Partners in Population and Development (PPD)
An Inter-Governmental Organization
Promoting South-South Cooperation

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SHARING INNOVATIVE EXPERIENCES
FROM PPD MEMBER COUNTRIES

الديوان الوطني للأسرة والعمران البشري
Office National de la Famille et de la Population

STRATEGY OF MOBILE SERVICES IN FAMILY PLANNING AND MATERNAL HEALTH IN THE FRAMEWORK OF THE TUNISIAN REPRODUCTIVE HEALTH PROGRAM: EVOLUTION AND DEVELOPMENT

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LISTING OF ABBREVIATIONS

WB	World Bank
CIT	Center for International Training
MC	Mobile Clinic
MMHC	Multidisciplinary Mobile Health Caravan
CPS	Contraception Prevalence Survey
PSC	Personnel Status Code
CPC.	Senior Population Council
RCEFP	Regional Center for Education and Family Planning
IUD	Intrauterin Device
PHCD	Primary Health Care Directorate
M T	Mobile Team
IEC	Information Education Communication
TFR	Total Fertility Rate
PHI	Public Health Institute
VTP	Voluntary Termination of Pregnancy
TOG	Tunisian Official Gazette
TL	Tubal Litigations
MICS	Multiple Indicator Cluster Survey
NU	New User
WHO	World Health Organization
ONFP	National Board for Family and Population
ONPFP	ONPF and Population
CEO	Chief Executive Officer
FP	Family Planning
FP/RH	Family Plannig and Reproductive Health
S M	Supervisory Midwife
MCH	Maternal and Child Health
RH	Reproduction Health
FUB	Free University of Brussels
M U	Mobile Unit
UNFPA	United Nations Population Fund
NUTW	Union National Union of Tunisian Women
WSF	World Survey on Fertlity

ABSTRACT

After the country's independence in 1956, the Tunisian political authorities chose to integrate Family Planning into the country's overall development strategy. At that time, Tunisia was endowed neither with the health structures required nor with the human resources demanded to enable the population benefit from FP services. Thus, the need for mobile-service units was more than obvious in order to provide the citizens with the appropriate health services. It was then that the use of mobile service units became self-evident, the aim being to offer FP services in health structures. This approach was initially impeded by the lack of competent staff members and the limited number of such facilities.

Following a two-year experimental phase, which was highly instructive, the program was generalized throughout the country. In the same vein, and for practical reasons, the management of the mobile services was quickly decentralized and entrusted to the regional managers of the National Office of Family Planning and Population.

The mobile units had a dual task: one has an educational nature and the second a health one. The two tasks go hand in hand and come to complete each other. The Mobile Teams visited the fixed centers, while the Mobile Clinics served the rural areas that are deprived of health facilities. The educators played a key role in convincing the target populations to accept the services provided. Thus, the staff members in charge of mobile services have successfully accomplished their mission over the past five decades, and notably in terms of monitoring and supervision to ensure the availability and quality of the activities being undertaken.

Mobile services have evolved along with the program. Initially limited to family planning, these services have quickly expanded to include maternal and then family health. The emergence of the Reproductive Health concept broadened the list of services provided. As a result, the program has performed outstanding results in terms of demographic and health indicators.

Building on that success, the ONFP has embarked on a set of tripartite cooperation actions with southern countries where people are keen on exchanging know-how in this field. Thanks to the flexibility of the strategy applied and the duplication of the activities, reminiscent of the activities applied previously in similar contexts, we can boast a set of assets to engage south-south collaboration as advocated and supported by the PPD

Key words and phrases : *POPULATION **POLICY**- DEVELOPMENT – **FAMILY** PLANNING – REPRODUCTION HEALTH - MOBILE UNITS - RURAL-DEMOGRAPHIC INDICATORS*

INTRODUCTION

The present study was prepared at the request of "Partners in Population and Development" with a view to presenting “The mobile strategy of the FP and RH services of the Tunisian program”.

In order to comprehend the status of this strategy in the offer underlying the FP RH services, we deem it useful to submit it within the overall framework of the institutions entrusted with the implementation of the national demographic strategy.

The Tunisian program, launched more than 50 years ago (1964), was at the service of a more adamant project calling for the modernization of the country. Its implementation contributed greatly to controlling population growth and improving the health and fertility indicators of the Tunisian families.

1) OVERVIEW ABOUT THE COUNTRY AND POPULATION PROBLEMS:

In 1956, the year of independence, the Tunisian population was 3,448,000 ha (1). With a surface area of 164,000 km2, Tunisia did not witness any serious of demographic growth. It is in fact the mismatch between the population per se, on the one hand, and the socio-economic and health environment, in which this population live, on the other, that poses a real problem. Indeed, the socio-demographic indicators at the time were very marked by(2) :

1. A population predominantly rural (71% in 1956) (3)
2. A natural growth rate assessed to 3%
3. An illiteracy rate affecting more than 80% of the population

This trend has seriously impeded the economic development of the country. As a result, the state, led by President Bourguiba, opted for a population policy that is embedded into the overall development strategy and based essentially on controlling the population growth. The first and subsequent three-year development plans included quantitative objectives to be achieved in terms of contraceptives and demographic growth.

In his speeches(4), Bourguiba was quoted as saying : "... We were facing, on the one hand, an increasingly growing birthrate, and it behooves us the subsistence of the population, on the other, in a country that is provided with meager agricultural and industrial resources..."

To judge by the results of the C.A.P.(5) survey, conducted in 1964, the female population seem to be quite receptive of this policy that has revealed that women wanted an average of 3.6 to 4 children per household, (whereas the TFR was around 7) Moreover, 72% of women aged between 30 and 39 no longer wanted children, and 85% of them had no idea about modern methods of contraception (2) .

To encourage and motivate governors to implement FP programs in their respective governorates, a presidential award, called the President Bourguiba Award, for the Enhancement of Family Planning policies, was established as early as 1974 (6) .

2) PRINCIPLES AND OBJECTIVES

The principles, underlying the guidelines of the FP program, have clearly laid down by the CEO of the ONFP (Mr Mezri Chekir) as follows (7): “The guidelines of our program be put at the disposal of all out citizens, along with the adequate, health-education tools, as required, to help them enjoy their natural FP rights… Through these actions and family-planning services, we aim at underscoring the humanitarian aspect of the FP policies."

Thus, we can deduce, from this concept, three main principles and adopt three convenient approaches :

a) Basic principes:

1. The right of the citizen to be informed and to use contraceptives,
2. The service delivery for the closest target population
3. The free choice for couples about the most adequate method to use.

b) Three convenient approaches:

1. Delivery of public services free of charge
2. Decentralisation of the program management for the regional units
3. Need to coordinate interventions at the regional level.

C) The overall objective(8) as displayed by the program, consists in decreasing demographic growth and keeping it under control.

Moreover, the specific objective, deriving from the mission entrusted to the ONFP, as spelled out in the law N° 73-17, dated March 23rd 1973, calling for the need to establish the ONFP; as advocated in the following points:

1. To undertake studies and carry out economic, social and technical research topics view to providing the population with better welfare conditions…
2. Draw up and implement any program that is likely to establish and uphold the family equilibrium and protect the health of its members…
3. To guarantee, for natural and legal persons, operating in hospitals and health-care facilities, doctors' surgeries, pharmacies, clinics, health centers and any other unit deemed useful, the means to be informed and intervene, in various ways, so that we can contribute to the achievement of the objectives underlying the family balance and welfare.
4. To undertake the necessary training measures required by medical, paramedical and social training units.
5. To undertake a permanent outreaching program geared towards the targeted population....

The breakdown of the demography and health indicators is displayed in the various development plans of the country. In to reach these objectives, the program targets a twofold trend: First: to reinforce the FP service offer and Second: to further enhance the target population demand. In the same vein, priority has been given to the rural area where women are hardly informed by messages related to education and FP service availability. We definitely need such MOBILE CLINICS to guarantee the achievement of these objectives.

3) CONTEXT AND RATIONALE OF THE MOBILE STRATEGY

For various reasons, the program did witness a rather slow start which has somewhat impeded its dissemination:

1) The mindset, which is rather conservative, among some fathers and opinion makers, such as the imams in the rural areas notably, who would consider the boys, unlike, girls as a potential sources of free production in farmlands. This traditional mindset was mainly prevalent among the less educated, and even illiterate, population segment living mainly outside the urban areas.

(2) Health indicators (2) that display a low level as follows :

a. A TFR higher than 6 children per woman.
b. A life-expectancy at birth of 42 years in 1960
c. A crude-death rate of 19 per thousand (in 1961).
d. An infant-mortality rate of 145 per thousand.

3) Shortage of medicall staff: According to the World Bank: in 1960, there was 1 doctor for 10,000 inhabitants. Also, the first group of students, from the faculty of medicine of Tunis, graduated in 1971. The number did not exceed 24 students(2)

The shortage in the female medical staff members, among gynaecologists, was offset by the hiring of foreign doctors (and notably from Bulgaria). These doctors were working in tough conditions due to a lack of communication with the patients. This language handicap jeopardized the communication process with women, and notably about the contraceptive methods to be prescribed by doctors.

That is why, between 1975 and 1978 : 149 doctors, 846 midwives, caretakers and nurses, as well as 1485 social officials and senior national organizations were trained. (9) .

Since FS have been officially authorized to handle IUDs (insertion and removal), this has largely contributed to the spread of IUD use.(9) .

4) The inadequacy of first-line health units, In 1964, there were only 12 centers de Maternal and Child Protection, 9 of them were located inside the Great Tunis district (10) .

In view of these main constraints and the unfavorable environment for the generalization of FP services throughout the country, and in order to make the best use of the limited staff available for the program, there was no other alternative, right at the outset, but to create mobile information and education units, in addition to other centers that were meant for service delivery.

This approach of bringing the mobile units of FP services closer to the target has proven successful on the field, and notably in remote areas.

4) STRUCTURES REQUIRED FOR THE IMPLEMENTATION OF FIXED AND MOBILE SERVICES

Five formal structures have taken over the management of the FP program, starting from its experimental phase, in 1964, to the present day. These changes in structures are explained by the gradual extension of the program's coverage in the different regions and the upward development of the beneficiaries of the program. In chronological order, these structures are displayed as follows:

a) The Programming and Prevention Division within the State Secretariat of Public Health : This division was entrusted with the management of the experimental phase of the program from 1964 to 1966 and the following year (1967). Its mission ended in December 1967. Throughout this period, the FP program was managed without any particular distinction from the other medical activities which were under the responsibility of this division as well (2).

b) The FP Maternal and Child Protection Directorate (11) : This division was established in January 1968 within the State Secretariat of Public Health in order to implement the FP program and within the premises set up for the SMI. The Directorate was managed by a gynaecologisc doctor. It was porvided with four technical services as follows :

1. A communication service.
2. A training service.
3. A statistical services.
4. A medical service.

Under the aegis of this directorate, the program witnessed an increase in terms of the number of beneficiaries as displayed in the table below :

Unit entrusted with the program	Year	Female users of contraceptives (public sector)	Voluntary abortions and tubal litigations
	1968	8 765	3 878
Directorate of SMI-FP at the MPH	1969	10 400	5 373
	1970	13 390	5 244

Three and a half years after its establishment, this directorate was unable to handle the increasingly-growing expanded program.

c) The National Institute for FP and Maternal and Child Protection (12) : This institute was established on August 2nd, 1971. It is a public institution that operates under the direct aegis of the Ministry of Public Health. Its main task consists in "… ensuring the welfare of the family within the framework of the national economic, social and cultural development process...".

The life span of this institution was relatively short (less than two years), due to the rapidly growing workload of the program, in addition to its growing material and human needs. In view of the new users, the results recorded during this period are positive, as displayed in table (12) below:

Unit entrusted with the program	Year	Female users of contraceptives (public sector)	Voluntary abortions and Tubal litigation
Institute of SMI-FP	1971	17040	5477
	1972	18310	7088

The general fertility rate has been steadily decreasing between 1966 and 1972 (12)

Year	FMAR	Births	% of Total Fertility rate
1966	95700	206734	216
1972	1245000	198785	161

In order to meet the increasing needs of the program, the state has opted for the establishment of a « specific » unit to be entrusted with the management of the FP and Population program. Thus, we have heralded the emergence of the fourth unit, i.e.; the ONFP.

d) The ONFP (14) : It was established on march 23rd, 1973 . It is a « …public institution… that is endowed with a civil personality and financial autonomy .. and operating under the aegis of the Ministry of Public Health ». This unit became the strong leverage underpinning the population strategy as decided by the "Senior Population Council" (CSPop). This Council, that was chaired by the Prime Minister, gathered all ministries involved in the population strategies, i organizations. Equally, the Council was required to lay down the trends underlying the ONFP actions and set up the guidelines of the action plan. To underscore the highly significant political strategies of the ONFP program, the CEO of the ONFP would endeavor to submit an annual report to President Bourguiba.

e) The ONFP (15) This former unit has been revamped to illustrate the shift of the program towards a comprehensive family-health policy. This unit, which was established on August 6th, 1984, still exists until this very day.

One had to wait until the inception of the ONFP, that is entrusted with the specific components of the FP program, to concentrate all efforts on the attainment of the overall demographic objectives. This is operated on the basis of a thorough revamping of the program-management system.

5) EVOLUTION OF THE FP PROGRAM ON THE BASIS OF MOBILE SERVICES

TERMINOLOGY :

1. Mobile Team (MT) means a non-commercial vehicle that is equipped with 4 or 5 seats and a rear trunk. This vehicle is used to transport service providers and their equipment to front-line health centers to provide FP RH services. Example: Land Rover, Peugeot 504 family car

2. Mobile Clinic (MC) means a truck with a long chassis and carrying a compartmentalized cabin. This facility is equipped with a gynaecological examination table, running water and various storage units for medical equipment, medicines, medical records, etc., It is amenable for medical consultations. The MC is meant to transport providers and offer FP RH services in areas where fixed health units do not exist..

Inner side of a MU

Gynaecological examination table

Washbasin and workspace

Pharmacy corner

3. EM and CM these two acronyms stand for " Mobile Units (MU) ".

Right at the outset, the offer of services has gone through several successive stages, often dependent on the availability of adequate health units, as well as the service-providers who are specifically trained in the medical and communication fields. These steps can be summarized as follows:

a) EXPERIMENTAL PHASE (2) :

In 1963, an agreement was concluded with the Ford Foundation, to carry out an experimental FP program over two years (1964 - 1965). Thanks to the technical support of the Population Council, this program was placed under the aegis of the Secretary of State for Public Health.

It is worth indicating here that " ...this experimental phase took place in an adequate political and social context that was conducive to the use of contraception. The obstacles encountered were generally related to a precarious mindset (and notably religion). Massive information on contraception was smoothly and widely disseminated. This was amenable thanks to positive role played by the mass media...". (12)

The program comprises the three major components: training the stakeholders, information-education and FP services. These services were provided on the basis of two intertwining approaches:

1) Fixed services:

FP services were initially offered in 12 PMI centers (2), entirely free of charge, including 9 in Tunis, where women were entitled to oral contraceptives, spermicidal creams, as well as jellies and condoms. A few months later, the offer of the "Boucle de Lippes", a kind of* IUD, gave the program fresh impetus. In view of the greater acceptability of the IUD, compared to other contraceptives, it was decided to extend the offer of this method and equip the 39 regional hospitals with competent staff. It should be noted that, at that time, the gynaecologists considered IUD insertions and removals to be medical acts that fall under the scope of the exclusive competence of their specialty.

2) Mobile Services:

During this phase, "Mobile Teams", numbering five (5), were created and attached to regional hospital, in 5 of the 13 governorates of the country. Their function consisted in offering FP services to the populations in the PMI and health centers located in the relevant governorates.

These MT depended on the availability of the gynecologist (the only one authorized to handle the IUD). They would operate on the field only 4 working days a week and visit peripheral units that are provided with the minimum equipment to provide FP services, and notably the gynecological examination tables (needed to handle the IUD). The rest of the essential equipment was provided from the hospital.

The results of this phase were encouraging and allowed about 30,000 women to visit, on average one fixed or mobile center, at least once and helped use about 20,000 IUD insertions.
These achievements have encouraged both the Ford Foundation and the Population Council to extend their assistance for another two-year period.

b) EXTENSION PHASE[2] :

1) IEC Services: In each of the 13 governorates of the country, a man and a woman, recruited from among the regional senior staff members, to make a pair in charge of disseminating the public information and education program in the area where FP modules were applied.. They received basic training focused on the principles of communication and the messages to be conveyed to the population.

The work of these "educators" was done through group meetings that were organized by professional stakeholders operating in specific settings of the public and private sectors, as well as through individual or small group meetings held for the community population.

2) Medical Services

Based on the positive results, achieved during the previous phase, the managers have decided to extend services to encompass the 13 governorates of the country. Therefore, a Mobile Team is ready to deliver services, right at the outset, for each one of the governorates.

Scheduled visits were made on the basis of 1 to 3 centers, on average, per outing. The traveling distances are often long and take the medical staff members up to great 100km beyond their location. i.e.(the regional hospital), at the risks of diminishing the number of new IUD insertions to 10 and sometimes even less.

3) Results and discussion:

The IEC activities, undertaken according to standard practices, constitute a "sine qua non" condition to reshape the mindset of people and attract new users of contraceptives. Unfortunately, the messages conveyed by during this phase by peers, operating as educators, did not generate the expected impact required for the popularization of contraception. To judge by the number of new users* and the number of new IUD insertions, we can state that during the two extra years (1966-1967), we have registered (10) :

- 22,280 new users (NU), in other words, an average of 38 per working day for all fixed and mobile centers of the country.!!!
- 18,800 new IUD insertions. This figure is far below the expected number which had been scheduled for 120,000 insertions over 2 years.

* users and acceptors : Widespread words in Tunisia to refer to the people who use modern contraception methods

Results yielded by the « national » FP program (1966-67)

	Year	User of contraception (Public Sector)	Voluntary abortions and tubal litigations
Program extension phase (MSP)	1966	11150	2162
	1967	10630	2073

This setback of the program is ascribed, up to a large extent, to a certain mistrust on the part of women regarding the side effects deriving from the insertion of the IUD (temporary lengthening of the duration of menstruation during a few cycles following insertion); and for which they women not fully prepared. There was also a lack of information on the part of service providers such as gynecologists. In sum, the educational messages were not as accurate as they should have been.

It should be noted, however, that use the gynaecologist, for unprofitable mobile services, constitutes a shortfall for a specialized skill that would have been more profitable, if employed otherwise, such as in abortions and tubal ligations. This is all the more relevant as the medical density was 1 doctor per 10,000 inhabitants (in 1960).

6) EVOLUTION OF THE FP CONCEPT

Since its inception, the FP program has gone through several stages. The initial concept of FP has changed in meaning depending on the achievements. From birth control to birth spacing, it has evolved to family health, then to reproductive health and now to service quality with a pledge to abide by the Millennium Development Declaration.

7) DESIGN AND PLANNING

The reorganization process, undertaken by the ONPFP, is based on the decentralization of the program to be devolved to the regions. With this in mind, the following achievements have made:

a) The establishment of the regional FP centers in education (C.R.E.P.F):

The CREPF is an administrative and technical unit that ensures the planning and implementation of the ONPFP program at the governorate level. A CREPF has been established in the principal town of each governorate (18 in 1974).

This unit consists essentially of an administrative area and an area allocated for medical and surgical services. The regional staff is composed of: 1) a regional delegate who is the team leader and who represents the ONFP vis-à-vis the regional authorities. 2) a midwife supervisor (SFS) who is in charge of organizing and supervising medical activities and managing technical staff. 3) a Regional Administrator who is in charge of administrative and financial affairs, in addition to the collection of regional statistical data.

b) Activities planning and implementation:

The regional staff members are accountable for all regional activities. Also, they organize all these activities on the basis of their regional characteristics. With regards to mobile activities, the CREPF managers are entrusted with:

1. The assignment of the staff members to operate in each unit,
2. The preparation of the weekly programs, in terms of outings, while identifying the units to visit and laying down to road map. This preparation is conducted jointly with the regional manager of the public health in the governorate.
3. The recording of the data relevant to the local authorities and staff members of the units to be visited, in terms of dates and times of the shifts of the mobile teams.

8) MOBILE UNITS

a) Organization

1. Staffing:

At the beginning of the program, the gynaecologist's presence was systematic because the handling of the IUD was considered as a medical act that only doctor could handle. This idea has proven to be wrong and reality, on the ground, has shown that competent midwives were capable of taking over from doctors (2).

This team is made as follows :

- A driver
- A competent midwife
- A nurse and a caregiver
- An educator is not an immutable member within the health team

2. Equipment and specific material:

- Gynaecological examination box containing sterile material (speculums of various sizes - neck forceps - tongue forceps)
- Pair of scissors
- Pad drums
- Sterile gloves
- Medical and obstetrical stethoscopes
- Tape measure
- Tensiometer
- Disinfectant solutions (Dakin - iodised alcohol - 90° alcohol)
- Adult bathroom scale
- Ayre spatulas for cervical sampling
- Pap smear fixative
- Cervical smear slide with identification label

3) Contraceptives:

- Oral contraceptives
- IUD
- spermicides
- Condoms
- Injectables

4) Medications:

- for pregnant women (iron-based medicines)
- for the management of STIs
- other commonly-used medications.

5) Working documents:

- blank medical records
- the statistical data register
- the booklet of referral forms for specialized consultations
- The medical records file is often kept at the health facility level.

6) Health services delivered:

- Delivery and monitoring of contraceptive methods
- Clinical diagnosis of pregnancies and pre-natal examination
- Postnatal consultation
- Gynaecology After addition of RH services
- Syndromic management of STIs
- Early detection of cervical cancer
- Clinical breast examination (early detection of cancer and other pathologies)
- Referral for infertility and sexology consultations

b) Circuit and organizational chart

The organizational chart of each mobile unit was devised to help the maximum number people profit from the mobile services.

As a result, the frequency of visits to the different areas would vary according to the density of the beneficiary population. The number of units visited was also variable, given the distances to be covered daily. The organizational charts were revised according to the results achieved and the vagaries of the weather conditions that sometimes prevented women from travelling. Also, and in order to reduce the distances and save fuel, the MT were often decentralized, at the level of delegations, and stay in the parking lots of the regional hospitals instead of returning to the principal town of the governorate where the CREPF is located.

c) Distribution:

All ONFP regional centers are equipped with MU, except for the capital Tunis, where urbanization has sreached 100%.

The MT, assigned to the Regions, increased from 15 in 1972 to 50 in 1979, then to 86 in 1994 and 100 in 1999 (10). In fact, this coverage hides obvious disparities in terms of use. In 1978, only 28% of rural FMAR used contraceptive methods, compared to 59% in Tunis and 58% in other urban areas.

The 6th Development Plan emphasizes "... the need to increase the supply of services in rural areas..." Furthermore, it is recommended to build new primary health centers and increase the number of mobile clinics. However, the commissioning of these vehicles was initially confronted with serious problems such as the one mentioned in the 1983 activity report, which states that the triggering of some MCs was somewhat delayed due to the lack of available FH on the spot. Hence, it was necessary to wait for a redistribution of available personnel and new FH assignments in order to launch mobile services in the rural areas.

d) Reorganization of mobile teams

The mobile strategy of the program, adopted as early as 1980, had made it possible to cover many of the country's front-line fixed units. In contrast, the majority of the rural population, living in deprived areas and without fixed health facilities, were unable to enjoy the services provided by the MT. As a result, and despite being a target population, they still could not have full access to the services of the IHP program.

In the same year, a seasoned woman, in the field of social affairs, was appointed as head of the ONPFP. Only then, was the Mobile Strategy given a new lease of life by planning to extend services to rural and remote areas and consolidate the breakthroughs performed in this sector.

Thanks to the support of the Population Council and financial assistance from USAID, provided in 1982, the program was able to consolidate its achievements and expand the scope of its mobile services:

a. 56 new cars "Dodge Omni"
b. Funds to train about 50 FP facilitators and assign 2 senior officials to monitor the activities conducted on the ground.
c. Funds to produce eight (8) new mobile clinics.



It is a three-pronged approach of creation and innovation that responds to the needs on the ground as follows:

1) Extension of services to encompass the deprived areas : The new MC were designed to work in rural areas lacking first-line health units. This mobile unit could accommodate gynecology and FP consultations (especially IUD insertions and removals). It is equipped with an external TV screen that can transmit visual information and education messages to the population at the assembly points. In order to ensure good quality of the services and guarantee their acceptability by the beneficiaries, the Education MT would arrive one day ahead of the MT members to pave the ground and inform the population of the visit.

To be fully discharged of its duty, the clinic was well equipped with a gynaecological examination table, an adequate light source, the necessary medical equipment, a sink with running water from a tank, toilets, an external generator, a table, stools, storage drawers, shelves and other functional utilities. It should be noted that the clinic is air-conditioned in order to offer the best working conditions to service providers.



Midwaife working in a MC **Blood-pressure measurement** **Vidoe-integrated education session at the MC**

The new MC were assigned to 8 governorates: in the north, west, center, south and border regions (in 1975, the country had 17 governorates, now the number has reached 24). Each CM works jointly with an education MB comprising a driver and one, or more, FP animators.

2) Establishment of education MT: A new profile of education staff called "FP Facilitators" has been set up to work on the ground in the rural areas. For this purpose, about 50 girls from rural areas, in the 17 governorates of the country, have been trained for 6 months to disseminate information and provide education. The training program covered, in particular, the state's demographic policy, the medical aspect of FP, the demographic component, communication and message transmission, the psycho-social profile of the rural population, data deriving from the latest fertility survey, the socio-cultural profile of Tunisian families and their attitude towards contraceptive use.

After graduation, the new facilitators were assigned to their home regions. At the same time, new drivers holding heavy-truck driving-licenses, were recruited to drive MC staff members all over.

3) Revamping the MC vehicles: Some of the "Dodge Omni" cars were used to replace some older cars that had been used by the MT staff members form more than 10 years. The remaining vehicles were spared to be used for education purposes, and notably in the newly-set rural areas to be receive FP services.

Some of the "Dodge Omni" cars were used to replace some older cars that had been used by the MT staff members form more than 10 years. The remaining vehicles were spared to be used for education purposes, and notably in the newly-set rural areas to be receive FP services.

e) Results performed after 1 year (12):

The 1983 ONFP activity report has revealed that the 1982 results were quite positive. We display the following points:

- The recent reinforcement of mobile services has made it possible to visit 762 health centers and assembly points with activities in SPFSR. This performance accounted for 78.8% of the actions undertaken with regard to the national program. The remainder was distributed as follows:
- The 38 CREPFs and ONFP clinics accounted for 3.9%
- The 167 centers, operating under the aegis of the Ministry of Public Health accounted for 17.3%.

These results do prove the paramount status that the mobile strategy holds in terms of success of the Tunisian FPRH program.

9) IEC STATUS WITHIN THE NATIONAL PROGRAM

Right at the outset, the education program was preceded or accompanied by the modules of FP services. Hence, the education staff members were either integrated with the mobile teams or operated through independent units that are specifically dedicated to education.

Even though IEC activities were aimed at the overall population, what happened on the ground is that some categories enjoyed some preferential treatment as the program evolved. Thus, WARMs was considered as a prominent segment in the IEC strategy given the paramount importance that was granted to fertility control. Subsequently, with the advent of the concept of "family health", increasing attention was paid to men as partners in the field of reproduction health. Also, and since the expansion of services to encompass the various components of RH, the IEC focused on the young category of both sexes, be it in terms of sexuality of reproduction health.

Given the decline in foreign aid to the program, the ONFP has concentrated its services on the rural areas, reinforced its activities in its own centers (the CREPFs) and devolved part of its activities to primary health care teams, as well as to certain maternity hospitals, particularly those qualified as university hospitals, since they were equipped with real clinical, operative and educational FP services (Rabta - Sousse - Sfax and Bizerte).

10) INFLUENCE OF EDUCATION ON SERVICE DELIVERY(13)

In order to evaluate the effect of IEC activities on the performance of FP medical services, a prospective study (12), based on a comparative experimental method, was conducted in a predominantly rural governorate, Mahdia, in 1984. This governorate was divided into four zones.

1. A first area that had not previously benefited from educational program and where a facilitator was assigned to work with local officials and social services to identify women who had recently given birth and who would be in need of FP services. She also made home visits to disseminate information on the availability of FP services and to ensure better follow-up for contraceptive users.
2. A second area that has benefited from a new service site that consists in introducing a new mobile team without adding any new IEC component.
3. A third zone, believed to be more rural than the previous ones, and that benefited from both types of interventions with the introduction of a new mobile clinic and the assignment of 6 new facilitators.
4. The fourth zone has not been granted any assistance. It was rather used as pilot area to double check the needs of this study.

The results, As displayed by the number of new acceptors, the results have revealed that :

1. All the areas that have received assistance have performed better than the pilot zone.
2. The highest rate was registered in the area that has been granted a dual support in terms of new service and educator sites
3. In terms of new acceptors, the introduction of the new IEC activity did generate a greater impact on recruitment than the area which was strengthened by the advent of a new service site.

To judge by the figures obtained, IEC activities can even double the volume of services provided by a MT, as the number of new acceptors more than doubled compared to what would normally be expected, if the team had continued working without any more contribution from the facilitator. This finding makes it possible to reduce the cost of the program by making the existing MT activities more cost-effective. This would be amenable simply by strengthening the IEC component, rather than by creating new service sites.

IEC activities are considered a key factor in FP programs, as they have a two-fold objective: a) To inform the population about the availability of contraceptive methods and services. b) To educate women about the correct use of contraception and inform them about what to do in case of discomfort due to possible adverse effects.

In 1982, the ONFP set up a program to extend services in 9 predominantly rural governorates by providing 8 mobile clinics and assigning 36 new FP facilitators. These facilitators were recruited among the women in the community. They were trained in communication techniques and equipped with a range of teaching materials, including figurative materials specially designed to meet the learning demands of the illiterate population in rural areas (flipcharts).

In 1983, one year after the launching of the program, the recruitment of new acceptors had increased by 27% in the regions covered by the program. One year later, the rate increased to reach 24%.

Furthermore, there is strong evidence showing the contribution provided by IEC in terms of new contraceptive users. In 1982, the purchase of the new mobile clinic, which was to be delivered to the governorate of Siliana, along with the assignment of the new facilitators, was delayed by one year. The IEC work carried out for one year, without the addition of a new service site, resulted in an increase in FP services of 57% over the previous year.

The facts mentioned above do confirm the possibility of taking better profit from the existing FP services. This would be amenable if we simply reinforced the educational activities imparted to the stakeholders concerned..

11) MULTIDISCIPLINARY MOBILE HEALTH CARAVANS (14)

a) Presentation: The Multidisciplinary Mobile Health Caravan (MMHC) consists of the common use of vehicles belonging to different health units and organizations, to transport paramedical and medical personnel, of various disciplines, in order to offer their services free of charge, in the same place and on the same day, to the population of any given locality that suffers from a lack of adequate health units.

b) History: The ONFP was the first actor to introduce this kind of mobile service, by means of an educational-test caravan carried out in September 1988, in the El Achaba locality of the El Jem delegation. After this first successful experience, the ONFP decided to launch this kind of service by involving the staff and the resources of three neighboring governorates under the name of "Triangular Multidisciplinary Caravan".

c) Objective: To operate jointly with the various ministries and professional organizations working in the field of RH, to bring health services, particularly specialized health services, closer to poor rural categories.

d) Organization: The area of intervention is laid down by the regional delegate of the ONFP. An organizing committee, representing the participating units, is set up to ensure the availability of the material and human resources. On average,

there are about twenty vehicles carrying 5 to 6 people each. As far as the ONFP is concerned, each outing involves 3 neighboring delegations which intervene with medical and educational MT, as well as a mobile clinic (if available).

e) Areas visited and services provided: Between 11 June 1989 and 29 August 1992, 17 areas were visited and services provided in various governorates. In addition to primary health services and medical specialties, FP, pre and post-natal services, as well as information and education service, are presented by the ONFP team. At the same time, the facilitators fill out individual cards to collect the population's opinions on these MMHC, to have an idea about the knowledge, attitudes and practices of the local population in terms of FP.

f) Evaluations: Analysis of the data collected by the ONFP showed that the evaluation of the populations, in the visited areas, about the organization of the MMHC were positive for 66% of the people surveyed, acceptable for 23.5% and mediocre for 10.5%. With regard to contraceptive use, the differences were significant, since the percentage of contraceptive users ranged from 11% to 79.7%, and the percentage of women who had never used contraception ranged from 9.7% to 82.7%. The number of men contacted is 1257, the number of women visited at home is 4839, whereas the number of women transferred for special consultations is 1206. These results are taken into account for the reorganization of ONFP's mobile services in each region in order to take better profit from field activities.

12) FAMILY HEALTH IN RURAL AREAS (15)

Prior to1992, there were two kinds of mobile teams operating on the ground:

1) Public Health MT: These teams are managed by the regional public health directorates (one per governorate), in order to cover the front-line health units that are not provided with fixed medical and paramedical staff. The periodicity of visits is fixed according to the territorial density of the population to be treated. The services offered are of the classic curative type.

2) MT operating under the aegis of ONFP: They visit the same kinds of centers to provide FP-RH and prenatal services.

In order to avoid this duplicated activity, a project called "family health in rural areas" has been developed. It falls within the framework of UNFPA - ONFP 1992-96 cooperation program and covers 11 governorates in the centre and south of the country. The aim is to ensure "operational coordination between MCH and FP programs. It provided for, among other things:

- **a)** The inclusion of all FP activities in the CSSB
- **b)** The reinforcement of vehicles for ONFP, replacement of obsolete cars, creation of new MS and acquisition of 15 CMs to cover rural areas
- **c)** The training and recycling of CSB staff in the field of contraceptive technology and communications
- **d)** The training of nurses who would be called upon to prescribe contraceptives, in order to make up for the lack of FS in the relevant areas.

This project created mixed SSB and FP MT. As a result of this redistribution of tasks, some ONFP teams redesigned their services to better serve the underprivileged or poor rural areas.

For a better profitability of medical and paramedical staff, those who conducted the mid-term evaluation (16) recommended to reinforce the technical skills of providers in order to provide better psychological and medical care to FP consultants. However, this project comes to ensure a wider coverage of front-line health centers and of bringing together two units that illustrate the same concern, i.e.; to foster family health.

13) FOLLOW-UP AND MONITORING OF FIXED AND MOSTLY MOBILE ACTIVITIES

a) Regional supervision: Activities are monitored by the midwife supervisor, who ensures that medical acts are performed in compliance with the standards and procedures, set forth, by the ONFP and provides on-site technical supervision for service providers:

1) The stress is put on the need to present the various methods available to new consumers of contraception, while taking the characteristics of each of them into account, so that woman can make a free and deliberate choice and choose the method that suits her. The midwife's role is to ensure, through clinical examination, that there are no contraindications to the use of the selected method.
2) In addition, it pays particular attention to the conduct of service providers concerning possible adverse effects related to the use of contraception and particularly those related to the IUD, the most widespread method. Emphasis should be put on the psychological preparation of users for the occurrence of temporary side effects during the first menstrual period following IUD insertion.
3) It is used to double check the recording of the data of the consultation, for the same day, on the medical file of the consultant.
4) Furthermore, the method provides any data that could be requested by the midwife or nurse. . This contribution is valuable as it is part of the "training on the job" approach.
5) Taking into account the various problems encountered during its visits, the SFS has organized ad hoc training sessions for specific persons or for the whole team. Also, it may request the support, whenever necessary, of the medical directorate for a medical opinion or for the holding of a local training seminar.

b) Central supervision : In addition to this regional supervision, the supervising physicians of the central medical directorate pay scheduled or unexpected visits to the regions. This is in line with the monitoring of activities and the application of the instructions and directives contained in the document "Standards and Procedures of PFSR".
Subsequently, and like the supervising physicians, a new profile was created: that of "Supervisor of educational activities" who is in charge of the activities of the educational staff (communication techniques and educational and informative materials).

c) Processing and analysis of statistical: The information relating to each consultant is recorded over time on a special statistical register which comprises the following parts:

1) Identifying the consultant by means of four pieces of data (name, age, address...)
2) Information on contraception with specific method and follow-up: IUD - pill - condoms - spermicides - injectables - implants - request for LT / surgical abortion / medical abortion.
3) Information related to RH services with its different components (STIs - Breast examination - cervical cancer screening - gynaecology - infertility - menopause - Adolescents and unmarried people – more likely examinations could be requested).
4) Prenuptial consultation (Certificate of good health before marriage is mandatory).
5) Prenatal consultation with research on risky pregnancies.
6) Postnatal consultation on the 8th day, the 40th day, or any other dates.

The day's statistics sheets are submitted to the Regional Secretary/Administrator who would forward them to the ONFP at the end of each month. They will be used as a basis to draw up the monthly statistical report of activities. In addition to the statistical data, produced by the ONPFP staff at the national level, the regional authorities receive additional statistics from their governorate.

d) Regular meetings between senior officials and regional staff members

The General Management of ONFP organizes regular meetings with regional delegates. More meetings with regional secretaries are equally held, along with meetings with supervisory midwives, in order to discuss with each of these participants the state of progress of the program and the difficulties encountered in different areas. These meetings, which are held on a shift system in each area, last for one day only (and rarely two). The decision to hold a meeting once a month, as set forth, in the beginning of the program, is not always respected.

e) Research: studies and surveys

Afin de suivre les activités du programme de PF/SR et d'évaluer leurs impacts sur les familles tunisiennes ainsi que sur l'environnement socioculturel, économique et environnemental du pays, l'ONPFP a entrepris des travaux de recherche souvent à étendue nationale et parfois ponctuelle, avec ou sans la collaboration d'organismes internationaux. Ces travaux de recherche constituent un précieux instrument d'aide à la prise des décisions stratégiques et politiques des décideurs. Nous citons à titre d'exemple les enquêtes suivantes (20):

In order to monitor the activities of the FP/RH program and assess their impact on Tunisian families and on the country's socio-cultural, economic and environmental environment, the ONPFP has undertaken research work, often at a national level and sometimes on an ad hoc basis. This work is conducted jointly with international organizations. This research work is a valuable tool to assist decision-makers in their strategic and political decision-making. The list of the research work conducted is displayed below:

- Tunisian survey on fertility - 1978
- Global survey on fertility - WFS - 1978
- Tunisian survey on the prevalence of contraception methods (CPS) - 1983
- Evaluation of the FP mobile units in Tunisia in 1985 - 1986
- Health and FP survey in the center and south of the country - 1987
- Demography and health survey in Tunisia - 1988
- Tunisian survey on mother and child - 1994
- Tunisian survey on family health - 2001
- Multiple Indicator Cluster Surveys: MICS 3 - 2006
- Multiple Indicator Cluster Surveys: MICS 4 - 2011
- Multiple Indicator Cluster Surveys : MICS 6 - 2018
- Tunisian Health Examination Survey - 2016 The health of Tunisians - ISP - February 2019

All of these follow-up activities (including supervision) have made it possible to ensure the continuity and consolidation of services, as well as the maintenance of satisfactory quality and compliance with established standards and procedures in the areas of education, information and medical practices.

14) EVALUATION OF THE FP MOBILE UNITS DURING 1985 (17)

Among the research studies carried out by the ONFP, there is one that stands out in terms of its subject matter. It is the survey conducted in 1985, entitled "Evaluation of mobile family planning units in Tunisia during 1985". This research (17) "...responds to one of the Office's major concerns, namely the identification of the difficulties and constraints which prevent the 62 mobile units from making the best use of the means available and making the most of the financial and human resources made available to them".

It is the only study of its kind, to be carried out by the ONFP, that discusses a subject closely related to the theme of this work. Due to its paramount importance, the study deserves to be .highlighted in a full paragraph on its own in the present report

a) Presentation :

This work, which was completed in 1985, was carried out jointly by ONFP researchers and the Population Council. The data sources, embedded in the present work, fall under two categories:

- **i)** Service statistics reflecting daily activities.
- **ii)** A questionnaire designed specifically to collect information on vehicles, education activities and the number of women requested to undergo tubal ligation and abortion.

b) Purpose of the study:

The main objective was to measure the profitability of the 63 MU, to analyze the factors influencing profitability and to compare the efficiency of the MU with that of the fixed centers.

In the same vein, the objective was to diagnose the obstacles that prevent MT from making the best use of the resources allocated to them and getting the most out of the funds invested and the human potential made available.

c) Means to measure indicators:

Performance was evaluated through 4 parameters which are: 1) The total number of visits (or consultations) 2) The number of new contraceptive applicants 3) The number of gynaecological visits 4) The estimated duration of fertility blockage through the use of contraceptive methods expressed in Couple Year Protection (CAP).

d) Results:

This study highlighted the important role played by the 63 MIUs (55 MT and 8 MC) in promoting the national FP program by carrying out one third of the total number of activities through education and the delivery of contraceptive services.

1. Geographic coverage:

- **a)** Change in the number of units visited by each type of MT, from 322 in 1971 to 868 in 1985. It has multiplied by 2.65 in 15 years.
- **b)** Number and types of centers: Three-quarters of the centers cover rural areas (rural dispensaries and health care wards).

2. Performance: Average activities per MU

- **a)** Total number visits: the median number of visits per unit is 4027, of which 61% are for contraception urposes.
- **b)** The average gain in Couple Year Protection per MI is 1211 years of protection.

3. Cost :

- **a)** The overall cost of MT is estimated at 44% of the operating budget allocated by the Government.
- **b)** The median annual cost per MT is 15,000 dt ($20,667).
- **c)** Salaries account for 58% of the overall cost of CM.

4. Factors impacting MC performance indices:

- **a)** Several factors come into play to varying degrees, in particular
- **b)** Population density and spread
- **c)** The % of educated population
- **d)** The number of centers served per month
- **e)** The monthly frequency of visits to health centers

f) The annual number of kilometers travelled
g) The level of educational activity
h) The annual number of activity days

5. Activity days : The study showed that the number of days off was very low: out of 296 annual working days, the EM worked for 291 days.

a) 19% of the days off were due to the absence and non-replacement of SF
b) 40 % are due to the non-replacement of the broken down vehicle
c) 40% are due to other factors

The study reports that MC have more days of inactivity than MT due to the fact that they break down more frequently because they work in more rugged and rocky terrain than MT.

6. Comparison of the MU with the non-mobile centers: On average, the MT carried out 1/3 of the program activities with:

1) 32% of the total number of consultations
2) 26% of new contraceptive users
3) 33.4% of follow-up visits
4) 31.3% of gynaecology visits

The study reported one of the major problems faced by CM in coping with the lack of availabililty of midwives in some areas of the southern and central parts of the country. For example, in Kasserine, the MC, that was assigned to this governorate, was never put into operation (1985!) because of the unavailability of a FS. Therefore, the vehicle was transferred to the governorate of Zaghouan.

7. Conclusion and recommendations:

a) The study highlights the high status held by MT within the general program of the ONFP.
b) The study indicates that the rural program consumes 25% of the ONFP's budget, even though it provides only 33% of the program results.
c) On average, the performance and cost of MT are fairly comparable to non-mobile centers.
d) Most vehicles are more than 10 years old and should be replaced.
e) Up to 46% of the cases, the causes of SF absenteeism are for annual leave and 27.8% of cases for maternity.
f) The replacement cost of FS represents 6.3% of the salaries of mobile staff.
g) The cost-effectiveness of MT could be improved through better management to ensure on-going service (availability of staff and operationall condition of the vehicle).
h) Nevertheless, they remain the most practical and cost-effective means of provide education and deliver services to the populations in the underprivileged areas.

15) PROGRAM SHIFT DURING 1984

In 1984, 20 years after the launch of the FP program, the country had already begun to reap the benefits of its population policy. Ito judge by WB statistics (19) for Tunisia, we can state that:

a) The fertility rate (births per woman) rose from 7.01 in 1964 to 4.59 in 1984
b) The fertility rate fell from 7 in 1964 to 5 in 1984
c) Life expectancy at birth increased from 45 years in 1964 to 64 years in 1984.
d) The population, aged 60 and over, rose from 4.3% in 1964 to 6.7 in 1984.

These indicators, and others, that display the evolution of the population and its fertility level, encouraged the political authorities to change the name of the National Office of Family Planning and Population to the National Office of Family and Population. Thus, FP and contraception are no longer the major assets of the program, although they still play an important role among the components of the services provided to the beneficiaries.

16) ADOPTION OF THE CONCEPT 'REPRODUCTIVE HEALTH' AND IMPLEMENTATION OF ITS VARIOUS COMPONENTS

In 1994, the program underwent a further transformation which consisted in including the reproductive health services and their various components, and more notably: combating IST, early detection of breast and cervical cancer, infertility, sexual and reproductive health of young people and combating violence against women. In order to equip itself with the necessary means to implement its new policy, new units have been set up, such as The Information and Documentation Centre, The Audiovisual Production Center, Specific units for young people offering education and sexual and reproductive health services.

More attention was paid to the underprivileged areas with the launch of a specific program called: "Strengthening mobile activities in grey areas".

17) REINFORCEMENT OF MOBILE ACTIVITIES IN THE "GREY AREAS" (20)

In 1993, the State launched a national program aimed at improving the living conditions of people living in the country's poorest areas. 1,817 so-called "grey zones" were identified with the aim of providing paved roads, building and revamping housing, introducing running drinking water and electricity, and building primary schools and community health centers. The ONFP intervened in 1995 in this project with a specific program, conducted thanks to the UNFPA support in 230 areas spread over 9 priority governorates. The project has two phases: The first includes 100 zones and the second covers the remaining 130 zones.

It aims at reinforcing the existing FP services so as increase annually, by 10%, the following 3 aspects among the population of reproductive age: a) knowledge of RH. b) use of FP services. c) handling of modern contraception.

The first stage lasted from July 1997 to September 1999.

Facilitators were selected from these areas and received basic training in IEC in line with the FP/RH program. Equipped with educational materials, these staff members, undertook daily home visits to convey the appropriate educational message and direct MWRA (married woman of reproductive age) to the services offered by the MC..

At the end of the first phase of the project, the results were more than obvious and increased steadily:

1. pre-natal consultations by 29.6% (from 60.7 to 90.3%)
2. assisted childbirths of 19.1% (from 70.2 to 89.3%)
3. 39.9% of post-natal consultations (from 46.2 to 86.1%).
4. 20% contraceptive use (from 43.6 to 63.6%)

Results exceeded, by far, the initial 10% targeted by the project, and knowledge improved by 17%. Also, attendance at FP services reached 24% and contraceptive use amounted to 20%.

The second stage, which is also based on the same strategy, was aimed at reproducing the same work in 130 other grey zones. It was equally spread over two years from 1999 to 2001. Figures and statistics show that results were as satisfactory as in the first stage.

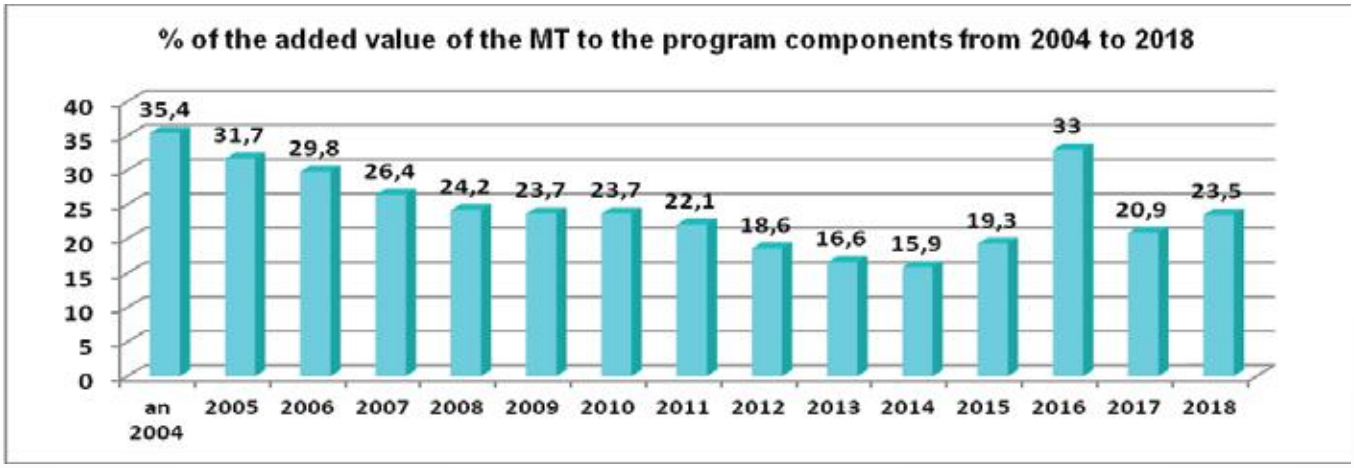
The strength of this project was that the work of educating and preparing the ground for the MC visits was not carried out by the MC of the ONFP in the traditional way, but rather, by accredited facilitators who are operating in their area of origin. As a result, the messages sent out to the population were well received.

18) CONTRIBUTION OF MOBILE SERVICES TO THE GOOD PERFORMANCE OF THE ONFP (21)

We propose to present and discuss, here, the contribution of the mobile units (teams and clinics) to the results of the program, in comparison to those recorded at the level of fixed centers. This has been done over the last 14 years (2004 - 2018). For the sake of comparison, we have retained the total number of the missions undertaken: (FP + SR + pre- and post-natal)

Year	2004	2005	2006	2007	2008	2009	2010	2011
Mobile	208363	210538	188570	167097	155798	156643	172329	136089
Total	289285	664800	632353	633612	644727	659957	728153	616258
%	35.4	31.7	29.8	26.4	24.2	23.7	23.7	22.1

Year	2012	2013	2014	2015	2016	2017	2018
Mobile	199771	105472	102985	132524	157085	142042	154205
Total	644115	634945	645953	688245	714646	6890388	654847
%	18.6	16.6	15.9	19.3	22.0	20.9	23.5



We notice that this diagram goes through two major phases:

1. The first downward trend reflects the gradual and continuous decrease in the share of mobile units at the level of the results achieved within the framework of the program, that will run from 2004 to 2014. This is explained by the progressive decrease in the number of functional mobile units, following the decommissioning of obsolete and hopeless state of vehicles. State budget restrictions did not allow for the purchase of replacement vehicles either. In 1999, the number of MU (teams and clinics) was 100. This number will witness a noticeable decline to drop to 42 in 2014.

2. In return, the second phase, has witnessed an increasing trend from 2015 onwards. This reflects the particular economic situation that the country is going through with a drop in the profitability of public health units, following the shrinkage in the state budget, the repeated strikes and the departure of several medical staff members to join the private sector or to emigrate. The population, then, fell back on the ONFP units, which are still operational and, above all, free of charge. With regards to MU, efforts were made to recover and revamp some of these components. This effort was crowned, in 2018, by the recovery of 48 units: 47 MT and only 1 MC.

Despite these annual changes, it can be noted that the MU are still operational and provide about one quarter of the services targeted by the program. This is considered as a good performance, after all.

19) STRENGTHS AND WEAKNESSES OF THE PROGRAM

An analysis of the MU contribution to the results, recorded by the Tunisian program, reveals the importance of this contribution: in 1985 it accounted for 30% of the activities achieved within the framework of the program (16). In 2018, 33 years later, the share of the same activities was 23.5% (20).

a) Strengths:

The program is characterized by the following strengths:

1. The political will to support the demographic strategy and ensure its integration, right at the outset, within the various development plans.
2. Free services for all social categories.
3. The change in the mindset to shift from a fixed conservative approach towards a better understanding and acceptance of modern-life requirements.
4. The decentralization process to devolve service management to the various regions for more adequate implantation on the ground.
5. Broadening the range of services delivered. Contraceptive activities are further, reinforced, by other measures, related to other maternal and family health services, and subsequently through more actions relevant to reproductive health.

The lessons learned from this experience are focused on the following three main areas:

1. **Process management:** the management of the mobile units ins carried out in conformity with clear and written organizational rules and steps to ensure more cost-effectiveness. Thus, and before the commissioning of any MT, the following preparations have been taken:

   a. Identify the routes according to the proximity of the centers and locations, while taking into account the easiest access of the beneficiaries to the service.
   b. Take the required measures, beforehand, to inform the population, the staff of the centers to be visited, and notify the local authorities of the dates and times of the MT visit.
   c. Set up a coherent team of service providers consisting of a midwife (team leader), a nurse or care assistant and educational staff. The driver plays a key role in safeguarding the rolling stock, given the state of the roads and the distances travelled on a daily basis.
   d. Provide services in accordance with a specific written job description for each team member.

2. To adopt an efficient training and recycling strategy to ensure competent and highly qualified technical staff members, in order to offer quality services that meet the needs of the beneficiaries and guarantee the sustainability of the program. This goes through:

   a. The midwife has a dual competence: in terms of medical knowledge related to SRH/FP and in the field of communication and information.

b. The supervising midwife plays a key role in the success of the program, and notably with regards to mobile units. She is both the technical reference and the leader of the regional staff. She ensures the good quality of services that are delivered to the population in accordance with written standards and procedures.

c. Educational staff members who perform their duty with full respect of the citizens, while disseminating messages and imparting information that encourage them to make free and voluntary use of the program services. The supervisors of the educational personnel guide the facilitators and help them to perform their work in a proper manner.

3. Monitoring of activities and evaluation of impact

a. A standard medical record is made available to FP / SRH service providers, along with an archiving system that facilitates data collection and analysis.
b. A statistical data collection register that allows the evaluation of the profitability and performance of the fixed and mobile consultations as spelled out in the program.
c. Regular meetings convened by CREPF staff to discuss the performance and operation of fixed and mobile services.

It should be noted, however, that these procedures are applied by human beings and that incidental or non-technical deviations are not to be excluded. Yet, the role of supervisors consists mainly in avoiding them and helping service providers to comply with the prescribed standards and procedures.

b) Weaknesses

Among the main obstacles that could impede the proper running of the mobile strategy, relevant to the FP/RH program, we can refer to:

1. The temporary or prolonged shutdown of a MT for a few days or weeks for various reasons, and notably due to:

a. The absence of mobile staff due to leave or illness and inability to ensure the takeover,
b. The unavailability of vehicles, for maintenance or repairing reasons, and for an unpredictable period of time,
c. The vagaries of weather conditions, mostly during rainy seasons, where countryside roads would hard to use for vehicles.

2. The contraception stock-outs that might jeopardize the program performance and would often cause unmet demands and exacerbate people's distrust in the program performance.

3. The poor scheduling of itineraries and the working time, allocated to each center visited, that often proves to be insufficient to meet the needs of the population.

4. the replacement of retiring persons by others who do not have the same level of competence as their predecessors, and who require more training in the technical and communication fields.

5. The scarcity of financial resources to be invested in the program in order to preserve an acceptable service quality.

20) ACKNOWLEDGMENTS

The Tunisian skills, acquired over the last 5 decades, through the national FP/RH program, can be shared with countries that face similar demographic and family health problems, as those experienced by Tunisia. Given the similar nature of the program, it would be safe to adapt to the socio-sanitary, demographic and cultural environments of the countries of the South. The achievements of the FP/RH program, and notably the strategy underlying the FP/RH mobile services, have been welcomed by international organizations that are active in the field.

Furthermore, some of these organizations have rewarded the ONFP for its outstanding performance in terms of population and health policy. Here, we propose to quote the following testimonials:

1. In 1994, and in recognition of the achievements performed by the ONFP program, and notably the CFR, the UNFPA designated Tunisia as a centre of excellence in population for Africa and the Arab world.
2. In 1999, JICA selected Tunisia as a provider of expertise in the field of RH for French-speaking African countries.
3. In 2009, the WHO included the ONFP training and research center to the list of Collaborating Centers for Training and Research in the field of Reproductive Health.
4. In 2008, the UNDP awarded the ONFP a prize for the success of the project implemented, jointly with the ONFP experts, in KOLO, Niger.
5. In 2008, JICA awarded its 1st prize to the ONFP for the exemplary nature of its bilateral and multilateral cooperation.

21) MOBILITY AND TRANSFER OF EXPERIENCES AMONG COUNTRIES OF THE SOUTH

Before talking about the collaboration between the countries of the South, it is important to underscore the key role played by Tunisia in the promotion of South-South cooperation. This move consists in the transfer, of the training program, geared toward the French-speaking African executives in the field of population and FP, from the ULB in Brussels to the International Training Centre (CEFIR) of the ONFP in Tunis, as agreed with the ULB.1990-1993. Subsequently, and after an evaluation of this experience, the CEFIR was designated as a centre of excellence.

Some African countries have benefited from the collaboration of ONFP experts within the framework of a triangular cooperation (Tunisia - Donor - Beneficiary country) (22). In this context, we can cite the following examples:

1. Niger has benefited from a 3-year project entitled "Project to support south-south cooperation in the field of reproductive health" with the support of the French Cooperation, in the KOLLO district which accommodates 350,000 inhabitants. It is a mobile FP/RH project that is focused on the development of local skills, the establishment of a network of mobile teams to serve isolated populations living far from health centers, the implementation of a management system with supervision and evaluation of project activities. The aim of the project was, first and foremost, to improve access to RH services and in particular: the rate of contraceptive coverage - pre- and post-natal - assisted childbirth.

The results of the project were very positive, and where success rates have reached 126% for contraception, 190% for vaccinations and 403.6 for prenatal and 323% for postnatal care.

This success has motivated the WB, UNFPA and JICA to support the promotion of FP/RH services in several areas of Niger such as Niamey, Dosso and Zinder.

2. Chad has conducted a project entitled "Mobile strategy in reproductive health and family planning in the rural region of Mayo Kebbi". The project was carried out with the support of the World Bank and the PPLS2. The overall objective of this project was the implementation of a mobile strategy for the promotion of FP/RH services in the area mentioned above. Here too, the results far exceeded the set objectives, as the following achievement rates show: Prenatal care at a rate of 419% - Postnatal care at a rate of 242.8% - Contraceptive methods at 118% - Vaccination at 183% and population coverage at 133.3%. At the end of the project, the health officials planned to extend the same strategy to all other health centers.

3. Djibouti benefited from a project in partnership with UNFPA entitled "Support for the establishment and management of a reproductive health centre in Djibouti". The two Tunisian experts were entrusted with the organizing of RH services, training providers and producing working documents as well as monitoring the activities and ensuring the supervision work.

4. Mali carried out a project entitled: "Support for the implementation of the reproductive health policy in the Kayes region" in partnership with the "Spanish Agency for International Development Cooperation". The objective of this objective was to contribute to the reduction of maternal and neonatal mortality by improving the use of RH educational and medical services. The Tunisian technical support, provided in this field, allowed the authorities in Mali to focus on the areas of communication and information, training delivery and supervision techniques.

5. Mauritania carried a project entitled: "Support for a national health and reproduction program". This project is supported by the Spanish Agency for International Development Cooperation and covers the capital Nouakchott and the Trarza region. It is scheduled for a period of 5 years (2007 - 2011). The organizers of this project have pledged to reduce maternal mortality by 25% and to support the components of reproductive health, ensure the upgrading of the technical platform and boost the competencies of program managers.

The experiences cited above demonstrate the wide opportunities that exist for the promotion of the health status of populations through collaboration and transfer of know-how among the countries of the South. Hence, the PPD is in a good position to give further impetus to this strategy. Development in the fields of population and reproductive health will continue to depend essentially on the political choices of high-level country officials, the motivation of service providers, the means being deployed and the degree of acceptability of the target populations.

CONCLUSION

More than five decades since the inception of the national FP program, and after going through several stages, it can be stated that the population policy, coupled from the outset with the socio-economic development of the country, has proven to be a relevant and cost-effective approach.

THE MOBILE STRATEGY , underlying service delivery, was not a simple choice but a duty, given the lack of qualified personnel and the limited coverage of the national territory in terms of fixed health units. Starting from the principle, calling for the need to bring activities closer to the target populations, mobile services made it possible to cover front-line health centers and provide the underprivileged rural areas with health facilities.

By mobilizing substantial material resources and employing qualified personnel, this approach has proven to be worthwhile: fertility has fallen to levels compatible with the country's means; population growth, once described as explosive, is now under control; and lastly, the small size of households has largely contributed to the improvement of family living conditions.

However, it is worth taking into account the cost of this program in an environment where budgetary resources are becoming increasingly scarce. A cost-effectiveness study of the mobile strategy would be conducive to a better understanding of this issue.

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