Increase the participation of the private sector pharmacists and physicians in family planning service delivery and strengthen the system of contraceptive distribution.

An initial phase of intensive preparatory consultations with ONFP management included the review of project objectives, implementation criteria, benchmarks, and modalities of carrying out activities. RONCO then embarked on the formal planning and development of a comprehensive social marketing plan.

It was agreed with the ONFP that this plan would serve as a multi-year framework for the proposed communication and social marketing program in Tunisia. It would be regularly reviewed and updated as might be required, on the occasion of the semi-annual Steering Committee meetings.

In order to maximize the potential for completing the marketing plan, yearly action plans were developed and included prioritizing various tasks, identifying the relevant human resources requirements and technical assistance needs, and determining the execution deadlines to move the program forward effectively.

The marketing plan consisted of the following elements:

- Media Research and Evaluation;
- Media Planning and Message Development;
- Media Production;
- Contraceptive Product Promotion; and
- Contraceptive Procurement and Distribution.

For this component of the project, RONCO entered into a subcontract with Manoff International, a U.S. marketing firm. Subcontracts were also made with the El Amouri Institute of Applied Psychology, a Tunisian market research firm, to assist in the execution of the initial baseline qualitative research and with Geovision, Inc., a U.S. production firm. Media consultants and marketing specialists were also hired directly under the RONCO contract. A total of approximately 28 person months of short-term technical assistance was made available to the ONFP during the four and a half year life of the project. This substantial volume of technical assistance was needed because the ONFP staff was unfamiliar with social marketing techniques and had to learn to deal with the private sector on many aspects of the program such as market research, media development, product promotion, packaging, and distribution. Another focal point of the TA was the consolidation of the administration of the CSM program in order to build up the institutional capacity of the ONFP to plan, manage, and monitor all of the elements of the social marketing program.

(a) Project Achievements

The first and second year consisted of activities necessary for establishing the social marketing program and for meeting the project objectives of increased product and service availability to the private sector physicians and pharmacists and the establishment of effective distribution channels.

These were combined with radio and TV messages designed to meet the needs of the primary target group (married women of reproductive age). Built-in market and media research mechanisms were developed to evaluate the effectiveness of the communication program and to plan future strategies.

The IEC/CSM program moved essentially into its second stage, that of monitoring and evaluation, during the third and fourth years of the project. Assistance to the ONFP was provided in the analysis of media research data and in fine-tuning the computerized management information system developed for monitoring product distribution and billing data. A revised marketing plan outlining all of the tasks required after the launch of the CSM products on the market and the airing of Phase I and Phase II media campaigns was prepared. Phase III, consisting of two series of two spots each for radio and TV, was developed. Based on the results of media research, Phase III targeted men (first series) and mothers/mothers-in-law of young couples (second series).

Another major emphasis of the CSM intervention during this time was to consolidate the gains made during the previous 24 months and reinforce the CSM structures as well as the capacity of CSM staff to conceptualize and administer all aspects of the marketing program. The extension by 18 months of the project assistance completion date (PACD), which became effective in March 1989, provided the necessary time required to work with ONFP to help them attain a higher degree of self-reliance in this field. During this 18 month extension, efforts were concentrated on consolidating progress made in the institutionalization of media communication and social marketing, and strengthening the management of this component of the project.

Finally, the ONFP was assisted in the development of IEC/CSM program strategies for the future and the establishment of its marketing plan for 1991.

(b) Situation Analysis and Recommendations

(1) The Media Program

At the inception of the project in June 1986, commercial and public service advertising on Tunisian radio and television were prohibited by the Government, which owns and operates all broadcasting stations in the country. At that time, the situation was also characterized by a very limited supply of trained technical personnel in the

media/marketing field at the ONFP. Those available lacked the skills and experience to produce public service media campaigns built around spot advertising. Therefore, a priority task was to train a core group of technicians to manage and monitor the intended TV and radio advertising program. Short-term training in North America was provided for the head of the ONFP's Social Marketing Unit and for two TV directors from the National Broadcasting Agency (RTT).

In addition to the scarcity of trained media technicians and the lack of a marketing and advertising tradition in the country's private commercial sector, the project was confronted with two additional problems in designing the CSM media program. The first problem was a tendency on the part of ONFP staff to want to please all audiences. The second problem was the paternalistic attitude toward the population on the part of many government officials and leading members of national organizations on media matters. This was further exacerbated by the fear of negative reactions of conservative groups in an era of increasing religious fundamentalism. As a result of this situation, there was less systematic reliance on message testing and media survey findings than planned. Fortunately, research results did confirm the positive attitute of the population vis-a-vis media advertising for family planning.

Another constraining factor in implementing the media program was the difficulty encountered in executing the media research plan. It had been agreed with the ONFP that the volume and timing of the research activities under the marketing plan precluded these activities being carried out "in house", given the limited capacity of the research staff at the ONFP and their heavy workload. In addition the researcher position in the CSM Unit was not filled until October 1988 when a junior employee was assigned to coordinate the implementation of some of the qualitative research work generated by the media plan. Unfortunately, offers received from the private sector research firms were priced excessively high. As a result, the ONFP reversed its initial decision to subcontract the research work. The arrangements for this work to be accomplished by the ONFP research staff itself have never proved satisfactory. It is recommended that the ONFP consider further restructuring of the media research function in the Marketing Unit in order to strengthen this important element of the social marketing program.

The project's radio and TV advertising strategy for the CSM media program called for the development of an initial series of deliberately low-key spots. They would be well-adapted to Tunisia's Islamic social and cultural traditions and demonstrate the positive impact of family planning on the general well-being of the family. This was to be followed, in a second phase, by method-specific advertising and, in a third phase, by spots designed to respond to the contraceptive information needs of specific target audiences. This strategy was adhered to during the entire life of the project.

Commercial and public service advertising (PSA) were introduced on Tunisian radio and television in January 1988. The ONFP family

planning spots were the first to be aired. Since the beginning of the project, a three-phase media campaign was produced providing, in the process, a full range of consultant assistance and on-the-job training to ONFP staff in the various stages of media development and research. As a result of this work, the staff of the Communication Division of the ONFP developed substantial experience in both the conception and production of a media campaign as well as in qualitative and quantitative media research. Ten television and radio spots with accompanying posters have been produced. A KAP study and a series of focus groups and mini-surveys were also undertaken to learn about the population's media behavior and family planning beliefs and practices, to test media materials, and to measure their impact on the population. A second KAP study to evaluate the overall media program and to measure behavioral changes among the population was also conducted during the final year of the project.

Since the ONFP pioneered public service advertising in Tunisia, other government and non-government agencies have adopted a similar communication approach. Several radio and TV PSA campaigns were developed for themes varying from oral rehydration and vaccination to energy efficiency and road safety. At the same time, commercial advertising experienced a rapid growth and provided a comparison for the PSA productions, particularly with regard to production quality. In May 1989, a colloquium on public service advertising was organized in Tunisia by the National Institute of Journalism that focused on the issues and constraints of media communication in Tunisia. The ONFP and RONCO actively participated in this coloquium. In addition, the National Broadcasting Agency (RTT) adopted a statute that sets norms and regulates television advertising for both the commercial and public sector.

Considering the existing situation at the inception of the project and the challenge of the task, tremendous progress has been made during the project life in promoting media communication in Tunisia and bringing about positive changes. However, despite the progress made and the substantial technical assistance inputs, the IEC/CSM media program still has some weaknesses, particularly in creating a communication program consistent with research data findings and in using the ONFP's in-house A/V production facilities to their full potential for the production of communications materials.

Further progress is needed both at the institutional and personnel levels in the following major areas of media interventions:

- Determining viable market targets at which to direct a media campaign;

- Developing resistance points and areas of opportunity from qualitative and quantitative research findings;

- Defining strategy based on resistance points and areas of opportunity;

- Developing scenarios based on media strategy;
- Production of spots and other video materials; and
- Editing spots based on media research findings.

(2) Contraceptive Product Distribution and Promotion

The two CSM products currently being marketed in the private sector by the ONFP are condoms and pills under the brand names Rifel and Norquest, respectively. In addition to these products provided to ONFP under the A.I.D. grant, three brands of UNFPA-provided pills are distributed by the ONFP in the private sector -- Anovlar, Microgynon, and Neogynon. All products are distributed from ONFP warehouses to wholesale pharmacists who, in turn, distribute to retail pharmacists. Overpacks and inserts with common designs and colors were produced along with several promotional items for physicians and pharmacists as well as five leaflets for users. These promotional items were designed using the same graphics and colors used for the product overpacks.

As of February 16, 1989, the sales price of the three pills that the ONFP receives from the UNFPA was raised from 50 millimes to 300 millimes to standardize the price of oral contraceptives. On the same date, the price of condoms was increased slightly from 10 to 30 millimes per unit. The parity pricing has greatly benefitted Norquest sales. It was also beneficial to wholesalers and pharmacists, as wholesalers receive a 10 percent profit margin and pharmacists receive a 32 percent profit margin on the sale of pills and condoms. The ONFP receives a 58 percent return on sales. Thus, pricing parity contributed to strengthening the interest of wholesalers and retailers in the CSM program while at the same time benefitting the ONFP. In addition, the higher price still represented a favorable price/value relationship for the consumer.

The ONFP plan calling for the introduction of two additional products in the CSM program was indefinitely postponed in September 1989. A vaginal contraceptive called Conceptrol was to be introduced in July 1989 and the Copper T 380A was to become available as a CSM product in December 1989. The postponement of this plan until further review was rendered necessary when it became evident that two issues of crucial importance to the future of the CSM program could not be addressed within the planned time frame for the introduction of the above-mentioned products. These two issues are (1) contraceptive supplies and procurement, and (2) the training needs of private sector general practitioners, particularly in practical training for IUD insertion. These issues are still under discussion with ONFP management.

Contraceptives Provided under the Project

Between 1986 and 1989, the project spent approximately $1,261,400 purchasing contraceptives for the ONFP. The following items were provided:

a)	LoFemenal	696,000 cycles
b)	Norquest	495,600 cycles
c)	Condoms	6,090,000 units
d)	IUD	346,000 units
e)	Vag. Contraceptives	1,517,000 units
f)	Medical supplies: foreceps, syringes, yoon rings, gloves etc.	

As part of USAID's efforts to turn the ONFP into a fully responsible and sustainable organization, it was agreed in early 1989 that the ONFP needed to begin purchasing a portion of the contraceptive supplies needed for the program.

USAID therefore repeatedly stressed the need for the ONFP to begin securing financial resources to partially cover its supplies fo contraceptives. In September 1989 the ONFP announced that an agreement in principle had been reached with the Tunisian Ministry of Plan and Finance for the allocation of funds to the ONFP to buy contraceptive supplies. The level of funding (TD 300,000) was established in January 1990. The procedures for procurement and import of contraceptives by ONFP were then defined. As of 1991, procurement will be made by the "Pharmacie Centrale" of Tunisia, the MOPH drug procurement agency, under norms and specifications established by the ONFP. Initial orders were placed in December 1990.

A strategy and a comprehensive plan of action for the training of private sector physicians that takes into account the large number of physicians who expressed an interest in family planning training and the requirements and characteristics of their profession was developed. RONCO's input in this field was coordinated with JHPIEGO, which will continue to cooperate with the ONFP in the implementation of the training program as of 1991.

During the first quarter of CY 1988, RONCO worked in close collaboration with the A.I.D. centrally funded Family Planning Logistics Management (FPLM) project to assist the ONFP in the establishment of a three-year forecast of contraceptive commodity needs and to conduct an assessment of commodities management needs for the public sector.

Inputs from the FPLM project were coordinated by RONCO in order to complement the computerized billing and distribution system for the private sector set up by RONCO. A software program was selected and purchased, and a consultant installed the program and trained the Medical Division staff in its use. The ONFP recruited a computer program specialist to operate the system. This technician worked with a consultant for five weeks in April and May 1988 when the system was being installed. The system was allowed to run for a period of three months (July to September) and the same consultant then returned (this time funded by the FPLM project) to make the necessary final adjustments. The system has now been in operation and functioning smoothly for more than a year.

In summary, all of the activities called for under the project's marketing plan for contraceptive commodities procurement, pricing, packaging, and distribution were carried out as planned. The objectives of the bilateral agreement in this specific aspect of the social marketing program were largely met by the end of 1989. Since then, the bulk of the effort has been to consolidate the capacity of ONFP staff to manage the program in a self-sufficient manner and to develop strategies for further expansion of the CSM program. As a result of these efforts, the MIS computerized model was extended to monitor other commodities such as pharmaceutical products used by the ONFP in 23 regional clinics. In addition, the ONFP is now purchasing contraceptive products with its own funds, and is poised to introduce new product lines under the CSM program, and adopt a pricing strategy that gradually decreases subsidies and helps achieve a higher degree of cost recovery.

The ONFP has also sought and obtained the approval of the Ministry of Health for codifying family planning procedures and establishing tariffs for private sector physicians to charge for the delivery of family planning services. This action constitutes a major step forward in the consolidation of the CSM program and paves the way for the reimbursement of family planning procedures by the health insurance system.

(3) Management

Staffing requirement agreement for the Social Marketing Unit of the ONFP was never met despite repeated efforts by A.I.D. and RONCO. The agreement stated that staff of the unit will be composed of a marketing manager, a media director, and a research director. The current overall administration of the social marketing program is divided among three departments of the ONFP: the Communication Division, the Research Division, and the Medical Division. A social marketing unit was established at the ONFP, but as a branch of the Communication Division and without direct linkage to ONFP top management. While the marketing manager position has been filled since the inception of the project, the research position remained vacant for almost two years before a junior-level employee with little research background was assigned to the job. The media director position was never filled, and it was left to the Communication Division chief to coordinate the media program. The media research program was implemented under the responsibility of the Research Division of the ONFP. The medical detailers, contraceptive procurement, and the MIS came under the Medical Division.

The current overall administration of the social marketing program at the ONFP is considered a major impediment to success because of the lack of a single unit to oversee all the components of the marketing plan. This plan was based on a series of integrated functions and tasks whose implementation required consistent monitoring and coordination in order to ensure maximum efficiency. USAID and RONCO had repeatedly recommended to the ONFP management the restructuring of

the social marketing activities into a single, all-inclusive unit directly responsible to the PDG. To date, no decision has been made by the ONFP to implement the recommendations, but some steps have been taken to improve cooperation among the various divisions involved in the social marketing program.

2. Training

Under Targeted and Evaluated Training, the TPFP Project was mandated to:

(1) Institute and strengthen family planning training programs in the medical schools, schools of public health, and school of social work so that the ONFP no longer would be responsible for basic professional family planning education;

(2) Reinforce the practical training program for several categories of health and social workers to respond to the information and family planning needs of different segments of the population;

(3) Train program administrators;

(4) Provide long- and short-term U.S. and third-country training to population specialists and support for attendance at international conferences.

The first two points formed the basis of the training activities under the TPFP project. Specific activities, approaches, and collaborative efforts from project inception focused on targeted and evaluated pre-service/academic and in-service training.

The training of program administrators is covered under the management section of this report. Long- and short-term U.S. and third-country training was addressed according to the needs expressed under each aspect of the project.

Over the 4 1/2 years of the TPFP project, RONCO employed approximately 21 person months of technical assistance for the training component. This component covers pre-service/academic training, post-graduate training for private physicians and pharmacists, and the decentralization of in-service training.

Pre-Service/Academic Training

A major effort was placed on institutionalization and strengthening of family planning pre-service/academic training for midwives, physicians, nurses, and social workers. Introducing a comprehensive approach to family planning in the academic training of health and social workers had several important advantages:

(a) It shifted the role of the ONFP, and its limited number of training staff, from that of principal pre-service family

planning trainers to technical advisors for curriculum development and specialized training in a pre-service setting.

(b) It allowed for a more integrated approach to family planning by furnishing aspects of family planning throughout a provider's training and emphasized the role that family planning plays in overall health services. No longer will family planning approaches be viewed as an afterthought, as could be construed by the previous training of graduates of health and social service schools in a special pre-service course that came after basic training. It was anticipated that this new integrated approach would alleviate some of the most serious recurring field level service-delivery problems that seemed to be related to the difficulty of placing family planning in an overall maternal and child-health context.

(c) The reduction of training responsibility would add to the ONFP's effort to streamline its budget. Specialized pre-service training for new graduates was very expensive and produced no revenue, unlike international training, which, at the very least, can recover costs.

The strategy for developing a pre-service family planning component within the existing curricula focused on a modular approach and relied heavily on linking educational objectives to field-level task requirements. This fits in very well as several of the medical schools, particularly the Medical Faculty of Tunis, were already in the process of revising their curricula in such a fashion.

The overall achievements under this activity were:

(a) Establishment of a dialogue between pre-service/academic institutions and the ONFP;

(b) Creation of modules for family planning training in:

Midwifery Schools:
- Community Health - Year I
- Community Health - Year II
- Community Health - Year III
- Contraception - Year II
- Neonatal - Year III
- Pediatrics - Year III
- Practical Training Guide - Year II - MCH
- Practical Training Guide - Year III - Family Planning

Public Health Schools
- Family Planning

Medical Schools
- Psycho-Social Aspects
- Gyneco-Obstetrics
- Demography

Social Work School
- Family Planning
- Medical Aspects
- Demography

(c) Training of nine "Techniciens Superieurs" in modular curriculum development;

(d) Training of three graduate students from the Institut de Travail (Social Work Administrators) through intensive practical training; and

(e) Organization and implementation of an international conference for francophone Africa representatives in Pre-Service Family Planning Training using the Tunisian experience as a case study. Details on problems and progress for this activity are contained in the RONCO final semi-annual report. In addition to the short-term training managed by RONCO, two long-term participants were sent to the USA. One went for an M.S. in Epidemiology and then took a two-year fellowship at the Centers for Disease Control in Atlanta, Georgia, the other participant was sent for an M.S./PhD in Development Sociology/Population Development at Cornell University.

Post-Graduate Training for Private General Practitioners and Pharmacists

An essential ingredient of the social marketing program, which aims to introduce new (and already-used) contraceptive products into the private sector, is a post-graduate family planning training program for private general practitioners and pharmacists. The current post-graduate training offered by the ONFP's Training Center targets public sector physicians. Although much of the content of this training would be pertinent for the private general practitioners and pharmacists, it needed to be expanded to include additional information. The formula of a two-week seminar as used for public sector physicians would not be feasible for private sector physicians who would be unable and unwilling to leave their practices for such a long period.

Beginning with an Information Day on Hormonal Contraception, all private general practitioners were invited to take part and were sent a survey to seek their interest in future training as well as their preference for type and logistics of such training. Eighty persons attended and many more expressed interest.

The method of self-teaching modules was investigated. To further explore the development of these modules and the program in general, based on an overall strategy and general plan developed by the ONFP's Medical Division, a Canadian physician who is a member of the Quebec Federation of General Practitioners (FMOQ) provided advice. After an initial visit to Tunisia in June 1990, a draft plan for a program was

developed with the ONFP's Medical Division and Training Center. This effort was followed by a final TPFP consultancy in December 1990 by a team of two physicians from UNAFORMEC, a French organization responsible for medical in-service training in France. Because JHPIEGO had shown interest in continuing to assist this work after the end of TPFP, RONCO facilitated the presence of JHPIEGO's Africa Region Medical Director during this final consultancy to promote collaboration among the ONFP, UNAFORMEC, and JHPIEGO.

In addition, a concerted effort was made to involve the Tunisian professional organizations. Le Conseil de l'Ordre des Medecins Tunisiens, l'Association des Medecins Tunisiens, and the Syndicat des Medecins de Libre Pratique have all been involved in planning meetings on more than one occasion. These organizations have expressed interest in collaborating with the ONFP and, as a result of meeting with them and some of their constituents, a plan for the implementation of a post-graduate training program has been developed. The plan basically includes content, potential training methodologies, and an approach to evaluation. It is anticipated that JHPIEGO will fund a first seminar to introduce the program in early 1991.

Decentralized In-Service Training/Evaluation

In response to the mandate of developing targeted training for different segments of the population, in-service training played an important role. Running almost parallel with TPFP, RONCO's PAC II project (centrally funded by A.I.D./Washington in 1985-1989 and mandated to provide training primarily to non-physician workers) focused on the institutionalization of a decentralized in-service training process that could respond to the specific needs of the various regions.

Since project inception, TPFP collaborated with PAC II in the institutionalization of this decentralized in-service training process: Diagnostic-Programming-Evaluation (DPE).

Beginning with the creation of inter-regional teams, this process, which focuses on remedying field-level problems, put the emphasis on training ONFP personnel in the skills to carry out not only actual training activities, but also an effective needs assessment (diagnostic) and evaluation, which are key for maximum impact of all training programs (in-service, pre-service/academic and post-graduate). Since there have been and will continue to be many changes in these different types of training (family planning integrated into academic training curricula, post-graduate training for private physicians, etc.) this type of process will not only continue to identify changing needs, but will also serve as an overall evaluation tool for measuring the impact of these changes on the family planning program.

TPFP collaborated with PAC II, particularly in this area, by providing the TPFP long-term training consultant to work closely with the PAC II

Project Manager (these positions were subsequently held by the same person as of January 1988) as well as by providing technical assistance for training evaluation workshops for the inter-regional teams.

The collaboration extended further into the assessment of progress of the decentralized in-service training system, which is now being recognized as a management tool for the potential decentralization of the rest of the ONFP's departments (service delivery, training, education, and research). The desire to expand the decentralization process was clearly stated during the first of a series of activities in the development of a management training strategy.

To a large extent, decentralized in-service training has been institutionalized at the inter-regional level. Having initially been introduced by the PAC II project, it primarily evolved as an approach to identifying regional-level problems that could be resolved totally, or in part, by training. Over the years it became clearer that a replication of the effort made by the ONFP Training Center in coordinating and supporting this DPE process would be advantageous in the other divisions. An initial attempt to involve other divisions and a willingness of their staff to take part in the Diagnostic exercise was initiated and demonstrated in 1988 and 1989.

Over the last calendar year, TPFP has focused on the refinement of the Diagnostic process. After a series of technical assistance field visits, the CIRs (inter-regional teams) refined their 1989 Diagnostic and found, as a result, that they had, in fact, better targeted their training needs. A Guide to the Regional Level Diagnostic was subsequently produced.

During the final year's Impact Workshop for regional staff, an attempt was made to evaluate the effort of training over the past five years. The basis for most of the information was the PAC II evaluation reports. However, an important effort was made to utilize results from the ONFP KAP Population Studies from 1987 and 1990, the ONFP KAP Study of Service Provideers, and the DHS. This was the first time that a number of different studies were examined together, particularly at the regional level, for the purpose of looking at programmatic implications. The result of this workshop demonstrated the role that training plays in the overall advancement of the program. It is clear that training, although important, cannot resolve all the problems of the family planning program (other components must play an important role) and the level of effort needed may not be at the same level in all regions. The main conclusions have been thus that decentralization is essential and that the other ONFP departments have an important role to play in the DPE process.

Natural Family Planning

Project funding was given to a non-governmental organization providing natural family planning (NFP) services. Since 1982 this organization

- l'Action Familiale/Prelature de Tunis - has engaged in educational activities to further NFP practice among the Tunisian population, particularly poor, underserved areas of Tunis. A Training Specialist met with the staff from l'Action Familiale on numerous occasions to assist in developing an evaluation plan, to explore the possibilities of a pilot project that would try to reach more couples, and to encourage collaboration with ONFP structures. TPFP provided direct assistance for:

- Three-month training for a senior staff member in Mauritius (this staff person was eventually responsible for supervision and training of other staff); and

- Ongoing expenses for educators' training, salaries, and recurrent costs.

The major achievements were:

(1) Employed and trained three supervisors/trainers.

(2) Employed and trained eight educators.

(3) Visited approximately 200 couples at their homes. Over 400 persons have received information at fixed weekly locations.

(4) Introduced a program for basic "sex education" at a professional school for young women.

Management of Training Activities

The ONFP Training Center is currently overloaded for the number of staff it has available. At this time, the Training Center relies heavily on consultants from universities to assist in training. Eventually, training activities may decrease due to the number of new graduates of institutions who have profited from the new family planning modules. However, this is not yet the case and will probably not be the case for many years. In fact, the Center is becoming responsible for more activities all the time: increased international training, management training, initiation of new post-graduate training, etc. In addition to the use of Tunisian consultants, there has been a move to coordinate training activities inter-departmentally and thus share some of the burden. Still it is not sufficient to ease the load of the Center, which has the ultimate responsibility for training. It seems essential that additional staff -- at least one Medical Trainer, and an Evaluation Specialist -- be assigned to the Training Center.

3. Resource Targeting

The purpose of this component was to:

- Develop proposals for activities that would lead to targeting family planning service delivery resources, project evaluation, and strengthening Tunisian population research and implementation capabilities;

- Identify the proposed impact of these activities in measurable terms and implement evaluative procedures to examine their success in achieving the desired outcome;

- Develop proposals for activities that build on service delivery in agencies other than the ONFP and that directly address increased cost-effectiveness or coverage of service delivery.

At the inception of the project, a series of work sessions were held during the summer and fall of 1986 with ONFP management and research staff to review in detail the project objectives, implementation criteria, and the modalities for carrying out activities under this component of the TPFP project.

Immediately following this initial phase, formal planning and development of resource targeting activities designed to meet the project's objectives began. As part of this process, ONFP management was encouraged to involve resource persons from other institutions and government agencies as well as to establish interdepartmental planning groups in order to seek the opinions and practical suggestions of the ONFP senior-level central staff in the resource targeting program activities. This participatory approach to research design met with partial success. Participants in the planning sessions could not devote a sustained level of effort to this activity due to the demands of their regular work, and this collaborative planning process, while advocated at the top management levels, had not yet found its roots within the organization.

This lack of effective collaborative work in the planning and design phase of the resource targeting activities continued to characterize the program during its implementation and analysis phases. The situation was rendered even more difficult as this was combined, at the inception of the project, with a pronounced reluctance on the part of the ONFP research staff to recognize its own lack of experience in operations research design and analysis and to accept technical assistance. Consequently, the development of a detailed strategy for this component of the project and the subsequent design of operations research-type proposals and other collaborative research activities geared to improve the utilization of program resources proved rather arduous, particularly during the first year of the project life. Short-term TA was devoted primarily to assisting the ONFP staff in the design of activities and the development of implementation and data analysis plans, in a first phase, and in the analysis of data generated by the various activities in a second phase. Only limited technical assistance was provided during field work and report preparation.

The TA level of effort under this component of the project was established on the assumption that activities would be designed and implemented by the ONFP in a partnership with other national institutions as called for under the terms of the bilateral agreement. While the project succeeded in achieving a degree of collaboration among Tunisian researchers, this was not substantial enough to have had a positive impact on the pace of implementation and data analysis. As a result, the activities that were planned under this component of the project ultimately proved to be beyond the capacity of ONFP's limited research staff, which throughout the project life continued to be further depleted.

A total of approximately 13 person months of technical assistance services was provided by RONCO from January 1988 to December 1990. RTI provided 2 person months. A more intensive involvement of technical assistance personnel during the implementation process would almost certainly have led RONCO to take direct charge of the project research program, but this would have defeated one of the primary purposes of this component of the project, which was to strengthen Tunisian population research and implementation capabilities.

(c) Project Achievements

Eight research activities were implemented under the TPFP project. Six were developed with RONCO technical assistance and one was conducted in collaboration between the ONFP and Research Triangle Institute (RTI). They consisted of:

- A KAP survey of medical and para-medical service providers;
- A national survey on continuation and failure rates of pill and IUD acceptors;
- Integrated family health and family planning in the North and North Western Governorates;
- A pilot project for integrated family planning services in peri-urban areas;
- A family health operations research project in the maternal and child health centers of Monastir and Sayada;
- A survey on the determinants of fertility in Tunisia (RTI);
- A survey and cost analysis of family planning service delivery functions in both the public and private sectors;
- Demographic Health Surveys (ex-Westinghouse Institute for Resource Development-Macro Systems, Inc.).

(1) KAP Survey of Family Planning Service Providers

The purpose of this survey was to learn enough about the government and private sector physicians, pharmacists, midwives, and paramedical workers -- their attitudes, current practices, interest, and their knowledge of Tunisian demographic challenges and of family planning services -- to guide the ONFP in its efforts to better mobilize, train, and motivate these groups. Using the profiles of these groups of service providers obtained through the survey, the ONFP hopes to be able to conduct better targeted training and motivational activities in order to increase their contribution in support of the national objective of making family planning services and contraceptive methods universally understandable, available, and acceptable throughout Tunisia.

The ONFP engaged a social demographer from C.E.R.E.S. to work on this survey. Selection of the sample was accomplished with the assistance of the Institut Naetional de Statistique (INS). Recruitment and training of interviewers was completed by March 1988 and field work was completed by June 1988.

A workshop for ONFP cadres was organized in December 1989 to share preliminary findings and to seek requests for further data analysis. In June 1990, an interministerial workshop was successfully conducted with the Ministry of Health with the production, printing, and distribution of 11 papers. Two additional workshops were held, in Sousse in October and in Sfax in November 1990, to discuss with regional health personnel and private sector practitioners the general findings of this KAP survey. Dissemination of data generated under this survey was widespread and has led to general recognition of the inadequate participation of a variety of health cadres in family planning in Tunisia.

A summary volume has essentially been completed; however, due to the pressure of other commitments, none of the final reports has been completely finished as of the date of this report.

(2) National Survey on Continuation and Failure Rates of Pill and IUD Acceptors

The survey was designed to provide a basis for converting service statistics on new users of these methods into "couple-years of protection" and "births averted," and to enable the ONFP to learn what factors were associated with discontinuation and/or change from one method to another. This information will be used to develop programmatic initiatives to increase continuation rates.

The universe sampled was the records on file in CREPFS of women who first accepted either the IUD or oral contraceptives during the past five years. Preliminary life tables for continuation rates for IUD and pill use were produced by December 1989, as were initial cross tabulations of continuation rates with independent variables for women

sampled. A workshop for presentation and discussion of the findings was envisioned for November 1990, but has been postponed. It now appears unlikely that the analysis report will be produced before 1991, which will delay the findings presentation workshop and competition of the final report until probably the end of 1991.

(3) Integrated Family Health and Family Planning in North and North Western Governorates

This activity proposed the reprogramming of mobile and integrated family planning services by local and regional personnel of the ONFP and MOPH with other "partners" such as the Ministry of Social Affairs and Non-Governmental Organizations. Efforts were focused on the redeployment of mobile teams and the addition of mobile clinics in an attempt to achieve an optimal and cost-effective redesign of service activities at the local level. Two important accomplishments of this programming effort were consideration of the findings and lessons of earlier operations research studies, and better analysis and use of routine service statistics to assist decision-making for reprogramming and management of family planning services at the governorate level.

A diagnostic assessment of the priority problems in each of the five concerned Governorates and a detailed examination of service statistics, center by center, were accomplished. Meetings were organized to discuss with all interested parties how their activities could be better integrated and services reprogrammed for improvements in program outputs in their areas. This process led to the development of work plans by June 1988. Preliminary findings indicate that impressive effects were achieved by converting from mobile teams to mobile clinics and by preceding mobile visits with well-programmed educational and promotional efforts. Further observation and evaluation of the new services needs to be carried out and well documented before this activity can be brought to conclusion.

(4) A Pilot Project for Integrated Family Planning Services in Services in Peri-Urban Areas

During January 1988, TA was provided to assist the ONFP's research staff to consolidate the conceptualization and initial design of a peri-urban operations research project. This task has resulted in the preparation of the following documents:

- Strategy Orientation on the question of integration of services in the peri-urban areas;

- Methodology Orientation on the conduct and evaluation of an operations research activity in the peri-urban areas; and

- Background paper on the characteristics of the zones of intervention.

These documents, which provided the outlines of a peri-urban operations research activity, were used by the ONFP in the elaboration of a revised project proposal and budget that was approved in April 1989.

The research activity based on this work consisted of the design, implementation, and evaluation of operations research interventions for an integrated approach to service delivery in three peri-urban zones in Tunis and Sfax. Three technical working groups composed of personnel from the ONFP, the Ministry of Social Affairs, and the Ministry of Public Health were established and have defined approaches for improved integration and selected a series of indicators to measure the impact of service input of each of the concerned agencies in the project. However, the working groups have worked slowly, with difficulty and with high turnover of the members. As a result, post-intervention surveys to demonstrate the effects of the interventions will not be meaningful until mid-1991.

(5) Operations Research on Increasing the Availability and Acceptability of Contraceptives in MCH Centers in Monastir and Sayada

The objective of this study is to demonstrate the effect on acceptance and use of contraceptive methods that can be obtained by providing a complete package of MCH/FP services to women who visit the MCH centers of Monastir and Sayada. Two groups of potential acceptors were selected from the register of the centers. One group was the recipient of a variety of health and family planning services usually not provided as a matter of course, and the second, which received only ordinary care, was the control group. The project has now been under way for more than a year. A series of written reports has been produced and four workshops were held to discuss the findings from analyses of data on selected fertile women who use the MCH centers and who (a) receive ordinary care (control group), and (b) accept the tendered package of unrequested services and follow-up (intervention group) at entry, 3, 6, 9, and 12 months. The most recent workshop was held on December 22 in Sfax. Contraceptive use, complaints with methods, and pregnancy rates at the ninth month after the beginning of intervention were presented with contrasts between the control and intervention cohorts.

A final workshop to present results at 12 months was held the last week of December 1990 including results from integrated efforts in other MCH centers in Tunisia. Preparation of the proceedings of this workshop and writing the final report will be carried out in 1991.

(6) A Survey of the Determinants of Fertility in Tunisia

This study used existing data such as the 1983 Contraceptive Prevalence Survey, the 1978 World Fertility Survey, and the 1988 Demographic and Health Survey to determine the socio-economic factors that can explain changes in the levels of fertility and to link these

to expected demand for family planning services. This will allow the ONFP to prepare family planning targets that are consistent with the expected development of the country.

The project consisted of a statistical analysis phase and a modeling phase. The modeling phase used models developed by RTI in conjunction with the Ministry of Plan and has also drawn upon other models for family planning and fertility developed by RTI/INPLAN. A computer-assisted visual presentation was prepared to help in disseminating the results. The final report and workshops were completed in November 1990 and this project has now terminated.

(7) Cost-Effectiveness Analysis

The principal purpose of this activity is to initiate at the ONFP a cost-effectiveness study of family planning services in the public and private health sector with a particular focus on ONFP inputs in terms of commodities and human resources at both central and regional levels. Unfortunately, the decision to carry out this activity was repeatedly postponed until late August 1990 when the decision to go ahead was obtained. A research agenda for cost-effectiveness analysis was developed and a questionnaire was elaborated that will be used to gather data at the field level. Start-up activities conducted during the final four months of the TPFP project were financed. Because of its late start, this project will be continued by the ONFP during 1991.

(8) Demographic Health Surveys

Situation Analysis and Recommendations

As with CSM, which has had a very positive impact on the way the Communication Division conducts its work, one of the most significant impacts of the Resource Targeting component of the project was to catalyze and accelerate changes in the nature and role of the Research Division at the ONFP. Throughout project implementation, the Division has gradually shifted from a role of demographic research and statistical data collection to one of broader service support and applied research. The Research Division, which was almost exclusively linked to the ONFP central management, has now established linkages at both central and regional levels within the ONFP, as well as external linkages with other institutions and government agencies. This tendency now appears to be well established and chances for reversion to the pre-project situation appear rather remote. Unfortunately, the human resource and capacity building-implications of this shift in the role of the Research Division, as well as the need for a participatory approach to research, took a long time to be accepted and internalized by the research staff at the ONFP.

Another principal source of slowdowns and delays was the volume of research. Seven research activities and a DHS survey were conducted during the project life in addition to the regular service statistics, data collection and analysis. This proved too much of a workload for

the existing capacity of the Research Division. Unless the ONFP seeks and secures a more effective participation of its partner institutions in the design, implementation, and evaluation of new research activities, it is recommended that over the next two to three years the ONFP research staff concentrate its efforts on finalizing the analysis of the present research work and conducting second generation analysis of the wealth of data they now have on hand rather than engage in new research.

With regard to training, despite the substantial efforts devoted by consultants to train the research staff on the job in the use of computer software programs and the application of computer technologies to research, serious difficulties in terms of logistics and staff availability prevented meaningful and effective transfers of knowledge in this particular area. This situation was further excerbated by the lack of computer literacy of most of the research staff at the ONFP. There is a real need for the ONFP research staff to master fundamental statistical concepts and use of computer software if further progress is to be achieved. ONFP management should prepare a medium- to long-range plan for staff development and training to be established and institutionalized at the earliest possible date.

4. Management

A condition precedent of the bilateral agreement called for a management needs study. After repeated and unsuccessful attempts to obtain the agreement of the ONFP management to conduct this study,the condition precedent was considered met by A.I.D. since the ONFP was undertaking similar work using internal resources. As an alternative, the focus became the development of a management program that would include a training component and thus address the TPRP mandate to train program administrators. The Training Resources Group (TRG) carried out a series of activities to address the primary management issues of the ONFP.

These management activities were developed and carried out through a sequence of phases. The overall approach was to begin with interviews and seminars for both central and regional-level staff so that an eventual consensus could be reached concerning the vision of the ONFP and values that would help to guide this vision. In addition, consensus was to be reached on a priority plan of action.

Project Achievements

The results of the five phases of activities include:

1. Consensus from central and regional ONFP staff on a common vision of the Tunisian Family Planning Program: "The FP Program, which focuses on the health and well-being of the population, must take into consideration its socio-economic and cultural evolution and respond to its needs by helping the couple choose their desired family size in a non-coercive fashion."

An organizational vision of the ONFP was developed as well that focused on:

- Planned decentralization;
- Greater integration of family planning services into health structures;
- A strategy for self-sufficiency; and
- A new approach in the management of human resources.

The ONFP also has come to a consensus on the 10 most important values that support these visions. These visions and values should provide an essential framework for the ONFP over the next 10 years in order to guide the ONFP's daily activities, develop plans of action, and help create new management improvement strategies. An initial plan identifying priority actions was developed as a result of these first two activities.

Over the life of the project the ONFP accomplished two of these priority actions, the finalizing of the personnel statute, and an organigram. The remaining RONCO/TRG activities focused on the training of the ONFP staff in management techniques, another priority action identified in this plan.

2. Fifty ONFP staff (37 regional and 13 central) participated in one of three management techniques workshops. The main outcome of these workshops, aside from gaining specific management skills, is that all of these staff are now capable of "speaking the same language" concerning management functions. In applying what these individuals have learned through their individual plans of action, they will be able to improve their individual work units' performance through improved management skills.

3. All the ONFP Directors, except for one, participated at a workshop of "reflexion" and "apprentissage" on management techniques that focused specifically on the resolution of conflicts and decision-making. Therefore, they too are now able to speak this same "management language" and should be putting into practice some of the same new techniques. This potentially could improve not only their own departments' performance but also improve inter-departmental communication.

4. The Training Program Director has acquired the necessary skills to become a co-trainer in similar workshops on management techniques. TRG, which owns the copyright for this course, has given exclusive permission to the ONFP to utilize the training plan for this workshop in the interest of reinforcing the ONFP's institutional capacity in training and management. With the assistance of other trainers, the ONFP could soon organize its own management workshops for ONFP personnel, other Tunisians, and foreigners.

5. The basic elements for a plan of action to improve the ONFP's management system that could run through 1995 have been refined and finalized.

Situation Analysis and Recommendations

At this point, the ONFP seems to have a solid base from which to begin major management reforms. The level of interest and the demonstrated potential of ONFP staff to improve management has proven to be exceptionally high. The staff who have participated in the workshops demonstrated their commitment to master management techniques and put into practice what they learned. They now need not only to actually begin to utilize these techniques, but to be supported at each level of the organization.

All staff, but most importantly the top-level managers, must:

1. Promote the organizational vision and be consistent with the values identified;

2. Ensure that lines of communication are open;

3. Share tasks so that each person's competencies are utilized in the best possible manner;

4. Give performance feedback to help motivate, correct, and build upon successes;

5. Accept that all teamwork generates some conflict situations and that those situations need to be dealt with and managed at the opportune moments and with a positive attitude that leads to effective new solutions.

In addition, the ONFP must focus on following up and maintaining the momentum of the work that has been done over the last year and a half. The following are specific recommendations to accomplish these tasks:

1. Create a management committee composed of two or three directors who would work closely with the "Direction Generale" and would have the responsibility to propose concrete actions linked to the recommendations made by staff. The committee would also coordinate management activities to be undertaken with other organizations.

2. Carry out the recommendations for training and organizational development made by the directors and staff.

3. Create a training team capable of carrying out management workshops and following up individuals' plans of action. These two or three persons should have good training and management experience that would be gained by first attending

the management workshop(s) and second by co-training with experienced management trainers.

4. Encourage an analytical approach to program planning (that would focus on reinforcing the ONFP's visions) through retreats for both the top-level managers as well as within each department and regional delegation.

E. PROJECT INPUTS

1. Technical Assistance: $3,013,000 (RONCO)
2. Training: $187,600 (CRS)

3. Commodities

Contraceptives:	$1,261,400
Automation Equipment:	$ 95,600
Mobile Clinic:	$ 88,870
A/V Equipment:	$ 138,130
Other Costs:	$ 38,500
	$1,622,500

The ONFP has very effectively used all the commodities supplied by the project. This was a sound investment of project resources.

4. ORT

$698,900 Oral Rehydration Therapy (sub-project with CRS)

5. Local Costs/ONFP Account

$2,762,500 Research Studies and other program support expenses

V. END OF PROJECT STATUS

Section IV. C., Project Activities, provides details on sustainability of Activities and Recommendations.

A. INSTITUTIONAL STATUS

An institutional analysis of the ONFP was undertaken by two consultants in December 1990.

Their principal findings are as follows:

- The ONFP is a mature institution capable of carrying out its principal mission, i.e., the planning and implementaqtion of a complex, effective national family planning program;

- USAID assistance over the past 5 years has been quite effective in strengthening the ONFP institutional capacity, particularly in areas of training and IEC/CSM;

- significant gains have also been made in areas of research and overall management of the program, but much remains to be done;

- with A.I.D.-financed assistance under the RONCO contract, the ONFP has achieved remarkable success in transferring primary responsibility for pre-service training of physicians, midwives, and nurses to outside Tunisian institutions, demonstrating the effectiveness of collaborating with institutions in the parapublic and private sectors; and

- the ONFP has also developed a good IEC/Contraceptive Social Marketing program which was "undreamed of" by Tunisian counterparts just 4/5 years ago.

Despite these impressive results and a generally healthy institutional capacity, the ONFP needs to improve its abilities in several areas. Areas for improvement include: (a) overall management, especially of personnel and of information; (b) use of computers and information technologies; (c) quality of service delivery (in order to improve client continuation rates); (d) operations research and media research; (e) consolidation and strengthening of contraceptive social marketing (CSM) activities; and (f) full involvement of NGOs, private sector, and appropriate public sector institutions.

Details on the institutional status of the ONFP are available in the report "Review of the Institutional Capacity of the Office National de la Famille et de la Population" by James Echols and William Trayfors, RONCO 1990.

B. LESSONS LEARNED

After twenty-five years of donor assistance, the ONFP is a mature organization with capable and dedicated staff and is relatively self-sufficient financially. Contraceptive prevalence rates are increasing and provision of services is gradually being assumed by the private sector. This project achieved objectives to a remarkable extent; however, it almost overloaded the implementation capacity of ONFP. Examples are as follows:

- The research staff with limited previous experience in operations research, were given too many projects to manage; yet but they were unwilling to call on outside collaborators to help them.

- The CSM program has worked despite the unorthodox organizational structure of the ONFP. But, this can be attributed to solid TA which managed to help the ONFP succeed

despite bureaucratic in-fighting. It is not clear whether progress can be maintained in the future.

- After two decades of having A.I.D. purchase contraceptives for the ONFP, they strongly resisted attempts to wean them from dependence on an outside donor. Yet for sustainability reasons, it is essential that a country as supportive of family planning as Tunisia is, should begin to pick up some of the tab.

- Excellent working relations between USAID, ONFP and RONCO staff ensured the high level of accomplishment shown by this project.

- The ONFP will need targeted TA to ensure the continuation of innovative program elements which is too premature to ask the GOT to ensure and for which there is little in-country experience.

VI. DIARRHEA DISEASE MANAGEMENT

Implemented by Catholic Relief Services/Tunisia
(June 1986 - May 1989)

A. Executive Summary

Initiated as an Oral Rehydration Therapy (ORT) project (TN-5D-005) in June 1986, it soon evolved into a Diarrheal Disease Management Project. USAID provided funding for the project, PRITECH participated with funds and technical assistance, and CRS implemented the project through the Tunisian Ministry of Public Health and the National Committee for Social solidarity. PRITECH and CRS/NY provided advance funding ($196,931) for eight months at the start of the project until a Cooperative Agreement between USAID and CRS was signed on december 15, 1987, with funding (amounting to $724,588) retroactive to March 1, 1987. The total project budget was approximately $1,000,000.

The long-range project goal was to reduce morbidity and mortality resulting from diarrheal disease in children under five years of age. According to WHO, diarrheal disease account for 55% of all child deaths in Tunisia. The project goal was consistent with the Child Survival and Family-Health Strategy of USAID and with Tunisia's Sixth Development Plan (1982-1986), which called for "preventive health-education training for public health workers and programs to prevent malnutrition and reduce morbidity and mortality caused by diarrheal disease".

In order to achieve this objective, the project focused on the implementation of the following six components, using the structures of the Ministry of Health and the National Committee for Social Solidarity (CNSS):

1 - Mother KAP surveys on the treatment of diarrhea at home, with pre-project research providing a basis for project activities.

2 - Training of mothers to treat diarrhea at an early stage in the home, using the salt-sugar solution, rice water, fennel water carrot water, and Oral Rehydration Salts in order to reduce dehydration and malnutrition amont children with diarrhea.

3 - Training of medical (from the private and public sectors) and paramedical personnel in handling diarrheal cases and educating mothers.

4 - Reinforcing these educational activities through the mass media, face-to-face communication, and the curriculum development for the training of health personnel.

5 - Design, production and dissemination of educational materials (training manuals, posters, leaflets and technical charts) and media messages (TV and radio spots) using a multi-media approach.

6 - Purchase of equipment for the local production of Oral Rehydration Salts. (cancelled at the end of subproject due to misunderstandings with UNICEF).

In this respect, pre-program research studies were conducted to provide a basis for the development of training and educational materials as well as for mass media activities. Both qualitative and quantitative research activities were carried out by local staff and encompassed the assessment of CNSS Centers, focus group interviews, KAP surveys with CNSS Center managers, health professionals and mothers. In addition, the project relied modestly on foreign technical assistance.

The training of public health personnel exceeded initial expectations in coverage, thoroughness and systematic approach. Regional Training Teams and training modules constituted a real asset for the continuation and further development of the Child Diarrheal Disease program. The training of Ministry of Health personnel was probably the project area where the most significant achievements have been accomplished in terms of number of people trained, diversity of topics covered and development of training materials. The number of people trained was at least twice as high as was planned, new categories of personnel were added during implementation, and a set of training modules was produced by the project which was not initially planned.

Ten TV spots/sketches and ten radio spots were produced and broadcast on the Tunisian Public Television and Radio network. In addition, training manuals, posters, leaflets, and promotional materials were prepared and disseminated through the Tunisian Ministry of Health structures.

Even with the bureaucracy of the institutions, a strong institution-building was achieved through investing into the training of the permanent regional coordinators instead of temporarily-hired area coordinators, who represented an attractive alternative for a prompt and visible project success.

B. PROJECT DESCRIPTION

1. INTRODUCTION

In June 1986, CRS/Tunisia engaged with the Government of Tunisia (GOT) in a three-year project to promote effective management of diarrheal disease (DD) and of dehydration associated with it. Initially conceived as an Oral Rehydration Therapy (ORT) effort, the project soon enlarged in scope to incorporate other aspects of diarrhea disease control and became a Diarrhea Disease Management (DDM) project. The project was first implemented by CRS with the National Committee for Social Solidarity - an autonomous organization under the sponsorship of the Ministry of Social Affairs - which manages a countrywide network of some 450 centers offering nutrition supplement for pre-school children and health education for the mothers. Although enjoying the agreement of USAID and the Ministry of Health at the beginning, the project started in June 1986 on the interim solution of advance funding from PRITECH (a USAID-centrally funded project to promote Technologies for Primary Health Care) and CRS/New York. CRS/NY committed $73,240 for general administration and logistics costs while PRITECH agreed to reimburse salaries and per diem for essential staff up to $123,691 for an 8-month start-up period. On 15 December 1987, a Cooperative Agreement was signed between CRS and USAID/Tunisia with funding retroactive to March 1, 1987. USAID was able to identify $724,588 through the Family Planning Project, where upon the Project Agreement between GOT and AID was amended (Amendment No. 5 of AID Project No. 664-0331 dated September 29, 1987).

As discussed with and approved by USAID, it was decided that the DDM project would be terminated by May 31, 1989, i.e. one month earlier than originally planned.

2. BACKGROUND: NATIONAL CDD PROGRAM

Diarrhea and malnutrition-related diarrhea with respiratory diseases rank as Tunisia's top child-health problems. In 1982, WHO estimated Tunisia's diarrheal mortality at 55 percent of all child deaths. In September 1985, CRS conducted a countrywide sampling of 1000 mothers whose children attended CNSS centers. The study noted that children in half the families had had diarrhea in the previous two weeks and among the families in which a young child had died, diarrhea was implicated in nearly half the deaths.

The Tunisian health leadership had been concerned about diarrheal dehydration and consequent malnutrition since the 1960's when

guidelines for treatment of acute diarrhea were published for use in Maternal Child Health (MCH) centers. A system of scoring to determine the level of dehydration was developed in Nabeul and officially adopted by the Institute of Child Health in 1978. In 1979, both the scoring and treatment methodologies were published by the Institute of Child Health and distributed as Guidelines to the MCH Centers.

In 1980, Tunisia launched an Oral Rehydration Therapy program through the Institute of Child Health with support from WHO. The goal of the 1980-84 program was to reduce infant mortality and morbidity linked to diarrheal disease.

After four years of program operation, a WHO evaluation showed that positive results were achieved in the area of training. The system of scoring to determine the degree of dehydration and the proper treatment of diarrhea and concurrent dehydration was believed to be generally practiced within the public-health facilities, though no systematic evaluation had been done on these specific issues. Pre-packaged ORS were provided free through the public health facilities. The salts were inconsistently available in private pharmacies and were generally not promoted by pharmacists.

No final quantitative evaluation of the program could be carried out because of the lack of baseline and monitoring data. However, the program review did document fewer severely dehydrated children in hospitals, lower rates of diarrhea-caused mortality among hospitalized chidren and a 50% reduction in the prescription of antibiotics for diarrheal disease. However, a number of problems were reported:

- Some hospitals continued to use intravenous treatments in the interest of saving time.

- The program achieved modest success in reaching private physicians and pharmacists who were still not sufficiently aware of the importance and efficacy of ORT.

- Only a limited effort was made to educate the community at large.

- Minimal use was made of the mass media to reinforce the ORT activities within the health structures.

- The data collection system proved inadequate, precluding precise determination of progress in terms of, e.g., ORS utilization rates.

Tunisian health leaders, who either worked in the WHO/UNICEF/GOT program or who knew it first hand, concluded that the results were very encouraging but that much remained to be done. One of the main conclusions of the program evaluation was that ORT health education activities needed to be greatly expanded and reinforced on a national scale.

Within the last several years, there had been a growing conviction on the part of Tunisian public health authorities that greater attention needed to be given to improving mothers' ability to intervene at home at the earliest stages of diarrhea, thus preventing dehydration. In many cases, and particularly in rural areas, where access to health services was more difficult, children with bouts of diarrhea continued to be seen late in the course of the illness. Early intervention by mothers at home was a key to improved diarrhea disease management; therefore health education of mothers became a priority.

3. PROJECT HISTORY

It was in this context of a clear need to support the ongoing program that CRS, in collaboration with USAID and PRITECH, proposed to initiate a project to assist the Tunisian Government effort in the control of diarrheal diseases.

Catholic Relief Services has worked in Tunisia since Independence in 1956. In close collaboration with the Government, CRS had worked with an indigenous organization, the National Committee for Social Solidarity (CNSS) with the purpose of providing a nutritious food supplement to the poorest children three to six years of age in remote areas. With CNSS, CRS had shared responsibility for delivering Title II food to approximately 450 CNSS centers countrywide and for educating mothers in health and nutrition. An Operational Program Grant, approved in 1977, provided support for upgrading CNSS center facilities and for training center managers in health education. Despite CRS's long involvement in preschool feeding activities and nutrition education of mothers, there was no direct collaboration with the Ministry of Health before the DDM project was launched. Negotiations and design for the present project began in 1985 with government institutions such as Mother and Child Health of Ezzouhour, Institute of Nutrition, Institute of Child Health. In collaboration with PRITECH, CRS/Tunisia prepared in April 1986 a draft proposal for a three-year direct health education and mass media intervention which was favorably reviewed by the MOH, CNSS, and USAID. USAID did not expect to commit funds until FY 1987. However, as the project objective was compatible with Mission mandate, all parties supported the interim solution of advance funding from PRITECH and CRS/New York.

In June 1986, CRS/New York committed $73,240 for general administration and logistics costs while PRITECH agreed to reimburse salaries and per diems for essential staff up to $123,691.

The purpose of the advance funding was to enable the project staff to carry out the necessary pre-program planning, baseline data collection and qualitative research so that mother education courses and the mass media campaign could be launched during the peak diarrheal season beginning in May 1987.

While negotiating project approval with USAID and the Ministry of Health, several external factors intervened: budgetary restrictions

within USAID and unclear policy directives from MOH - which contributed to a significant delay in the implementation of the project with the Ministry of Health.

The Mission had planned to fund the project from the 1986 Fiscal Year operating budget. However, subsequent cuts in centrally funded foreign assistance programs worldwide precluded this. AID financial commitments for socio-economic projects in Tunisia were reduced by 23%.

The absence of a designated CDD program coordinator at the MOH caused unclear guidance regarding the national CDD strategies and the integration of project activities within a larger framework.

Under these new circumstances, CRS/Tunisia prepared a proposal in April 1987 which requested resources of $857,000 from USAID and $189,000 from CRS/New York. USAID approved the project in principle and prepared a draft Cooperative Agreement based on several potential funding sources (bilateral Family Planning Project, Rural Community Health and fall-out funds). USAID was able to identify $724,588 through the Family Planning Project, whereupon the Project Agreement between GOT and AID was amended (Amendment No. 5 of AID Project No. 664-0331 dated September 29, 1987). No other AID funds proved to be available.

The Cooperative Agreement, signed in Tunis by the CRS/Tunisia Country Representative and USAID/Acting Director on 15 December 1987, committed $422,000 for the period from March 1, 1987 to February 29, 1988. The total Grant was $724,588 through June 1989. These in-country funds were to be drawn upon through a workplan prepared by MOH and CRS for submission to USAID. Each workplan included a brief summary of anticipated goals and cashflow projections for the period covered.

4. PROJECT GOAL AND PURPOSE

PROJECT GOAL: The long-range project goal was to reduce morbidity and mortality resulting from diarrheal disease in children under five years of age. This goal was consistent with the Child Survival and family-health strategy of USAID and with Tunisia's Sixth Development Plan (1982-86), which called for "preventive health-education training for public health workers and programs to prevent malnutrition and reduce morbidity and mortality caused by diarrheal disease".

PROJECT PURPOSE: The project purpose was to promote effective management of diarrheal disease (DD) and of dehydration associated with it through direct health education and mass media activities, and the provision of ORS.

C. PROJECT ACHIEVEMENTS

PRE-PROGRAM RESEARCH ACTIVITIES

CNSS Center Assessment

The initial operational research activity consisted of a comprehensive assessment of the CNSS centers. The purpose of the survey was to provide current information regarding the center personnel, facilities and activities.

The CNSS preschool infrastructure consisted of 454 centers generally located in isolated communities and a total of 700 center managers (some centers had two managers). Despite CRS's large support to upgrade CNSS center facilities and to train centers' managers in health and nutrition education, a large number of these centers were not considered functional to deliver health services at the beginning of the DDM project. Based on a functional assessment, the project had targeted 315 centers and 450 center managers at the rate of 105 center managers trained each year. These centers were to carry out structured non-formal activities with groups of 15-20 mothers each week during the peak diarrheal season, June through October.

The assessment was carried out countrywide by the 7 coordinators in two stages: July 1986 for 180 centers and September of the same year for the remaining 270 centers. A questionnaire was developed with the CNSS preschool program manager and was pretested by the coordinators who had previously received training in interviewing techniques conducted by the PRITECH Training/Education consultant. The main categories of questionnaire data were: personnel and beneficiary numbers, physical conditions, existing materials, furnishing and equipment, mother attendance and weight surveillance program. These data were anlayzed by the Evaluation/Research Specialist and results were shared with CNSS to serve many purposes.

Based on the type of activities found in those centers, CNSS established 4 categories of centers C1-C4:

-C1 : centers with child development activities
-C2 : feeding centers with weight surveillance
-C3 : strictly feeding centers
-C4 : non-functional centers (to be replaced eventually).

Based on the furnishing/equipment inventory, CNSS established equipment needs per center and guidelines for upgrading those centers.

Assessment results also served to identify Phase I CNSS Centers for face-to-face mother education in the first year. The selection of the 105 centers was based on the following two sets of criteria:

1) Center Facilities:

a. at least one female manager,
b. the center manager participated in 1984-85 CRS nutrition education workshop,
c. benches/chairs for at least 15 mothers,
d. a room to accommodate 15 mothers.

2) High-risk population with respect to diarrheal disease. Governorates were ranked based on statistics of the following variables:

a. child mortality rate,
b. diarrheal disease incidence,
c. income,
d. housing conditions.

The selection process determined 84 centers that met both criteria sets. In order to meet the proposed number, 21 more centers were selected to be included after additional furnishing and/or renovation are made. A total number of 118 center managers were eligible for training. With these data in hand, project staff, with CNSS, established a strategy for upgrading centers during phase II and phase III corresponding to years 1988 and 1989.

The process of upgrading CNSS centers turned out to be very slow and could not reach the targeted 315 centers and 450 center managers. By the third year of the project, there were only 242 centers and 302 center managers eligible for DDM activities.

D. CONCLUSIONS

1. The educational approach for CNSS mothers was based on participatory activities and focused on practice learning rather than on teaching new knowledge. Mothers' attendance in educational activities in CNSS centers was considered satisfactory and determined the extent of the positive behavioral change that took place.

2. A strong institution-building was achieved through investing into the permanent regional coordinators instead of utilizing temporarily-hired area coordinators, who represented an attractive alternative for a prompt and visible project success.

3. The training of public health personnel exceeded initial expectations in coverage, thoroughness and systematic approach. Regional Training Teams and training modules constitued a real asset for the continuation and further development of the CDD program.

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